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

To: Medicaid Eligibility Handbook Users

From: Rebecca McAtee, Bureau Director
Bureau of Enrollment Policy and Systems

Re: **Medicaid Eligibility Handbook Release 18-02**

Release Date: 08/10/2018

Effective Date: 08/10/2018

EFFECTIVE DATE		The following policy additions or changes are **effective** 08/10/2018 unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY UPDATES		
1.1.2	Subprograms of Medicaid	Updated names of Medicaid subprograms.
1.1.3.3	Disabled Minors	Added note.
2.3.1	Where to Apply Introduction	Updated text to align with BC+ HB.
2.5.1	Valid Signature Introduction	Updated text to align with BC+ HB.
2.5.1.1	Signatures From Representatives	Updated Authorized Representative to include an organization. Changed links to current forms.
2.5.4	Telephone Signature Requirements	New section.
2.5.5	Valid Signature on the Federally-Facilitated Marketplace Application	New section.
4.1	Who is Nonfinancially Eligible for Medicaid?	Added link to Section 28.14 Home and Community-based Waivers Long-term Care Children's Long-term Support.
5.1	Elderly	Clarified definition of elderly.
5.2	Determination of Disability	Clarified eligibility disability.
5.9.5	Eligibility	Clarified eligibility determination.
7.1.1	US Citizens and Nationals Introduction	Updated requirements for citizen documentation.
7.2.1	Documenting Citizenship and Identity Introduction	Updated requirements for citizen documentation.
7.2.1.2	Exempt Populations	Updated requirements for citizen documentation.
7.2.3	Citizenship Verification through Data Exchange	New section.
7.2.4	Hierarchy of Documentation	Renamed section and updated documentation requirements.
7.2.5	Reserved	Deleted section.
7.2.6.4	Non-citizens	Removed case processing instructions.
15.1.1	Elderly, Blind, or Disabled Fiscal Group	Added MAPP information.
15.1.2	Special Financial Tests for Disabled Minors	Added eligibility information for Children's Long-Term Support Waiver program.

15.3.28	Wisconsin Works Payments	Updated to include CMF+ payments
15.7.2.2	Plan to Achieve Self Support	Updated with PASS information.
16.4.1	Joint Accounts	Added note about joint ownership of stocks and bonds.
17.5.2	Calculating the Penalty Period	Updated amounts and dates.
17.14	Both Spouses Institutionalized	Removed penalty period length.
18.4.6.2.2	Loses Medicaid Eligibility But Remains Institutionalized	Updated Example 4.
18.6.2	Community Spouse Income Allocation	Updated amounts.
18.6.3	Family Member Income Allowance	Updated amounts.
20.3.5	Assets	Added AVS asset verification information.
20.7.1.3	Late Renewals	Updated program name to SSI-related Medicaid.
20.7.3	Date of Death Matches	New section.
20.10	Verification Resources	Updated AVS CWW integration information.
21.4.2.4	Covered Services	Updated NEMT coordination.
21.5	Copayment	Updated age requirements.
21.6.1	HMO Enrollment Introduction	Added MAPP.
22.1.2	Recoverable Services	Reformatted for clarity.
22.5	Representatives	New section.
28.8.1	Home and Community-Based Waivers Long-Term Care Introduction	Deleted text to indicate that Katie Beckett cases are processed outside CARES.
28.14.1	Children's Long-Term Support Waiver Program Introduction	Updated text to clarify CLTS Waiver program.
28.14.2	Children's Long-Term Support Waiver Program	Updated information about the CLTS Waiver program.
39.4.2	Elderly, Blind, or Disabled Deductions and Allowances	Updated effective year and amounts.
39.4.3	Institutional Cost of Care Values	Updated effective year and amounts.

