WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
1 W. Wilson St.
Madison WI 53703

To: BadgerCare Plus Handbook Users

From: Jori Mundy, Bureau Director
Bureau of Eligibility and Enrollment Policy

Re: **BadgerCare Plus Handbook Release 23-02**

Release Date: 04/17/2023

Effective Date: 04/17/2023

EFFECTIVE DATE		The following policy additions or changes are **effective 04/17/2023** unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY UPDATES		
4.2.1	**Covered Programs**	Updated to align with policy in Medicaid Eligibility Handbook.
4.2.2	**Exempt Populations**	Clarified verification of identity.
4.2.4.1	**Stand-alone Documentation of Citizenship**	Clarified verification of identity.
4.2.4.2	**Evidence of Citizenship**	Clarified verification of identity.
4.2.4.3	**Evidence of Identity**	Clarified verification of identity.
4.2.7.4	**Child Citizenship Act**	Clarified verification of identity.
4.2.7.5	**Non-U.S. Citizens**	Clarified verification of identity.
4.2.7.6	**Persons in Institutional Care Facilities**	Clarified verification of identity.
4.3.3.4	**Afghan Parolees**	Updated dates. Effective 12/29/2022.
4.3.4	**Public Charge**	Section rewritten. Effective 12/23/2022.
5.2	**Medical Support/Child Support Agency Cooperation**	Updated to align with policy in Medicaid Eligibility Handbook and added an exemption reason.
9.2	**Application**	Updated verification dates. Effective 02/25/2023.
9.3	**Eligibility Reviews**	Updated verification dates. Effective 02/25/2023.
9.4	**Changes**	Updated verification dates. Effective 02/25/2023.
9.4.1	**Date of Death Matches**	Updated to align with policy in Medicaid Eligibility Handbook.
9.9	**Mandatory Verification Items**	Clarified verification of identity.
9.9.1	**Social Security Number**	Updated verification dates. Effective 2/25/2023.
9.9.6	**Income**	Clarified policy on validation of expected annual income. Effective 02/25/2023.
11.1	**Out-of-Home Care (Foster Care)**	Added a placement that is categorically eligible for Foster Care Medicaid.
11.2	**Former Foster Care Youth**	Clarified policy on former foster care youth conditions.
16.2	**#50 Certain Payment Types Related to the COVID-19 Pandemic**	Clarified information on Education Stabilization Fund payments per federal change.

16.9	**Gap Filling**	Section rewritten. Effective 02/25/2023.
18.1.1	**Introduction**	Clarified extension policy.
18.2	**Increase in Earnings**	Clarified extension policy.
18.3	**Increase in Spousal Support or Family Support**	Clarified extension policy.
18.4	**Income Changes During the Extension**	Clarified extension policy.
25.6	**Filing date**	Added introduction sentence.
25.7	**Application Processing Time Frame**	Section rewritten. Effective 02/25/2023.
25.9.2	**Denial**	Clarification on late verification received after the application denial date.
26.1.2	**Late Renewals**	Updated verification dates. Effective 02/25/2023.
28.1	**Overpayments Introduction**	Updated policy on health care member overpayments. Effective 04/01/2023.
28.2	**Recoverable Overpayments**	Section removed.
28.3	**Unrecoverable Overpayments**	Section removed.
28.4	**Overpayment Calculation**	Section removed.
28.5	**Member Notice**	Section removed.
28.6	**Refer to District Attorney**	Section removed.
28.7	**Fair Hearing**	Section removed.
29.2	**Fair Hearings**	Added information from the Income Maintenance Manual decommission.
34	**Legal Guardians, Conservators, Power of Attorney, and Other Representatives**	Updated section title.
34.2	**Legal Guardians and Conservators**	New section.
34.3	**Power of Attorney**	New section.
36	**Applicant and Member Access Rights**	New chapter. Added information from the Income Maintenance Manual decommission.
37	**Releasing Information**	New chapter. Added information from the Income Maintenance Manual decommission.
39.1.2	**Emergency Services Special Rules**	Clarified policy on verification of identity.
39.1.3	**Emergency Services and Public Charge**	New section. Effective 12/23/2022.
41.2.2	**BadgerCare Plus Prenatal Program and Public Charge**	New section. Effective 12/23/2022.
41.3	**Policy for Non-Qualifying Immigrants**	Clarified policy on verification of identity.

4.2 Verifying U.S. Citizenship ~~Verification~~

4.2.1 Covered Programs

The U.S. citizenship verification requirement ~~covers~~applies to all non-exempt applicants and members of ~~any 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)

> ~~**Note**~~ ~~Katie Beckett, TB, and Wisconsin Well Woman Medicaid eligibility are not determined in CWW. If citizenship has already been verified for one of these programs, do not require citizenship verification for applicants in CWW.~~

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 currently receiving Social Security Disability Insurance (SSDI~~).~~) or a Disabled Adult Child benefit (SSDC)
- Anyone currently receiving Supplemental Security Income (SSI) benefits~~.~~
- Anyone currently receiving Medicare~~.~~
- Anyone currently receiving Foster Care (Title IV-E and non-Title IV-E)
- Anyone currently receiving Adoption Assistance
- Anyone who has been eligible for Wisconsin Medicaid or BadgerCare Plus as a Continuously Eligible Newborn (CEN) at any time on or after July 1, 2006~~. This includes~~ (including CENs born on or after July 1, 2005~~.~~)
- ~~The~~Anyone not claiming to be a U.S. citizen

Identity verification is only required in certain situations as part of citizenship verification ~~requirement does not apply to persons who are not~~ . Persons not applying for or receiving any health care benefits~~. This requirement also does~~ and persons who are

not ~~apply~~claiming to ~~persons who~~be a U.S. citizen are not required to verify identity (see SECTION 4.2.4.3 EVIDENCE OF IDENTITY~~claiming to be a U.S. citizen.~~).

Note	Workers must use data exchanges to verify receipt of SSI, SSDI, SSDC, and Medicare prior to requesting verification from the ~~member~~recipient.

Losing Exempt Status

Medicare, SSDI, SSI, Foster Care, and Adoption Assistance recipients lose their exemption from the citizenship verification requirement when their enrollment in these programs ends. However, ~~s continues~~ CENs continue to be exempt after their eligibility for CEN status ends. Their exemption from citizenship requirements is permanent.

4.2.4 Citizenship Verification through Documentation

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 ~~an individual~~ a person presents a stand-alone document, no other citizenship verification is required. See the chart below or Process Help, Section 68.3.2 Stand-Alone Documentation of Citizenship, for a list of ~~stand-alone~~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.

4.2.4.2 Evidence of U.S. Citizenship

For applicants whose U.S. citizenship has not been verified by the Social Security Administration (SSA), if the person was born in Wisconsin, the agency should attempt to verify U.S. citizenship through the online birth query before requesting documentation of U.S. citizenship from the applicant.

If an applicant whose U.S. citizenship has not been verified by SSA 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 68.3.3 Documentation of Citizenship Only ~~, for a list of acceptable 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 ~~individual~~person, under penalty of perjury, who can reasonably attest to the applicant's U.S. citizenship~~, and that contains~~ . 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.

~~For any applicant born in Wisconsin, attempt to verify~~Applicants whose U.S. citizenship cannot be verified by SSA or through ~~the on-line birth query before requesting~~stand-alone documentation of citizenship must also provide documentation of identity (see SECTION 4.2.4.3 EVIDENCE OF IDENTITY~~from the applicant.~~).

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.
Birth Query	A birth record query confirms a person's birth in Wisconsin.

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, or • Was a CEN, but born before July 1, 2006, The infant will be considered a U.S. citizen who has met the citizenship documentation requirement. If citizenship is not verified through a data exchange, identity documentation is still required.
Medical record (doctor, clinic, hospital)	The document must show a U.S. birthplace. An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.
Official Military record of service	The document must show a U.S. birthplace.
Admission papers from nursing home, skilled nursing care facility or other institution	The document must show a U.S. birthplace.
Other MA Program Verified Citizenship	An individual has already provided proof of citizenship while they were receiving Wisconsin Medicaid outside of CARES. For example, use this for members previously enrolled through the Katie Beckett program.
Birth Certificate Paid by IM Agency	A U.S. public birth certificate (paid for by the Income Maintenance agency) showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam, 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	The Department of State issues a DS-1350 to U.S. citizens

of Birth	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.
SAVE database	Using the SAVE system to verify citizenship status for non-citizens who gained U.S. citizenship.
Written Affidavit	If the applicant cannot produce the accepted documents verifying citizenship, then a Written Affidavit may be used. If the documentation requirement needs to be met through an affidavit, the following rules apply: • It must be signed by an individual other than the applicant, who can reasonably attest to the applicant's citizenship, and • That contains the applicant's name, date of birth, and place of U.S. birth. • The affidavits must be signed under penalty of perjury. • The affidavit does not have to be notarized.

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~~, in addition to providing evidence of citizenship,~~), they must ~~also~~ 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~~ The applicant may provide any~~).
- U.S. citizens whose citizenship is verified by SSA or stand-alone documentation of ~~identity listed in the chart below or Process Help, to prove~~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 ~~document has~~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 68.3.4 Documentation of Identity Only~~.~~).