1.1 INTRODUCTION TO MEDICAID

1.1.2 Subprograms of Medicaid

There are different subprograms of Medicaid:

Full-Benefit EBD Medicaid Programs

- *SSI*-related Medicaid
- Medicaid Purchase Plan (MAPP)
- Katie Beckett Medicaid

Wisconsin Well Woman Medicaid (~~MAPP~~

- WWWMA)

Long-Term Care Programs

- Institutional Medicaid~~LTC~~
- Home and Community-Based Waivers (HCBWLTC), including:
  - Community Integration Program I (CIP 1A and CIP 1B)
  - Community Integration Program II (CIP II)
  - Children's Long Term Support Waiver Programs (CLTS)
  - Community Options Program Waiver (COP-W)
  - ~~o~~ Include, Respect, I Self-Direct (~~HCBWLTC~~
  - IRIS)
- Long-Term Managed Care programs:
  - Family Care ~~LTC~~
  - Family Care Partnership ~~LTC~~
  - Program of All-Inclusive Care for the Elderly (PACE)

Limited-Benefit EBD Medicaid Programs

- ~~•~~ Tuberculosis-Related Medicaid (~~PACE~~
- ~~• IRIS~~
- ~~• Katie Beckett~~
- TB MA) ~~related~~
- Medicare Savings Program:
  - Qualified Medicare Beneficiary (~~MSP:~~ QMB)
  - Specified Low-Income Medicare Beneficiary (~~,~~ SLMB)
  - Specified Low-Income Medicare Beneficiary Plus (~~,~~ SLMB+)
  - Qualified Disabled and Working Individual (~~+,~~ QDWI)
  - Emergency Medicaid
- SeniorCare

A person may qualify for~~fit into~~ one ~~(~~or more~~)~~ of the ~~above~~ subprograms listed above, and will be found~~based on nonfinancial factors. A person is~~ eligible if he or she meets all the~~Medicaid nonfinancial and financial~~ requirements for a given subprogram.~~.~~ Individuals who do~~are~~ not qualify under a subprogram listed above~~elderly, blind or disabled~~ may be eligible for BadgerCare Plus. See the BadgerCare Plus Handbook for more information.

1.1.3.3 Disabled Minors

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

Note: EBD Medicaid testing procedures are different from those used for HCBW Medicaid for the Children's Long-Term Support Waiver Program. (See Section 28.14 Home and Community-Based Waivers Long-Term Care Children's Long-Term Support.)

2.3 WHERE TO APPLY

2.3.1 Where to Apply Introduction

The agency (county/tribe or consortium) of the applicant's county of residence should process the individual's application.
~~2.3.2 Intercounty Placements~~
~~2.3.3 Applications Outside Wisconsin~~

~~2.3.1 Where To Apply Introduction~~

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

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

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

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

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

2.5 VALID SIGNATURE

2.5.1 Valid Signature Introduction

The *applicant* or his or her representative (see below) must sign **one** of the following:

- The Paper application form
- The Signature page of the Application Summary, either over the telephone or face to face
- The ACCESS ~~or FFM~~ application ~~form~~ with an electronic signature
- The online or paper Application for Health Coverage & Help Paying Costs from the FFM

- ~~Telephonically~~

2.5.1.1 Signatures From Representatives

An applicant's representative can be one of the following:

~~Except when:~~

~~2.~~1. Guardian: When an application is submitted with a signature of someone claiming to be the applicant's guardian, obtain a copy of the document that designates the signer of the application as the guardian. From the documents provided, ensure that the person claiming to be the applicant's guardian can file an application on his or her behalf. Only the person designated as the guardian of the estate, guardian of the person and the estate, or guardian in general may sign the application. When someone has been designated as the guardian of the estate, guardian of the person and the estate, or guardian in general, only the guardian, not the applicant, may sign the application or appoint another representative.

~~**or**~~

~~4.~~2. *Authorized Representative*: The applicant may authorize someone to represent him or her. An authorized representative can~~must~~ be an individual or~~,~~ ~~not~~ an organization. See Section 22.5 Representatives for more information.

~~If the applicant wishes to authorize someone to represent him or her when applying by mail, instruct him or her to complete the authorized representative section of the application form.~~

If the applicant needs to appoint an authorized representative when applying by telephone or in person, instruct the applicant to complete the Appoint, Change, or Remove an Authorized~~Authorization of~~ Representative form (Person~~,~~ F-10126A or Organization F-10126B). ~~10126.~~

An authorized representative is responsible for submitting a completed, signed application and any required documents.

When appointing an authorized representative, someone other than the authorized representative must witness the applicant's signature. If the applicant signs with a mark, two witness signatures are required.

3. Durable power of attorney (Wis. Stat. ch. 244): A durable power of attorney is a person to whom the applicant has given power of attorney authority and agrees that the authority will continue even if the applicant later becomes disabled or otherwise incapacitated.