In addition, ~~you~~ 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 ~~individual~~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 and/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, then a Written Affidavit may be used. If the documentation requirement needs to be met through an affidavit, the following rules apply: • It must be signed by an individual other than the applicant, who can reasonably attest to the applicant's identity, and • That contains the applicant's name, and other identifying information such as, age, sex, race,

	height, weight, eye color, or address. • The affidavits must be signed under penalty of perjury. • The affidavit does not have to be notarized. A signed Statement of Citizenship and/or Identity (F-10161) may be used for individuals who are unable to obtain any level of acceptable documentation.

4.2.7 Situations Which Require Special Documentation Processing

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~~). Within the context of the BadgerCare Plus citizenship verification requirement, this means that for any applicant or member claiming citizenship through the CCA, IM workers should not request documentation for that person. In these cases, IM workers must acquire documentation proving the citizenship and identity of at least one U.S. citizen parent. The parent's U.S. citizenship is the basis for the child receiving derivative citizenship.~~) (see Section 4.1.1. Child Citizenship Act).

~~For persons who meet the~~IM workers should not request citizenship ~~verification requirement~~documentation for persons claiming U.S. citizenship through the ~~means allowed in~~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 ~~CCA, this~~child receiving derivative citizenship.

The parent's U.S. citizenship is considered evidence of ~~citizenship. Therefore, this counts for~~ the child's citizenship only ~~and the individual needs to~~. The child must provide another document to verify their identity (see SECTION 4.2.4.3 EVIDENCE OF IDENTITY~~.~~).

~~See~~

4.2.7.5 Non-U.S. Citizens

~~As a reminder, do~~Agencies must not request or require citizenship ~~and~~ or identity documentation from ~~individuals~~persons who have not declared that they are U.S. citizens. Non-U.S. citizens who apply for IM programs are not subject to ~~this~~ the citizenship verification policy. ~~Legal~~Documented non-U.S. citizens are subject to the

verification process through Federal Data Services Hub (FDSH and) and Systematic Alien Verification for Entitlements (SAVE,), and undocumented non-U.S. citizens do not have any status that can be verified (see Process Help, Section 44.2.1.12 Immigrant/Refugee Verification for instructions on using FDSH and Process Help, Chapter 82 SAVE for instructions on using SAVE). Undocumented non-U.S. citizens can apply for Emergency Medicaid or BadgerCare Plus Prenatal Program and shouldare not be subject to the citizenship and identification verification policy.

When an individualA person who had legaldocumented non-U.S. citizen status and subsequently gains gained U.S. citizenship, this is recorded in should be verified through SAVE. Therefore, SAVE can be used to verify these individuals' citizenship. The verification result from SAVE will be "individual is a US Citizen." These individuals still must provide proofProof of identity is still required for these persons.

4.2.7.6 IndividualsPersons in Institutional Care Facilities

Disabled individualsApplicants 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 Inin 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, IMDs, Institutes of Mental Disease (IMD), and hospitals.

4.3 Immigrants

4.3.3 Immigrants Eligible for BadgerCare Plus

4.3.3.4 Afghan Parolees

Afghans and persons with no nationalities who were residing in Afghanistan and subsequently paroled into the United States ~~between~~ on July 31, 2021~~, and~~ through September 30, ~~2022~~2023, are to be treated ~~like they are~~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 ~~like they are~~as refugees when determining their eligibility for BadgerCare Plus if they are one of the following:

- The spouse or child of ~~an individual~~a person paroled ~~between~~on July 31, 2021, ~~and~~through September 30, ~~2022~~2023
- The parent or legal guardian of ~~an individual~~a person paroled ~~between~~on July 31, 2021, ~~and~~through September 30, ~~2022~~2023, who is determined to be an unaccompanied child

All of the above ~~individuals~~persons are to continue to be treated ~~like they are~~as refugees until either March 31, 2023, or the date their parole status expires, whichever is later.

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

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

4.3.4 Public Charge

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

~~Undocumented, non-qualifying, or qualifying immigrants are considered to be a public charge if, while receiving BadgerCare Plus, they are in a medical institution for more than the length of a rehabilitative stay.~~

~~Undocumented, non-qualifying, or qualifying immigrants concerned about being considered a "public charge," should be directed to contact the to seek clarification of the difference between rehabilitative and other types of institutional stays.~~

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 status (get a green card). A public charge is someone who the government believes is likely to rely on cash assistance or government-funded institutionalization for long-term care to survive.

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

For non-U.S. citizens who are subject to public charge determinations, enrolling in 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.

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 ~~applicant or~~ 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 ~~applicant~~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 ~~applicant~~member may be required to:

- Provide verbal or written information known to, possessed by, or reasonably obtainable by the ~~applicant~~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 ~~exempt~~ 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). ~~Check~~Information on children's categories funded by Separate CHIP or state funds is available in the BadgerCare Plus categories table in~~ to determine funding source.~~ Section 51.1 BadgerCare Plus Categories. The child support agency (CSA) will monitor the child's BadgerCare Plus funding source.
- The child under their care is on SSI.
- The parent or caretaker relative is~~:~~ one of the following:
    - Eligible for the BadgerCare Plus Extension~~,~~.
    - A pregnant ~~woman~~person, until the end of the month in which the 60th day after the termination of pregnancy occurs.
    - 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.
- ~~Absent~~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 ~~people~~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 ~~or~~ , 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.

9.2 Application

The time period for processing an application for BadgerCare Plus is 30 days from the date the agency receives the application.

- For paper applications, this 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, this is the date a valid signature is received by the agency.
- For electronic applications from ACCESS or the Marketplace, this is the next business day if the application is delivered weekdays after 4:30 p.m., on a weekend, or on a holiday.~~—~~

Note	The date received may be different from the filing date (see SECTION 25.6 FILING DATE~~. See for information on the filing date.~~).

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

- ~~10th~~20th day after requesting verification~~, or the~~.
- 30th day after the application filing date.

Advise the applicant of the specific verification required. Give the applicant a minimum of ~~10~~20 calendar days to provide any necessary verification.

If verification is requested more than ~~10~~20 days prior to the 30th day, the applicant must still be allowed 30 days from the application filing date to provide the required verification.

9.3 Eligibility Reviews

The group's eligibility should not be denied for failure to provide the required verification until the ~~10th~~20th day after requesting verification or the end of the renewal month whichever is later.~~–~~

Example 1	Fred's eligibility renewal is due in April. He submits a mail-in renewal form on April ~~10~~8. The eligibility worker requests verification of his income on April ~~11~~9. If the verification is not submitted by April 30, his eligibility will end on April 30.
Example 2	Shannon's eligibility renewal was due in June. At~~–~~ adverse action in June a notice was sent to Shannon to let her know her BadgerCare Plus eligibility would end June 30 because she had not yet completed her renewal. A telephone interview was conducted on June 30. A request for verification, with a July ~~10~~20 due date, was sent to Shannon. Because the required verification (including signature) was not submitted by July ~~10~~20, her eligibility beginning July 1 was denied.

Requested verification turned in within three months of the renewal due date should be processed as timely (see~~–~~ SECTION 26.1.2 THREE-MONTH LATE RENEWALS).

9.4 Changes

When a change is reported that requires verification, the member must be notified in writing of the specific verification required and allowed a minimum of ~~10~~20 days to provide it.

9.4.1 Date of Death Matches

~~When a~~ 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 ~~eligible member or~~ applicant or member has died, and the IM agency has not received any other information to confirm the death, the applicant or member, ~~another~~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, ~~renewal or~~ 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 ~~individual~~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 ~~VCL~~verification checklist (VCL) due date logic). The refutation period may only be shortened when either:

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

9.9 Mandatory Verification Items

The following items must be verified for BadgerCare Plus:

- SSN
- Citizenship ~~and identity~~, but only for certain applicants who declare they are U.S. citizens (see ~~-~~ SECTION 4.2 CITIZENSHIP VERIFICATION)
- Immigrant status
- Medical expenses (for deductibles only)
- Documentation for Power of Attorney and Guardianship
- Migrant worker's eligibility in another state (see ~~)~~ Section 12.3 Simplified Application)
- Income
- Health insurance access
- Health insurance coverage (see ~~)~~ Chapter 7 Health Insurance Access and Coverage Requirements)
- Family re-unification plan for child welfare parents (see ~~)~~ Chapter 10 Child Welfare Parents)
- The placement status of a Former Foster Care Youth ~~(see)~~ on their 18th birthday (see CHAPTER 11 FOSTER CARE MEDICAID)
- Tribal membership or Native American descent
- Pre-tax deductions
- MAGI tax deductions
- Huber Law participation, for incarcerated individuals qualifying for the Huber Law exemption (see ~~)~~ Section 45.8.4 Huber Law)

Unless determined questionable, self-declaration is acceptable for all other items.

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 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 ~~must be given a minimum of 10~~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 ~~pended~~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~~).

9.9.6 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).

11.1 Out-of-Home Care (Foster Care)

Children or youth ~~placed into~~in any of the following placements or agreements are categorically eligible for Foster Care Medicaid:

- Foster Care (either IV-E or non-IV-E)
- Active Subsidized ~~guardianship~~Guardianship Agreement
- Court-ordered Kinship Care
- Active Adoption Assistance Agreement

Eligibility determinations for Foster Care Medicaid are not the responsibility of the IM agency. Child welfare agencies determine eligibility for Foster Care Medicaid when a child has been removed from the home and enters an out-of-home care placement, often referred to as Foster Care.

11.2 Former Foster Care Youth

Youths who were in foster care, subsidized guardianships, or court-ordered Kinship Care on their 18th birthday qualify for a special status under BadgerCare Plus when they leave out-of-home care if all the following conditions are met:

1. The youth was receiving foster care (either IV-E or non-IV-E), subsidized guardianship, or court-ordered Kinship Care on the date that they turned 18 years old. It does not matter what state they were residing in when they turned 18 years old.
2. The youth is younger than 26 years old.
3. The youth meets the following BadgerCare Plus eligibility criteria:

    a. Is no longer receiving foster care benefits (which includes subsidized guardianships and court-ordered Kinship Care) but was receiving the benefits on their 18th birthday. Verification of the placement status on their 18th birthday is required.
    b. Provides an SSN- or cooperates in applying for one.
    c. Is a U.S. citizen or national or is a qualifying immigrant.
    d. Provides verification of U.S. citizenship and identity or qualifying- immigration status- or makes a good faith effort to obtain it.
    e. Cooperates with child support enforcement agencies in obtaining medical support (if a parent).
    f. Cooperates with ~~TPL~~ third party liability (TPL) requirements.
    g. Physically resides in Wisconsin and intends to reside in the state.

    ~~a. Is not an inmate.~~

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

Note	If a Former Foster Care Youth (FFCY) is included in another household member's- assistance group (AG~~,~~), their tax filing information may be needed to determine eligibility for those household members.

In addition, they are not subject to the BadgerCare Plus insurance access or coverage policies and are not required to pay any premiums for themselves. Regardless of income, they are eligible for the BadgerCare Plus Standard Plan unless they are found otherwise ineligible or until the end of the month in which they turn 26 years old.

A 12-month recertification renewal is required to continue eligibility.

16.2 Income Types Not Counted

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~~. 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 ~~(HEERF)~~ 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.

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 ~~at or~~ 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 ~~under a process called~~. This is also known as "gap filling."

16.9.1 ~~Processing Gap Filling Referrals~~Annual Income Eligibility Determinations

When a parent, caretaker relative, or childless adult has monthly income above 100% FPL, and ~~**Requests**~~they meet all other eligibility requirements, their eligibility will be determined using their annual income. The annual income limit is 100% FPL.

Gap filling ~~referrals and requests~~ determinations use the expected annual income for the current year. Since the person may ~~be~~not have yet received ~~through any~~the income, documentation of ~~the following:~~

- ~~The Marketplace will transfer an~~ this income may be difficult or impossible to obtain at the time of application ~~as a gap filling referral if it determines that the applicant's~~or change report. Verification of expected annual income is ~~at or below 100% of~~not required. However, the ~~FPL but monthly~~expected annual income ~~is above 100% of~~reported by the ~~FPL.~~
- ~~The applicant's monthly income is above 100% of the FPL, but they provide a copy of their Marketplace denial letter stating they may be eligible for BadgerCare Plus.~~

~~The~~ applicant or member must be validated by the agency using all available information. This may include, but is ~~denied~~not limited to:

- Income reported on the application.
- Income discovered or ~~terminated due to excess monthly~~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 ~~and requests~~.

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 ~~gap filling~~request to the applicant or member for more information.

- This method should also be used when determining eligibility ~~determination.~~

~~The worker initiates a gap filling eligibility determination because it is apparent that the person is ineligible for BadgerCare Plus based on current monthly income but would be eligible~~ under gap filling rules~~.~~ for backdated months (see SECTION 25.8.1 BACKDATED ELIGIBILITY).

~~The IM agency must assess the referral or request to determine the following for each person in the household:~~

- ~~If a person meets the BadgerCare Plus nonfinancial and financial eligibility rules based on their monthly prospective income, BadgerCare Plus should be certified with a 12-month certification period beginning from the first of the month of the Marketplace application date. There is no need to determine the person's eligibility under gap filling rules.~~
- ~~If a person is found ineligible due to a nonfinancial reason, BadgerCare Plus should be denied for the nonfinancial reason for that person. There is no need to determine the person's eligibility under gap filling rules.~~
- ~~If a person has a gap filling referral or request and is found ineligible for BadgerCare Plus solely due to excess monthly income, BadgerCare Plus eligibility must be assessed under gap filling rules (see). This includes eligibility determinations for backdated months.~~

~~16.9.1.1 People Found Eligible Under Gap Filling Rules~~

~~When a person is found eligible under gap filling rules, the IM agency must document in case comments the income used to make the determination and how that amount was calculated. The worker must also clearly document the following information in the case comment:~~

- ~~Name of the eligible person(s)~~
- ~~Assistance group size~~
- ~~Monthly income on which the original BadgerCare Plus denial was based~~
- ~~Annual income~~

- ~~Eligibility begin and end months (The end month will always be December of the calendar year in which the application was filed, unless the member is eligible for gap filling for certain months due to having other eligibility through the remainder of the calendar year.)~~
- ~~Med stat code (The current med stat codes for adults with income between 0% and 100% of the FPL are "BL" for parents/caretakers and "9P" for childless adults.)~~
- ~~Copay limit~~
    - ~~If the annual AG income is less than or equal to 50% of FPL, the member's copay limit is $0~~
    - ~~If the annual AG income is greater than 50% of FPL, the member is in the >50-100% of FPL copay limit tier~~
    - ~~If the member is married and the spouse is also in a health care program with a copay limit and the spouse is not exempt from copays, use the prorated amount. If the member and spouse are in different health care AGs and neither spouse is exempt from copays, the AG with lower income should be used to determine the copay limit tier for both spouses.~~

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	~~Deb applies for BadgerCare Plus on April 14 with no backdate request. Deb provides her paystubs to the IM agency. Deb is found eligible for BadgerCare Plus under gap filling filing rules from April 1 through December 31.~~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 ~~2~~1	~~Katy~~William applies for ~~BadgerCare Plus~~ health care on ~~August 25 with a three month backdate request. She was employed but her~~June 8. He works a seasonal job ~~ended in August. She provides paystubs for May, June, July~~, and ~~August. Her income is over the BadgerCare Plus~~ his monthly income ~~limit for May, June, and July, but she is below the BadgerCare Plus~~ is above 100% FPL, but his annual income ~~limit. Her income~~is below 100% FPL. He is ~~below the BC+~~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 ~~for August and ongoing months. She is eligible for BC+ under gap filling for May, June, and July. She~~has decreased below 100% FPL and provides verification of his new income. William is now eligible ~~under regular~~ for BadgerCare Plus ~~rules for August and ongoing months~~using monthly income. His BadgerCare Plus certification period end date remains May 31.

~~**Note** Because their eligibility is manually certified, childless adults determined eligible under gap filling rules cannot be subject to the premium or treatment needs question requirements (see SECTION 44.2 PREMIUMS FOR CHILDLESS ADULTS and SECTION 44.3 TREATMENT NEEDS QUESTION FOR CHILDLESS ADULTS.~~

~~IM workers should work with their CARES coordinator who~~Renewals will ~~email to indicate when a person has been found eligible~~ be conducted the same as ~~a gap filling referral. The email must include the following items:~~

- ~~Case number~~
- ~~Assistance group size~~
- ~~Monthly income on which the original~~ other BadgerCare Plus ~~denial was based~~
- ~~Annual income~~
- ~~Eligibility begin and end months~~
- ~~Med stat code~~
- ~~Copay limit~~

~~EM CAPO will manually certify the person~~renewals (see CHAPTER 26 RENEWALS for ~~BadgerCare Plus and send a notice of decision informing the person of their eligibility and change reporting rules.~~

16.9.1.2 People Found Ineligible Under Gap Filling Rules

When an applicant is determined ineligible under the gap filling rules, IM workers should document in case comments the income used to make the determination, how that income was calculated, and confirm the denial in CWW to send the notice of decision. IM workers must also send one of the following manual letters, which provide more information about the denial under gap filling rules and next steps:).

- The Member Request Gap Filling Eligibility Determinations Supplemental letter () must be used if both of the following conditions apply:
  - The applicant or member has requested a gap filling eligibility determination.
  - The applicant or member does not have a gap filling indicator or a denial letter from the Marketplace.
- The Marketplace or Indicator Gap Filling Eligibility Determinations Supplemental letter () must be used for gap filling denials when either of the following conditions applies:
  - The agency processes an application for someone with a gap filling indicator.
  - The applicant has received a denial letter from the Marketplace.

A copy of the letter must be scanned into the ECF.

If the applicant contacts their agency about the denial, the IM agency may need to clarify the reason for denial, which should be documented in case comments, and help explain the next steps for the applicant to follow up with the Marketplace in order to get health care coverage. For gap filling referrals from the Marketplace, certain income may not have been reported or may have been inaccurately reported during the Marketplace application process. The applicant can either apply at the Marketplace and report all expected annual income or file an appeal at the Marketplace within the allowable 90-day timeframe if they have applied and been denied for coverage at the Marketplace.