   When a submitted application is signed by someone claiming to be the applicant's durable power of attorney:

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

   Do not consider the application properly signed unless both of these conditions are met. An individual's durable power of attorney may appoint an authorized representative for purposes of making a Medicaid application if authorized on the Durable Power of Attorney form. The Durable Power of Attorney form will specify what authority is granted.

   The appointment of a durable power of attorney does not prevent an applicant from filing his or her own Medicaid application nor does it prevent the applicant from granting authority to someone else to apply for public assistance on his or her behalf.

4. Someone acting responsibly for an incompetent or incapacitated person.

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

5. A superintendent of a state mental health institute or center for the developmentally disabled.

6. A warden or warden's designee for an inmate of a state correctional institution who is a hospital inpatient for more than 24 hours.

7. The superintendent of a county psychiatric institution, who has been designated by the county social or human services director, for residents of the institution.~~:~~ The social or human services director may end the delegation when there is reason to believe that the delegated authority is not being carried out properly.

2.5.4 Telephone Signature Requirements

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

1. Create an audio recording of the following:

- Key information provided by the household during the telephone interview
- Signature statement that includes:
  - Rights and responsibilities
  - Attestation to the accuracy and completeness of information provided
  - Attestation to the identity of individual signing the application
  - Release of information

~~1.~~2. Store the audio recording in the ECF.

3. Send the applicant or member a written summary of the information provided during the interview. Include a cover letter that outlines the applicant or member's responsibility to review the information provided and notify the agency within 10 calendar days if any errors are noted.

4. Store a copy of the written summary and cover letter in the ECF.

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

2.5.5 Valid Signature on the Federally-Facilitated Marketplace Application

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

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

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

4.1 WHO IS NONFINANCIALLY ELIGIBLE FOR MEDICAID?

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

1. Be *elderly*, blind, or disabled (~~see~~ Section 5.~~1 Elderly or Section 5.~~2 Determination of Disability, or Section 28.14 Home and Community-based Waivers Long-Term Care Children's Long-Term Support)
2. Be a resident of the state of Wisconsin (see Section 6.1 Residency Eligibility)
3. Be a U.S. citizen or Qualifying Immigrant (see Section 7.1 US Citizens and Nationals)
4. Cooperate with medical support liability (see Section 8.1 Medical Support)
5. Cooperate with *TPL* (see Section 9.1 Third Party Liability)
6. Provide *SSN* or apply (see Section 10.1 SSN Requirements)
7. Pay a premium if required (see Section 11.1 Premium or Cost Share)
8. Pay a community waiver/FamilyCare cost share if required (see Section 11.1 Premium or Cost Share)

5.1 ELDERLY

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

5.2 DETERMINATION OF DISABILITY

Definition of Disability

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

One exception to this~~An individual who~~ is that a MAPP disability determination does not involve the SGA test. ~~blind or disabled is non-financially eligible (~~see Section 26~~4~~.1 ~~Who is Nonfinancially Eligible for~~ Medicaid Purchase Plan Introduction for the *MAPP* disability definition.

~~?).~~ Disability and blindness determinations are made by the *DDB*. ~~in the Department of Health and Family Services.~~ The *IM* agency should submit an application for a disability determination even if the applicant/*member* has already applied for *SSI* or *SSDI* (see Section 5.3 Disability Application Process), except for children applying for home and community-based waivers. An application for a disability determination should only be submitted for these children at the parent's request. ~~).~~

Note that for some long-term care programs, eligibility is based on level of care determinations rather than on a disability determination. For example, there is no disability determination required for children to be eligible for home and community based waivers. The appropriate level-of-care determination as established by the functional screen is used as an indicator of the child's need for services. This is also true for some adults. See Section 28.14 Home and Community-Based Waivers Long-Term Care Children's Long-term Support and Section 38.1 Community Long-Term Care (Non-Institutional Medicaid).