16.9.2 Determining Annual Income for Gap Filling Referrals and Requests

When determining annual income under gap filling rules, use the income reported on the application, income discovered or verified through data exchanges, and other income to determine annual income. This includes, but is not limited to, using wages earned for previous quarters verified through SWICA, wages verified through the FDSH wage match, wages verified through an Employer Verifications of Earnings form (EVFE), or 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 verified through available data exchanges, the IM agency must send a verification request.

This method should be also used when determining eligibility under gap filling rules for backdated months (see) and when determining whether someone would have qualified under gap filling rules as part of reviewing a potential overpayment (see).

When budgeting expected annual income for eligibility in the same calendar year, consider the person's employment history and pattern of employment to determine if they are reasonably expected to have a change in income that would impact eligibility. For example, if an applicant has been working a seasonal job, such as construction or farming, with wages in the second and third quarters and unemployment in the first and fourth quarters of the past several years, it would be reasonable to expect the person to continue that pattern of employment and unemployment unless the person reports a change that indicates they are not returning to that employment.

Example 3	Megan's application has an August 1 filing date and is sent with the Gap Filling Indicator. She reports that she is currently on unemployment and receives $1,452 per month. When the worker is processing the application, there are wages earned for the first quarter in the amount of $7,500, and the unemployment query shows that she was fired in February and that she started receiving unemployment compensation on March 1. Based on income she has already received this year ($7,500 in wages plus $7,260 in unemployment from March to July), she has already received $14,760 this year, which is over 100% of the FPL for a group of one, so she does not meet gap filling rules. Megan is not eligible for BadgerCare Plus. The worker confirms the denial in CWW and sends the Marketplace or Indicator Gap Filling Eligibility Determinations Supplemental letter (F-01915).

Example 4	Greg's application has a November 15 filing date and is sent with the Gap Filling Indicator. He reports that he is currently on unemployment and receives $1,000 per month. When the worker is processing the application, there are wages earned in the second and third quarters of the last three years at a local roofing company. Wages earned so far in the current year total $5,200. Unemployment received so far includes $2,400 received from January through March, $1,000 received in October, and $500 so far in November, for a total of $3,900. He is still filing unemployment and has more than $3,000 available to be paid. To determine

	~~the anticipated income for the remainder of the year, the worker would continue to budget $1,000 for unemployment per month for November and December. Greg's total income expected for the year is $10,600 ($5,200 in wages, $2,400 in unemployment from January through March, and $3,000 in unemployment from October through December). Because his annual income is expected to be under 100% of the FPL, Greg is eligible for BadgerCare Plus under gap filling rules.~~
~~Example 5~~	~~Erin's application has an August 1 filing date and is sent with the Gap Filling Indicator. She reports that she is currently working and earns $1,400 per month (paid biweekly with earnings of $700 per pay period) with no other income. Her job started July 1 and she received one paycheck in July. Her anticipated annual income is $7,700 ($1,400 per month from August through December and $700 for July). Because her annual income is expected to be under 100% of the FPL, Erin is eligible for BadgerCare Plus under gap filling rules.~~
~~Example 6~~	~~Amber and Ryan are married and reside together. Their application has a February 15 filing date and is sent with the Gap Filling Indicator. Amber is currently on unemployment and receives $1,452 per month and reports that they have no other income. When the worker is processing the application on February 28, SWICA shows earnings between $15,000 and $20,000 per quarter for the first, second, and third quarters of each year for the past four years. The unemployment query shows that Amber is currently receiving $1,452 per month, which started October 1 and she has $9,500 remaining to be paid; the query also shows that she received unemployment from October through December for the past four years when laid off from her job. However, the most recent claim shows that Amber was not laid off, she was fired. The worker contacts Amber to clarify that she will not be returning to that job and Amber confirms that in the past, she had been laid off at the end of the season, but she was fired on October 1, and has been on unemployment since then. Because she is not expected to return to that job, their anticipated annual income is $12,404 ($2,904 in unemployment from January through February and $9,500 in unemployment anticipated from March through September). Because their annual income is expected to be under 100% of the FPL, Amber and Ryan are eligible for BadgerCare Plus under gap filling rules.~~
~~Example 7~~	~~Monica submits a BadgerCare Plus application on July 23. She reports that she started a seasonal job in June and that it will end in September. Monica earns $1,500 per month and has no other source of income. Monica believes her income might be over the monthly limit, but will likely be below the annual limit. She contacts the IM agency to request a gap filling eligibility determination.~~ ~~Based on her monthly income, Monica is over the limit for BadgerCare Plus. However, her expected annual income is $6,000 (employment wages from June to September). Because her annual income is expected to be at or below 100% of the FPL, Monica is eligible for BadgerCare Plus under gap filling rules.~~
~~Example 8~~	~~Byron has been enrolled in BadgerCare Plus as a childless adult since October. At the time of his enrollment, Byron had no income. In March, Byron began receiving SSDI income in the amount of $1,500. Since he is over the monthly income limit, his BadgerCare Plus eligibility ends on April 30, and he is sent a notice of decision. Byron contacts the IM agency on May 3, to request a gap filling~~

	~~eligibility determination. Byron's anticipated income is $15,000 (SSDI income in the amount of $1,500 per month for the 10 months from March to December). Since his annual income is expected to exceed 100% of the FPL, Byron is not eligible for BadgerCare Plus under gap filling rules. The worker confirms the denial in CWW and sends the Member Request Gap Filling Eligibility Determinations Supplemental letter (F-01915A).~~
~~**Example 9**~~	~~Samantha applies for BadgerCare Plus on August 20 and reports she will begin receiving SSDI payments in the amount of $1,400 per month beginning in September. Employment queries show that Samantha has not earned any wages for the year. Samantha will be eligible for BadgerCare Plus for August but will be ineligible for September due to her monthly income exceeding 100% of the FPL. Since Samantha had no other annual income, the worker believes that Samantha may be eligible for BadgerCare Plus under gap filling rules. Her expected annual income is $5,600 (SSDI income in the amount of $1,400 per month from September to December). Her annual income is expected to be at or below 100% of the FPL, so Samantha is eligible for BadgerCare Plus under gap filling rules.~~
~~**Example 10**~~	~~Kyle has been enrolled in BadgerCare Plus since April. At the time of his enrollment, he reported his employment ended last February and he filed for unemployment, but he has not yet heard if he qualifies. When processing the application, the IM worker noted in case comments that Kyle had consistent wages from a job he had in the previous year, but his wages for the first quarter were $2,200, which was significantly lower than his wages from the third and fourth quarters of the previous year.~~ ~~On July 25, Kyle contacts the IM agency to report that he started receiving unemployment in the amount of $1,300 per month. The unemployment query confirms that Kyle received unemployment compensation beginning July 1, in the amount of $1,300 per month. He will receive $7,800 for the months of July through December. Based on his monthly income, Kyle would be over the limit for BadgerCare Plus. However, the worker believes that Kyle may still be eligible under gap filling rules based on his expected annual income, which is $10,000 ($2,200 in wages from the first quarter and $7,800 from anticipated unemployment benefits from July to December). His annual income is expected to be at or below 100% of the FPL, so Kyle would be eligible for BadgerCare Plus under gap filling rules.~~

16.9.3 Change Reporting for People Eligible Under Gap Filling Rules

~~People~~Members are still subject to change reporting requirements while enrolled in BadgerCare Plus under gap filling rules. A ~~person~~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.

When a person is no longer eligible for the reasons noted above, the IM agency should inform EM CAPO to end eligibility and send the termination notice. If the person has exceeded the annual income limit during the gap filling certification period, include the person's new reported annual income amount in any communication with EM CAPO when requesting the person's eligibility be terminated.

16.9.4 Certification End Date Under Gap Filling Rules

Because the Marketplace considers annual income on a calendar-year basis, the manual gap filling certification will last until the end of the calendar year. Approximately 45 days prior to the end of the year, members will receive a notice from EM CAPO advising them that their eligibility is ending and directing them to return to the Marketplace (or, if appropriate, to reapply for BadgerCare Plus).

16.9.5 Eligibility Under Another Category of

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 or Medicaid

- If the member becomes eligible in another category ofwill be terminated following adverse action rules (assuming they are not eligible for BadgerCare Plus or Medicaid, the gap filling certification will end. EM CAPO does not send a notice of termination to the member if the gap filling certification ended due to the member becoming eligible in anotherunder monthly income rules or any other category of BadgerCare Plus or Medicaid.).

- ~~18.1 BadgerCare Plus~~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.

16.9.5 Premiums

Childless adults eligible for BadgerCare Plus under gap filling rules do not have a premium.

If a childless adult becomes eligible for BadgerCare Plus based on monthly income, they may have a premium (see Section 44.2 Premiums for Childless Adults).

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 (AGs) monthly income increases above 100% FPL either due to an increase in earned income ~~and/or~~ , spousal support, or both, and otherwise meets the BadgerCare Plus eligibility criteria for people with monthly incomes below 100% FPL.

A parent/caretaker relative or pregnant ~~woman~~person can enter an extension due to ~~an~~ a monthly income increase above 100% FPL in the ~~assistance group's~~AG's earned income, spousal support, or both. The children, stepchildren, and non-legally responsible relative (NLRR) children of the parent/caretaker will also enter the extension at this time, provided they are under age 19, living with the parent/caretakers, and meet the income requirements (see SECTION 18.1.3 CHILDREN~~outlined in .~~).

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.

In late renewal situations, the renewal must have been submitted in the month the renewal is due in order for the family to 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	The Brown family's health 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 family's monthly income is now over 100% of the FPL and no financial verification is required since all members of the family meet the criteria to be eligible under a BadgerCare Plus extension. The Brown family enters into an extension starting August 1.
Example 2	The ~~Brown~~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 3	Janine and her son, Zachary, are open for BadgerCare Plus under an extension, and her daughter, Amy, is open for regular BadgerCare Plus (not an extension). Janine reports

	an increase in income. She will be required to verify her new income since her income is counted when determining Amy's BadgerCare Plus eligibility.

While on the extension, children are not subject to the health insurance access and coverage requirements. ~~For example, having access~~ See Section 7.1 Health Insurance Conditions of Eligibility for the full list of people exempt from the policies related to ~~employer~~ health insurance ~~when the family income increases from 80% to 175% FPL will not make them ineligible for the extension.~~access and coverage requirements.

Example 4	Kevin and his children, 8-year-old Bianca and 12-year-old Tori, are open for regular BadgerCare Plus with monthly income at 80% of the FPL. Kevin reports an increase in income due to moving to a full-time job position. He also reports that he and his children are now enrolled in an employer-sponsored health insurance plan through his job. This earned income increases the household's monthly income to 175% of the FPL, and Kevin and his children enter into an extension. Since children in an extension are not subject to the health insurance access and coverage requirements, Bianca and Tori can enter into the extension, even though children ages 6 through 18 with household income over 156% of the FPL are generally subject to these requirements.

18.2 Increase in Earnings

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 ~~woman~~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:
    1. Increased earnings (of anyone in the same AG~~)~~).
    1. 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 ~~percent~~% 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.

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~~1	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.

18.3 Increase in Spousal Support or Family Support Income Extensions

18.3.1 Support Extensions

If a parent, caretaker, or pregnant ~~woman's~~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 for more information on counting spousal support and family support.~~ (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~~, or~~.
    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.

18.4 Income Changes During the Extension

During an extension, a group or ~~individual's~~person's monthly income may decrease to an amount at or below 100% FPL for the group size and then increase again to exceed the 100% FPL. When the monthly income decreases, the ~~individual~~person will be removed from the extension and placed in regular 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 ~~individual~~person eligible in regular BadgerCare Plus. If income verification is not provided, the ~~individual~~person will remain in the extension for the remaining months.

If the ~~individual's~~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 ~~individual~~person is eligible for a new extension when the monthly income again increases, because they meet all of the criteria above, ~~choose the~~the person will enter into the new extension ~~which gives the longest coverage, and cancel the other~~.

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 regular 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, which would run from November through February. Since the four-month extension would be longer than the current extension, ~~apply~~ the new four-month extension applies.

25.6 Filing Date

~~For health care applications submitted to a local agency, the filing date is the day a signed, valid application or registration form is delivered to the IM agency.~~

The application filing date helps determine when an applicant can start getting benefits if they meet program rules (see SECTION 25.8 BEGIN DATES).

The filing date on an ACCESS application for health care is the date that the application is submitted electronically, regardless of the time of day it was submitted. The filing date on an application received from the Marketplace is the application date listed on the Marketplace application.

The filing date for paper applications is the day a signed, valid application form (F-10101 or F-10182) or registration form (F-10129) is received by the IM agency or the next business day if it is received after the agency's regularly scheduled business hours. When an application is submitted by mail or fax, record the date that the IM agency received the valid application form or the next business day if the application is received after the agency's regularly scheduled business hours.

When a request for assistance is made by phone, the filing date is not set until a valid signature is received by the agency.

Note	The filing date may be different from the date received for application processing purposes (see SECTION 9.2 APPLICATION~~. See~~ for information on the application processing timeline~~.~~).

25.7 ~~Timeframes~~

~~25.7.1~~Application Processing Time ~~Frames Introduction~~Frame

~~All applications received by an~~

The health care application processing period is 30 days. This means that, as a rule, the agency must ~~be processed~~process the application, determine eligibility, and ~~eligibility approved or denied as soon as possible but~~issue a notice of decision no later than ~~30~~the 30th calendar ~~days from~~ day after the date ~~the agency receives~~on which the application~~. For paper applications, this~~ is ~~the date a signed valid application is delivered to the agency~~ received (or the next business day if ~~it is delivered after the agency's regularly scheduled business hours. For phone applications, this is the date a valid signature is received by the agency. For electronic applications from ACCESS or the Marketplace, this is the next business day if the application is delivered after 4:30 p.m., on a weekend, or on~~ the 30th day falls on a weekend or holiday). However, the application processing period must be extended as needed to ensure the applicant has at least 20 days from the mailing date of a ~~holiday.~~

~~This includes issuing a notice of decision.~~

~~IM workers should not delay eligibility for an individual in a household when waiting for another household member's 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).~~

~~Extend the 30-day processing time up~~ request to ~~an additional 10 days, if you are waiting for the applicant to~~ provide ~~additional information. will issue a pending notice indicating the reason for the delay when appropriate entries are made on the Verification Due Page.~~

~~Deny the application for failure to provide information or~~the requested verification~~, if:~~.

1. ~~Requested information or verification is required by program policy to determine eligibility (see), and~~
2. ~~The applicant had the power to produce the information or verification, within the period, but failed to do so, and~~
3. ~~The applicant had a minimum of 10 days to produce the verification.~~

~~Example 1~~Note

For ACCESS and Marketplace applications, 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 ~~A signed application was received on March 15. The worker processed the application on April 7 and requested verification. Verification was due April 17 but was not received by that date. Even though the end of the 30-day application processing period was April 13, the application should not have been denied until April 18 to allow at least 10 days to provide verification.~~). The date received is the date on which the application is delivered to the agency or the next business day if delivered weekdays after 4:30 p.m., on a weekend, or on a holiday.

~~If the agency fails to take action (positive or negative) during the 30-day processing period, and the applicant is subsequently found eligible, determine eligibility using the original filing date.~~

Example ~~2~~1	A signed application ~~was~~is received on ~~May~~March 15. The ~~first day of~~worker processes the ~~30-day period was May 16. The end of the 30-day period would have been June 14. The~~ application ~~was approved~~ on ~~June 20,~~April 7 and requests verification. Verification will be due on April 27 to allow the applicant ~~is determined eligible beginning May 1~~at least 20 days to provide verification.
Example ~~3~~2	A signed application was submitted to the Marketplace on ~~March 2~~February 28. The Marketplace assessed the ~~individual~~person as potentially eligible for BadgerCare Plus and transferred the ~~individual's~~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 ~~March~~February 1.

~~25.7.2 Changes~~

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.

25.9 Denials and Terminations

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 ~~2~~3	James applied for health care and FoodShare on September 13. The IM agency processed the application on September 20 and denied health care for James, but approved FoodShare. James calls the IM agency on October 25 to re-request health care. James must submit a new application for health care since it is more than 30 days since the denial date of his application.

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

Note If someone who was determined eligible for an unmet deductible

wishes to request a new deductible period, a new application is required regardless of when the previous deductible period was established and regardless of whether they or anyone else on the case is eligible for another health care program (see ~~and).~~ Section 17.2.2 Deductible Period (Pregnant Members) and Section 17.3.1 Deductible Period (Children Under 19)).

26.1 ~~Renewal~~Renewals

26.1.2 ~~Three-Month~~ Late Renewals

Most health care renewals received within three months of the renewal month can be processed as a late renewal instead of requiring a new application. This policy applies to the following subprograms:

- BadgerCare Plus
- FPOS
- EBD~~-~~ Medicaid
- HCBW
- Institutional Medicaid
- MAPP
- Medicare Savings Programs (QMB,~~-~~ SLMB,~~-~~ SLMB+,~~-~~ QDWI)

The 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. Members whose health care benefits are closed for more than three months because of lack of renewal must reapply.

Agencies should consider late submission of an online or paper renewal form or a late renewal request by phone or in person to be a valid request for health care. The new certification period should be set based on the receipt date of the signed renewal. If verification is required during the completion of a late renewal, the member has ~~10~~20 days to provide it.

Example 1	Jenny's renewal is due on January 31~~, 2016~~. She submits an online renewal via ACCESS on March ~~15, 2016~~10. If the renewal is processed on the same day and verification is requested, the verification would be due on March ~~25, 2016~~30. If she provides verification on or before this due date and meets all other eligibility criteria for BadgerCare Plus, her eligibility and certification period would start on March 1~~, 2016~~. Her next renewal would be due February 28~~, 2017~~ of the following year.

Note	The three-month period starts after the month the renewal was due. It does not restart when a late renewal has been submitted. If Jenny submits her renewal on March 15 but does not provide verification until May, she will need to reapply after the three-month period that started with her January renewal date.

26.1.2.1 Verification Requirements for Late Renewals

If the BadgerCare Plus renewal was completed timely, but requested verifications were not provided as part of the renewal, BadgerCare Plus can reopen without a new application if these verifications are submitted within three months of the renewal month. The submission of the renewal-related verifications is considered a request for health care. Only the missing verifications must be provided. However, the verifications must include information for the current month of eligibility. If verification is submitted for a past month, a new Verification Checklist must be generated to request the current verification, allowing ~~10~~20 days to submit the verification.