5.9 PRESUMPTIVE DISABILITY

5.9.5 Eligibility

Medicaid coverage based on a Presumptive disability determination ~~Medicaid coverage~~ begins on the date the individual is found presumptively disabled, as indicated by DDB or the receipt of written attestation from a medical profession. If~~on which~~ the presumptive disability determination~~finding~~ is made by ~~DDB or~~ the IM worker, Medicaid coverage should begin the date the complete Medicaid Presumptive Disability form (F-10130) was received by the agency, as long as all other eligibility requirements are met. The effective date should not be delayed based on the date the worker takes action to confirm the case.

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

Example 4: Bob is Jack's son and authorized representative. Bob applied for Medicaid on behalf of his father by telephone on June 20. He reported to the IM worker that Jack had a stroke six weeks ago and is in urgent need of medical services. The IM worker determines that Jack may be eligible based on presumptive disability, but requests that a medical professional complete and sign the Medicaid Presumptive Disability form (F-10130) to attest to the urgent need and impairment. Bob also needs to verify Jack's assets. The completed Medicaid Presumptive Disability form, attesting to the impairment and urgent need, is received by the IM agency on July 2, and verification of Jack's checking account is received July 12. The IM worker processes the verification on July 15. The worker determines that Jack is presumptively disabled and eligible for Medicaid effective July 2.

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

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

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

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

7.1 US CITIZENS AND NATIONALS

7.1.1 U.S.~~US~~ Citizens and Nationals Introduction

To qualify~~All U.S. citizens and U.S. nationals are entitled to apply~~ for ~~and receive~~ Medicaid, persons who are otherwise eligible and declare that ~~if~~ they are U.S. citizens or nationals must provide documentation of their citizenship, unless they are exempt or their citizenship is verified by the Social Security Administration through a data exchange ~~and identity and meet all other eligibility requirements~~.

A U.S. citizen is anyone who:

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

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

7.2 DOCUMENTING CITIZENSHIP AND IDENTITY

7.2.1 Documenting Citizenship ~~and Identity~~ Introduction

~~The Federal Deficit Reduction Act of 2005 requires~~ persons applying for or receiving Medicaid, BadgerCare Plus, or *FPOS* benefits, who have declared that they are a U.S. citizen, must~~to~~ provide documentation of their U.S. citizenship unless they are exempt from this requirement (See 7.2.1.2) or their citizenship is verified by the Social Security Administration through a data exchange~~and identity~~.

Certain documents, such as a passport, are considered verification of citizenship by themselves. These are called “stand-alone documents”. Those who are not exempt from the ~~Agencies must comply with the Medicaid~~ requirement, have not had their citizenship verified by the Social Security Administration and do not provide a stand-alone ~~to~~ document, must provide ~~citizenship and identity in order for the state to obtain federal matching funds. As part of ongoing *DHS* quality assurance initiatives, periodic quality control reviews will be done on randomly selected cases throughout the state to monitor agency compliance. Cases will be examined to determine if proper~~ documentation of~~was used to verify~~ citizenship~~/identity~~ and of identity. ~~if the proper verification code was used. DHS will work with noncompliant agencies to achieve compliance.~~

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

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

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

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

Applicants who are otherwise eligible and are only pending for verification of citizenship (and identity when needed) must be certified for health care benefits within the normal application processing time frame (30 days from the filing date). Applicants are not eligible for backdated health care benefits while pending for citizenship and/or identity. Once verification is provided, the applicant's eligibility must then be determined for backdated health care benefits if they have been requested.

The applicant will have 95 days after the request for verification to provide the requested documentation. If the requested verification is not provided by the end of the 95 days, the eligibility will be terminated with *Adverse Action* notice unless the eligibility worker believes a good-faith effort is being made by the applicant or *member* and the worker chooses to extend the good-faith period. This 95 day period applies to applications, reviews, and person adds. An individual can only receive one 95-day good-faith effort period in his or her lifetime.

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

Note: Do not reverify~~re-verify~~ identity for a person who has had his or her identity verified through the signing of a Statement of Identity for Children Under 18 Years of Age, F-10154.

An electric copy of Documentation submitted by the applicant or member to satisfy the ~~new~~ requirement must be maintained in the case record.

See Process Help Section 68.1 General Citizenship and Identity Verification ~~Requirement Information for Medicaid, BadgerCare Plus, and Family Planning Only Services Benefits~~ for tools that IM workers can use to assist applicants and members in meeting this requirement.