Example 2	Jenny's renewal is due on January 31~~, 2016~~. She completes her renewal on January ~~20, 2016~~5, and a Verification Checklist is generated requesting income verification for the previous 30 days ~~prior to January 20~~. Jenny does not submit the requested verification, and her BadgerCare Plus eligibility is terminated as of January 31~~, 2016~~. On April 27~~, 2016~~, she submits her paystubs for April 10 and April 24. If she meets the eligibility criteria for BadgerCare Plus, her certification period will start on April 1, ~~2016,~~ and her next renewal will be due March 31~~, 2017~~ of the following year. If she had submitted the verification of her income for January, a new Verification Checklist should be generated asking for verification of her current income for April.

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. ~~The dollar amount of an overpayment is the amount of the BadgerCare Plus benefits incorrectly provided or the amount of underpaid premiums, whichever is less.~~ Effective April 1, 2023, DHS and IM agencies will no longer establish new BadgerCare Plus overpayment claims for members.

~~Overpayments can only be recovered if the member received a benefit they weren't entitled to receive, more benefits than they were entitled to receive, or a lower premium than they should have been charged because the member did one or more of the following:~~

- ~~Provided incorrect or incomplete information at application~~
- ~~Provided incorrect or incomplete information at renewal~~
- ~~Failed to report a change they were required to report~~

~~Overpayments not caused by the member, including overpayments caused by the agency, system issues, or timely notice requirements, can't be recovered.~~

~~If a member fails to correctly report income or a change in income which results in monthly income that makes the member ineligible, an overpayment doesn't exist if the member could have been eligible under gap filling rules (see).~~

~~Use the best available information to determine whether an overpayment exists in situations where verification has been requested but has not been provided (see).~~

28.2 Recoverable Overpayments

28.2.1 Date of Discovery and Look Back Period

The date of discovery of the overpayment is the date the worker creates the overpayment claim in the system and an overpayment notice is triggered to be sent to the member.

Most recoverable health care overpayments will have a look back period of 12 months prior to the date of discovery. The look back period for health care overpayments based on fraud convictions or a member receiving duplicate benefits is limited to six years prior to the date of discovery.

Duplicate benefits are defined as situations in which a member moved out of state, enrolled in another state's Medicaid program, and then BadgerCare Plus or Wisconsin Medicaid paid HMO capitation fees or fee for service claims were incurred more than two months after the member moved out of state.

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.

Example 1Note	Max applied for BadgerCare Plus and was determined eligible starting April 1, 2022. In October 2022, Max started a new job but did not report this to his IM agency. Max didn't complete his renewal, so his BadgerCare Plus ended on March 31, 2023. In August 2024, the IM agency discovered his job that was not reported and that his income was over the income limit for BadgerCare Plus. However, the IM agency found that Max misunderstood the change reporting requirements and there was no intention to commit fraud. There is no fraud conviction. The 12-month lookback period applies in this situation. Since the overpayment period is more than 12 months prior to the date of discovery, the overpayment is not recoverable. 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).

28.2.2 Overpayment Claims Minimum Threshold

The minimum threshold for each claim is $500 for recoverable health care overpayments. If the overpaid amount is less than $500, no claim will be established unless it meets one of these criteria:

- Health care overpayments based on fraud convictions
- Overpayments related to a member receiving duplicate benefits

Duplicate benefits are defined as situations in which a member moved out of state, enrolled in another state's Medicaid program, and then BadgerCare Plus or Wisconsin Medicaid paid HMO capitation fees or fee for service claims were incurred more than two months after the member moved out of state.

Example 1	John and his family were determined eligible for BadgerCare Plus starting January 1. John accepted a new job in South Carolina, and he and his family moved there on July 20. John and his family enrolled in Medicaid in South Carolina starting August 1. John did not report their change in state residency to his IM agency in Wisconsin, so capitation payments continued to be made for John and his family. John didn't complete a BadgerCare Plus renewal, so BadgerCare Plus closed December 31. Giving 10 days to report and following adverse action logic, the case would have closed August 31 had John reported the change timely to his IM agency. Two years later, the IM agency discovered that John and his family had duplicate benefits in Wisconsin and South Carolina for more than two months after the move. Since this is a duplicate benefits situation, the lookback period is six years, and the minimum threshold doesn't apply, fee-for-service claims and any HMO capitation payments for September, October, November, and December are recoverable.

See for information on determining the overpayment amount.

28.2.3 Recoverable Overpayment Types

BadgerCare Plus overpayments resulting from any of these reasons are subject to recovery:

- **Applicant or member error**

  Applicant or member error occurs when an applicant, member, or any other person responsible for giving information on the applicant's or member's behalf unintentionally misstates or omits facts at application or renewal, and this results in the member receiving a benefit that they are not entitled to or more benefits than they are entitled to. This can include having lower premiums or other cost share amounts than the member should have had.

  Applicant or member error also occurs when the member, or any person responsible for giving information on the member's behalf, fails to report required changes in financial (for example, income, expenses, etc.) (see) or nonfinancial (see) information that would have adversely affected eligibility, the benefit plan, or the premium amount.

  See for information about when members with eligibility or premium determinations based on income that was reasonably compatible can be subject to overpayments after failing to report required changes in financial information.

Example 1	Joe and his daughter Olivia are on a case. Olivia is open for BadgerCare Plus with a monthly premium of $10. Joe is not open for BadgerCare Plus. In November, Joe's worker learned that Joe had received a raise January 1 that Joe was required to report by February 10. Because of the new family income, Olivia's monthly premium increased to $82. The worker entered the new income in CARES and confirmed the increase in the premium amount for December. Because Joe did not report the increase in income, the premium amount for March through November is incorrect. Following the overpayment calculation policies in SECTION 28.4 OVERPAYMENT CALCULATION, the worker determined that the overpayment amount is $648, which is the difference between the correct premium for March through November (total of $738) and the premium amount that was paid (total of $90). This is a recoverable overpayment because it is within the 12-month look back period and is for an amount that is at least $500.

Example 2	Susan was determined eligible for BadgerCare Plus in January. She was pregnant with a due date of August 15. On February 3, she miscarried but did not report this change to her worker. Her BadgerCare Plus eligibility continued until the worker closed the case effective October 31. Once she was no longer pregnant, she would only have remained eligible for an additional 60 days after the last day of pregnancy through the end of the month in which the 60th day occurs. Susan was not eligible May through October. The change should have been reported in February. Allowing for the 60-day postpartum period, BadgerCare Plus should have closed April 30. The overpayment amount is the amount of the fee-for-service claims and the capitation payments made for her from May through October. This amount is $750. This is a recoverable overpayment because it is within the 12-month look back period and is for an amount that is at least $500.

- **Fraud**

  Fraud exists when an applicant, member, or any other person responsible for giving information on the applicant's or member's behalf does any of the following:

  - Intentionally makes or causes to be made a false statement or representation of fact in an application for a benefit or payment.
  - Intentionally makes or causes to be made a false statement or representation of a fact for use in determining rights to benefits or payments.
  - Having knowledge of an event affecting initial or continued right to a benefit or payment and intentionally failing to disclose such event.
  - Having made application to receive a benefit or payment and intentionally uses any or all of the benefit or payment for

~~something other than the intended use and benefit of such persons listed on the application.~~

~~If there is a suspicion that fraud has occurred, see for information about referral to the District Attorney (DA).~~

~~Overpayments based on fraud convictions have a look back period of six years preceding the date of discovery. The minimum threshold does not apply for these overpayments.~~

- ~~**Member loss of an appeal**~~

  ~~Benefits a member receives as a result of a fair hearing request order can be recovered if the member loses the appeal.~~

  ~~A member may choose to continue to receive benefits pending an appeal decision. If the appeal decision is that the member was ineligible, the benefits received while awaiting the decision can be recovered. If an appeal results in an increased patient liability, cost share, or premium, recover the difference between the initial amount and the new amount or the amount of claims and any HMO capitation payments the state paid for each month, whichever is less.~~

28.3 Unrecoverable Overpayments

28.3.1 Date of Discovery and Look Back Period

Overpayments for periods prior to the look back period are not recoverable.

28.3.2 Overpayment Claims Minimum Threshold

Claims under $500 can only be recovered if the claim meets one of the following criteria:

- Health care overpayments based on fraud convictions
- Overpayments related to a member receiving duplicate benefits

Duplicate benefits are defined as situations in which a member moved out of state, enrolled in another state's Medicaid program, and then BadgerCare Plus or Wisconsin Medicaid paid HMO capitation fees or fee for service claims were incurred more than two months after the member moved out of state.

28.3.3 Non-Member Errors

Overpayments resulting from non-member errors are not recoverable, including these situations:

- The member reported the change timely, but the case could not be closed or the benefit reduced due to the 10-day notice requirement
- Agency error (for example, keying error, math error, failure to act on a reported change)
- Normal prospective budgeting projections based on best available information
- The member's tax filing status is different from what they reported as their expected tax filing status for that year

Example 1	Susan and her daughter Kathy are open for BadgerCare Plus. Susan reported a change in income on April 1. The worker did not process the change until April 28, so it was not effective until June 1. There is no overpayment for May since the change was reported timely, but not acted on by the worker until after adverse action.

Overpayments for any months when rules preventing health care terminations during the COVID-19 public health emergency were in effect are not recoverable. This means benefits issued March 2020 and any months after

March 2020 for which continuous coverage due to the COVID-19 public health emergency is in effect for that member. This includes individuals whose health care was granted, extended, or both due to agency or state error.

In addition, some BadgerCare Plus childless adults were granted health care eligibility effective February 1, 2020, in error. For these individuals, do not initiate recovery for a Medicaid overpayment starting February 2020 and any months after February 2020 when the prevention of terminations policy is in effect.

28.3.4 Gap Filling Eligibility Considerations

If a member fails to correctly report income or a change in income which results in monthly income making the member ineligible, an overpayment doesn't exist if the member could have been eligible under gap filling rules.

For this reason, when researching a potential overpayment due to excess monthly income for a given calendar year, an IM agency must determine that the person surpassed 100% of the FPL based on their annual income before an overpayment can be established. A denial letter from the FFM, gap filling indicator, or specific gap filling request by the member is not required to determine eligibility during the overpayment period under gap filling rules. If the person's annual income has not yet surpassed 100% of the FPL, do not establish an overpayment until there is evidence that the person has surpassed 100% of the FPL. Establishing the overpayment may require waiting until the end of the calendar year for actual income to become available to determine if the person surpassed 100% of the FPL.

Example 1	Richard became eligible for BadgerCare Plus as a childless adult in March of last year and had no countable income. At his renewal in February, Richard reports that he has been working since April of last year. Verification shows that Richard's salary of $2,500 per month came to a countable income total of $22,500. Although Richard exceeded his reporting limit in April, the worker must look at what would have happened had he reported the change timely when determining whether an overpayment occurred. The worker finds that Richard was required to report his change in income no later than May 10. Since verification of his actual income for last year shows that he was over the annual income limit for gap filling, there is an overpayment for June 1 through December 31. The worker then evaluates the overpayment for January and February of the current year. So far, Richard has only received $5,000 in countable income. Because the IM agency doesn't have any information to indicate that Richard's job will not continue for the rest of the year, he would not be found eligible under gap filling rules. However, for benefit recovery purposes, he hasn't yet exceeded the 100% of the FPL annual income limit, so the IM agency can't say definitively

	that he wouldn't have been eligible under gap filling rules. The worker can't establish an overpayment for his eligibility in the current year until Richard's income has been found to be over the annual limit for gap filling coverage. The worker must manually track the case to review the case in January of the next year. In January of the next year, the worker reviews Richard's case for a potential overpayment from January 1 through February 28 of last year and determines his annual income. His earned wages were $6,700 for the first quarter, $5,100 for second quarter, and $4,250 for the third quarter. His fourth quarter wages haven't been updated yet. Based on the information available, Richard has surpassed the annual income limit for last year. His total wages through the third quarter total $16,050. There is an overpayment for the period of January 1 through February 28.
Example 2	Kimmy was eligible for BadgerCare Plus as a childless adult beginning in October of last year. In August of this year, the worker is processing a discrepancy created in July showing that Kimmy has unreported wages from the first quarter of this year. The worker requests verification from Kimmy, which shows that she works 32 hours per week and earns $15 per hour for a total of $1,920 per month. Had Kimmy reported her income timely by February 10, she would have been over the monthly income limit for BadgerCare Plus. SWICA shows that Kimmy has already earned $14,700 this year. Since the worker has evidence that Kimmy has surpassed the annual income limit for this year, the worker can proceed with establishing an overpayment for March 1 through June 30.

While an agency is waiting to verify if a person has surpassed the annual income limit for a potential overpayment, that person could experience changes in circumstances, including but not limited to, changes in income or assistance group size. If more current information is available at the time of determining an overpayment, these changes must be taken into consideration in the determination.

Example 3	Effective February 1, Delia was eligible for BadgerCare Plus as a childless adult with an assistance group size of one. In August, she reports that her 8-year-old daughter, Zoe, has moved into the household, and she plans to claim Zoe as a tax dependent. Beginning in September, Delia is determined eligible as a parent or caretaker adult with an assistance group size of two. In February of the next year, a worker is reviewing a SWICA discrepancy showing that Delia began a job in March of last year, which she did not report. The worker verifies that Delia's income is over the monthly income limit for April through November and sees that she had an annual income total of $14,700 for last year. For part of that period, Delia was in a group size of one and surpassed the annual income limit for a group size of one. However, starting in September of last year, Delia's group size increased when Zoe was added to the case. Taking into consideration the change in group size during the overpayment period and Delia's annual income ($14,700) compared to the annual FPL for a group size of two, there is no overpayment since Delia will be ending the tax filing year with a group size of two and will be below the annual

	income limit for a group size of two.

28.3.5 Eligibility and Premium Determinations Based on Reasonable Compatibility

If a member is not required to verify their earned income at the eligibility or premium determination due to reasonable compatibility and then verifies their earned income at a later date (for example, because verification is required for another program), the verified earnings must be used to determine eligibility and premium amounts. The member cannot be subject to an overpayment because the initial determination was based on income that was reasonably compatible with a data exchange.

If a member is not required to verify their earned income at the eligibility or premium determination due to reasonable compatibility and subsequently fails to report a required income change, the member can only be subject to an overpayment if their new income amount is more than 20% greater than the total income amount that was used to make the eligibility or premium determination.

Example 1	Cameron is a single childless adult with an income limit of $1,215 for BadgerCare Plus. He applies for BadgerCare Plus in January and reports that his earnings are $1,200 per month. The monthly earned income amount reported by Equifax is $1,300 per month. Because Cameron's reported income is below the income threshold and the Equifax-reported income is above the income threshold, the 20% threshold test is applied. The income reported by Equifax ($1,300) is less than the 20% threshold amount (120% of $1,200, or $1,440), so his reported information is reasonably compatible, and he does not need to verify his earned income. In April Cameron applies for FoodShare. Cameron must provide verification of his earned income when applying for FoodShare. His verified earned income is $1,400, and it is discovered that he failed to report in February that his income increased to $1,400. This amount is over the BadgerCare Plus income limit of $1,215, so Cameron is no longer eligible for BadgerCare Plus. However, this amount is not more than 20% greater than the income amount of $1,200 that was used to determine that he was eligible for BadgerCare Plus in January. Therefore, he cannot be subject to an overpayment. The amount that is 20% greater than $1,200 is $1,440. If Cameron's income had increased to an amount greater than $1,440 and he failed to report the increase, he could have been subject to an overpayment.

28.4 Overpayment Calculation

1.
2.
    1.
3.

28.4.1 Overpayment Period

Misstatement or Omission of Fact

If the overpayment is a result of a misstatement or omission of fact during an initial BadgerCare Plus application or renewal, determine the period for which the benefits were determined incorrectly and determine the appropriate overpayment amount (see) within the applicable look back period (see).

Failure to Report

For ineligible cases, if the overpayment is a result of failure to report a required change, calculate the date the change should have been reported and which month the case would have closed or been adversely affected if the change had been reported timely.

Fraud

For ineligible cases, if the overpayment was the result of fraud, determine the date the fraudulent act occurred. The period of ineligibility should begin the date the case would have closed or been adversely affected allowing for proper notice within the applicable look back period (see).

28.4.2 Overpayment Amount

The actual income that was reported or required to be reported is used in determining if an overpayment has occurred. If the information needed to determine if an overpayment exists is incomplete, the best available information is used to determine the overpayment. The amount of recovery may not exceed the amount of the BadgerCare Plus benefits incorrectly provided.

Earned income information available through the State Wage Information Collection Agency (SWICA) or through Equifax from the Federal Data Services Hub (FDSH) can be used as best available information when

determining if an overpayment has occurred. When using these data sources as best available information, Equifax information from the FDSH must be looked at first. If this information is reasonably compatible with what the member reported (see and), there is no overpayment. If there is no Equifax information from the FDSH or it is incomplete, SWICA information can be used. If this information is reasonably compatible with what the member reported, there is no overpayment.

Example 1	Camila is enrolled in Badger Care Plus. On October 1, an IM worker discovers an unreported job for Camila through a SWICA wage match and requests verification of historical wages. The verification due date is October 30. Camila does not provide verification to IM by the due date of October 30. The worker must use the best available information to calculate the overpayment, which is the information from SWICA.

In situations where all attempts to obtain verification are unsuccessful, information is not available in a data exchange, and it is not possible to determine the correct amount of benefits that should have been issued to the applicant or member, an overpayment must not be established.

If the case was ineligible for BadgerCare Plus, the overpayment amount is the amount of fee-for-service claims paid by the state and any HMO capitation payments the state paid, minus any premiums paid during the overpayment period.

If the case is still eligible for BadgerCare Plus for the time frame in question but there was an increase in the premium, the overpayment amount is the lesser of:

- The difference between the premiums paid and the premium amount owed
- The amount of claims and any HMO capitation payments the state paid for each month in question

When calculating the overpayment amount for premiums, the overpayment amount is the difference between the premium paid and premium owed, even if the premium that was paid was $0. Premium adjustments are only made on months where there is an overpayment. If there is a month in which there is no overpayment, then the premium calculation for that month should not be adjusted.