7.2.1.2 Exempt Populations

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

- Anyone currently receiving SSDI or a Disabled Adult Child benefit (SSDC)~~).~~
- Anyone who is currently receiving SSI benefits~~.~~
- Anyone currently receiving Medicare~~.~~
- Anyone currently receiving Foster Care (Title IV-E and Non IV-E)~~).~~
- Anyone currently receiving Adoption Assistance~~.~~
- Inmates applying for or receiving BadgerCare Prenatal Program benefits~~.~~

- AnyoneAll persons who hashave ever been eligible for Wisconsin Medicaid or BadgerCare Plus as a Continuously Eligible Newborn (CEN) born on or after July 1, 2005, are now exempt from ever having to provide documentation of citizenship.

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

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

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

7.2.3 Citizenship VerificationReserved Data Exchange

7.2.4 Hierarchy of Documentation

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

For individuals who meet the selection criteria below, the state will submit a file to the Social Security Administration (SSA) with the person's name, verified Social Security Number (SSN), and date of birth for comparison to SSA's data. If SSA is able to match the individual to its files and verify the declaration of citizenship, no additional verification of citizenship is required.

Only persons meeting all of the following criteria will be selected for the SSA Citizenship Data Exchange/Auto-Update:

- Applying for Medicaid, BadgerCare Plus or Family Planning Only Services (whether

- ~~If an individual needs to verify citizenship and/or identity at the point of application~~ or not they are simultaneously applying for other benefits such as FoodShare)
- Declaring~~renewal, he or she should try~~ to be a US citizen or national
- Provides an SSN
- Is not a member of an exempt population listed in 7.2.1.2
- Citizenship/nationality has not already been verified through other means

Non-exempt BCP applicants/members who do not provide an SSN or whose SSN cannot be verified, must meet~~fulfill~~ the citizenship/identity verification requirement by providing verification as defined in 7.2.4.

7.2.4 Citizenship Documentation

If an individual applying for Medicaid is not exempt from documenting citizenship and the Social Security Administration is unable to verify his or her citizenship through the data exchange, he or she needs to provide documents that verify citizenship (and identity when needed).~~with proof he or she already has available.~~ If an applicant or member contacts the agency, work with him or her to ~~check documentation levels 1 through 5 to~~ determine if anything on the document list in Process Help is readily available to the applicant or member.~~ If an applicant or member was born in Wisconsin, use the online Birth Query to verify citizenship.~~

In certain circumstances the agency can authorize payment of documentation for an applicant or member (see Section 7.2.4.3 Agencies Paying for Documentation).

7.2.4.1 Levels of Documentation

See Process Help Section 68.3 Acceptable Citizenship and Identity Documentation.

Stand-Alone Documentation~~Level 1—Evidence~~ of Citizenship~~ and Identity~~

Stand-alone documentation is a single document that verifies~~Primary evidence documents both~~ citizenship, such as a U.S. Passport. Stand-alone documentation~~ and identity. Primary evidence~~ of citizenship ~~and identity~~ is the most reliable way to establish that the person is a U.S. citizen. If an individual presents a stand-alone document~~documents from level 1~~, no other information is required; however, relatively few Medicaid applicants and members may be able to provide a stand-alone document. See Process Help Section 68.3 for a list of stand-alone documents~~documents from this group~~.

An applicant or member who does not provide a stand-alone document must provide documentation of citizenship and identity.

~~Level 2—~~**Evidence of Citizenship**

If an applicant is unable to provide stand-alone documentation ~~Secondary evidence~~ of citizenship, ~~is~~ the first thing he or she must provide~~next most reliable way to establish someone~~ is evidence or other documentation proving citizenship. (See Process Help, Section 68.3.3 Acceptable Documentation of Citizenship Only for a list.) If an applicant is unable~~U.S. citizen. Many Medicaid applicants and members will be able~~ to provide any of the acceptable~~present~~ documents of citizenship found in Process Help, he or she may submit an affidavit signed by another individual under penalty of perjury who can reasonably attest to the applicant's citizenship, and that contains the applicant's name, date of birth,~~from level 2 during the reasonable opportunity period~~ and place of U.S. birth. The affidavit does not have to be notarized. Provide the applicant with the Statement of Citizenship and/or Identity form, F-10161.~~should be encouraged to do so.~~ Note~~, however,~~ that a citizenship document ~~from this group~~ is evidence of only U.S. citizenship ~~only~~ and must be accompanied by evidence of identity.