Example 2	Tom and his daughter Candice are on a case. Candice is enrolled in BadgerCare Plus with no premium. Tom is not enrolled in BadgerCare Plus. A renewal for Candice's BadgerCare Plus eligibility is due in June. At the renewal, Tom failed to disclose income from a new second job, which would have resulted in a $55

	monthly premium for Candice. This new information was discovered the following March. Overpayment calculation: 10 months x $55 premium owed for each month (June - March) $550 total premium owed - $ 0 premium paid $550 overpayment The state paid the HMO $475 in capitation payments and $50 in claims each month during that 10-month period for Tom's family for a total of $5,250. Because the difference in premium amounts is less than the claims and HMO capitation payments, the overpayment is the $550 difference in premiums.

28.4.2.1 Deductible-Related Overpayments

If a member error increases a deductible amount before the deductible is met, there is no overpayment.

If the member met the incorrect deductible and BadgerCare Plus paid for services after the deductible had been met, there is an overpayment. The overpayment amount is the difference between the correct deductible amount and the previous deductible amount or the amount of claims and any HMO capitation payments the state paid over the six-month period, whichever is less.

If the member prepaid the deductible but was actually ineligible for the deductible, the amount prepaid toward the deductible is deducted from the overpayment amount.

Example 3	Victoria had a deductible of $2,000 for a six-month period. She met the deductible by paying $1,000 and sending in verification of $1,000 in outstanding medical bills. An IM worker discovers that Victoria moved out of state but did not report the move. After determining her overpayment amount, the worker must decrease the amount overpaid by the $1,000 that Victoria prepaid toward her deductible. The worker wouldn't decrease the overpayment amount by any of the medical bills that helped Victoria meet her deductible.

If the deductible was prepaid with a check that is returned for insufficient funds, an overpayment may have occurred for the benefits that BadgerCare Plus already paid for the member.

28.4.3 Liability

Overpayments are collected from the BadgerCare Plus member, even if the member has authorized a representative to complete the application or renewal for them. Legally married spouses living in the household at the time the overpayment occurred are jointly liable for overpayments. Members under age 18 are not liable for overpayments. Dependent 18-year-olds are not liable for overpayments in cases where their parent or other caretaker relative is the primary person for the case.

If a member age 18 or younger received BadgerCare Plus in error, the member's parent(s) or non-legally responsible relative is liable for the overpayment if the parent or non-legally responsible relative was living with the member at the time of the overpayment.

Other household members who were not enrolled in BadgerCare Plus on the same case during the time the overpayment occurred are not jointly liable for overpayments.

Example 1	Josie is Danielle's authorized representative, and Josie applied on behalf of Danielle for BadgerCare Plus in December. It was later found that Josie did not report some of Danielle's income when she applied, which would have resulted in Danielle being ineligible for BadgerCare Plus. Danielle's BadgerCare Plus case closed March 31. Danielle was determined to be ineligible for BadgerCare Plus from December- March. Danielle is liable for the overpayment. Even though Josie failed to report the information as the authorized representative, Josie is not liable.
Example 2	Alice and Jonas are married, filing taxes separately, and eligible for BadgerCare Plus as childless adults. An IM worker discovers that Alice did not report a new job that would have made her ineligible for BadgerCare Plus. Both Alice and Jonas are jointly liable for Alice's overpayment because they were married and living in the household during the time benefits were overpaid for Alice.
Example 3	Kevin and Linda are married, filing taxes jointly, and claiming their two children Grace (age 20) and Paul (age 22), who live with them as tax dependents. Kevin and Linda are enrolled in BadgerCare Plus as childless adults. Grace is enrolled in BadgerCare Plus as a childless adult on her own case. Paul is not enrolled in BadgerCare Plus. An IM worker discovers that Kevin and Linda earned more income than reported and it would have made them ineligible for BadgerCare Plus. Kevin and Linda are liable for the overpayment. Grace and Paul are not liable for the overpayment for Kevin and Linda's BadgerCare Plus enrollment.
Example 4	Susan applied for BadgerCare Plus for herself and her minor son, Billy, in January. Susan lives with Billy. Susan did not report some of her income when

	~~she applied, which would have resulted in her and Billy being ineligible for BadgerCare Plus. When the IM agency finds out about the income, Susan and Billy's BadgerCare Plus case closes April 30. They were determined to be ineligible for BadgerCare Plus from January-April. Susan is liable for the overpayment for both her and Billy because she is his parent and was living with him at the time of the overpayment.~~

~~28.5 Member Notice~~

~~The member or the member's representative must receive a notice of the overpayment that includes the period of ineligibility, the reason for their ineligibility, the amounts incorrectly paid, and information on arranging for repayment within a specified period of time.~~

~~28.6 Refer to District Attorney~~

~~Overpayments involving suspected fraudulent activity by the member may be referred to the Department of Health Services (DHS) Office of the Inspector General (OIG). If the investigation reveals a member may have committed fraud, the case may be referred to the district attorney, corporation counsel for investigation, or OIG. The district attorney or corporation counsel may prosecute for fraud under civil liability statutes. The agency may seek recovery through an order for restitution by the court of jurisdiction in which the member or former member is being prosecuted for fraud.~~

28.2 Reserved

28.3 Reserved

28.4 Reserved

28.5 Reserved

28.6 Reserved

28.7 ~~Fair Hearing~~Reserved

~~The IM agency's decision concerning ineligibility and amounts owed may be appealed through a fair hearing. During the appeal process the agency may take no further recovery actions pending a decision.~~

~~See for more information on the fair hearings process.~~

28.8 Reserved

28.9 Reserved

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 (DHA-28) or writing a letter with the request and sending it to ~~the~~DHA.

Division of Hearings and Appeals ~~(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 ~~individuals~~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.~~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, ~~and/or~~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~~, and~~.
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.~~3~~ 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. ~~that they may have to pay back any continued benefits received if they lose the hearing decision and 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.~~4~~ 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 ~~and/or~~, judicial review, or both. It is not necessary to request a rehearing before going to circuit court.

29.2.~~5 Recoupment~~7 Hearing Decision

~~If an agency's adverse action is upheld, or~~ 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 ~~is withdrawn or is~~thought to be abandoned~~, any overpayments caused by benefits having been continued~~ 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~~subject to recovery~~

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.

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 legal guardian of the person and the estate, legal guardian of the estate, or legal guardian in general is considered to be the applicant or member's legal guardian for BadgerCare Plus purposes. If a person or entity is one of these legal 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.

A person or entity with the guardian type **legal guardian of the person** is not considered to be the applicant or member's legal guardian for BadgerCare Plus purposes. The applicant or member must appoint the legal guardian of the person as an authorized representative if the applicant or member would like the legal 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 legal 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 legal guardian or conservator can take any action on the application or case on behalf of the applicant or member, unless the guardianship or conservatorship court order limits their powers.

Applicant and member notices and other communications from the agency will be sent to the legal guardian or conservator.

See SECTION 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 legal guardians or conservators.

34.3 Power of Attorney

A person may appoint a power of attorney. A power of attorney may act within the scope of authority granted in the power of attorney appointment.

A durable power of attorney is a person to whom the applicant has given power of attorney authority and agrees that the authority will continue even if the applicant later becomes disabled or otherwise incapacitated. Only a durable power of attorney for finances (may also be known as a durable power of attorney for finances and property) is considered to be the power of attorney for BadgerCare Plus purposes.

If a person has a 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 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 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 a power of attorney.

36 Applicant and Member Access Rights

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.

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).

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.

36.4 Access by Someone Else

An applicant or member may authorize someone else to act on their behalf in gaining access to their case record. This authorized entity has the same right of access to the case record as that of the applicant or member.

This authorized entity can be an attorney but does not need to be an attorney. The applicant or member must complete a release of information form, such as F-02340, if the entity is not 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.

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).

37 Releasing Information

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:

    a. Federal Title IV-E Foster Care program.
    b. Adoption Assistance program.

No other routine disclosure from client records is approved. The applicant, member, or their legal guardian, conservator, or power of attorney must authorize all other disclosures. See Chapter 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.

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.

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.

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.

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.

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.

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.

39.1 Emergency Services Introduction

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 ~~and/or~~ 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).

41.2 Eligibility Requirements

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).

41.3 Policy for Non-Qualifying Immigrants

1. For ~~immigrants who are legally present in the United States~~non-U.S. citizens with documentation, verify~~-~~ immigration status~~-~~ through normal~~-~~ SAVE~~-~~ procedures in order to determine eligibility for BadgerCare Plus. If SAVE verifies the pregnant woman is a non-qualifying immigrant, proceed with determining eligibility for the BadgerCare Plus Prenatal Program.
2. For ~~immigrants~~non-U.S. citizens who ~~do not have legal immigration status~~are undocumented, do not request SAVE verification and continue with the determination of eligibility for the BadgerCare Plus Prenatal Program.
3. A non-qualifying immigrant whose immigration status changes while ~~she is~~they are pregnant and receiving BadgerCare Plus Prenatal benefits must have ~~her~~their eligibility re-determined using the new immigration status. If ~~her~~their new status makes ~~her~~them eligible for BadgerCare Plus for Pregnant Women, ~~she is~~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.