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

~~**Level 3—**~~**Evidence of Identity**~~**Citizenship**~~

If an applicant~~Third level evidence of U.S. citizenship~~ is ~~acceptable and may be presented by applicants and members who are~~ unable to provide stand-alone documentation of citizenship, in addition to providing evidence of ~~obtain level 1 or level 2 evidence during the reasonable opportunity period. As with level 2 evidence, a document from this group is evidence of U.S.~~ citizenship, they ~~only and~~ must also provide ~~be accompanied by~~ evidence of identity. (See Process Help, Section 68.3.4 Acceptable

~~**Level 4—Evidence of Citizenship**~~

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

~~**Level 5—Evidence of Identity**~~

~~Level 5 documentation can only be used to verify identity.~~ Documentation of Identity Only for a list.)~~citizenship from levels 2 through 4 must be accompanied by evidence of the applicant's or member's identity.~~

~~The applicant may provide three or more corroborating documents, such as a marriage license, divorce decree, high school or college diploma, property *deed* or title, death certificate, or employer ID card, to prove identity. This option can only be used if~~ the

applicant may provide anysubmitted level 2 or 3, not level 4, citizenship documentation of identity listed in Process Help, to prove identity, provided such document has a photograph or other identifying information sufficient to establish identity, including, but not limited to, name, age, sex, race, height, weight, eye color, or address. The applicant may not use a document that was also used for citizenship verification.

In addition, you may accept as proof of identity a finding 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. If the applicant does not have any documentation of identity and identity is not verified by another Federal or State agency, he or she 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. Provide the applicant with the Statement of Citizenship and/or Identity form, F-10161.

7.2.4.2 Reserved

7.2.4.2 Naturalized Citizens

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

7.2.4.3 Agencies Paying for Documentation

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

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

Note: If a member has obtained and already paid for his or her own documentation and later asks the IM agency for reimbursement of those costs, the IM agency should not provide reimbursement. If an individual has requested and paid for documentation before applying but does not yet have the documentation, do not confirm program eligibility for this individual. Eligibility can only be granted once the individual receives documentation and provides it to the agency.

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

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

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

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

7.2.4.4 Tribes With an International Border

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

7.2.5 Reserved~~Policy for Special Populations~~

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

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

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

- ~~Are physically or mentally incapacitated and whose condition renders them unable to provide necessary documentation.~~
- ~~Are chronically homeless and whose living arrangement makes it extremely difficult to provide the necessary documentation.~~
- ~~Are minors.~~
- ~~Have religious beliefs that prevent them from securing the documentation.~~

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

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

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

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

- Hospital "souvenir" birth certificate
- Baptismal certificate
- Native American documentation

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

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

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

1. The Statement of Citizenship and/or Identity for Special Populations form, F-10161, can be used to meet the new requirement only when no other documentation is available from levels 1-5 or number one above.

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

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

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

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

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

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

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

7.2.6 Situations Which Require Special Documentation Processing

7.2.6.4 Non-citizens

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

process through SAVE and undocumented non-citizens do not have any status that can be verified. Undocumented non-citizens can apply for Emergency Medicaid or the BadgerCare Plus Prenatal Program and should not be subject to the citizenship verification policy.

When an individual who had legal non-citizen status subsequently gains U.S. citizenship, this is recorded in SAVE. Therefore, SAVE can be used to verify these individuals' citizenship. The verification result from SAVE will be used to verify these individuals' citizenship. The verification result from SAVE will be "individual is a US Citizen." See Process Help Chapter 82 SAVE for instructions on using SAVE. ~~Use the <SV> code in the Medicaid Citizenship Verification field when using SAVE for this population.~~ These individuals ~~do~~ still need proof of identity ~~since the SAVE verification is considered to be Level 2 citizenship documentation~~.

15.1 INCOME INTRODUCTION

15.1.1 Elderly, Blind, or Disabled Test Fiscal Group

An *EBD* fiscal test group (FTG) usually includes the individual who is non-financially eligible for Medicaid and anyone who lives with him or her and who is legally responsible for him or her. EBD fiscal test groups are groups~~will always be a group~~ of one or two. Spouses who live together are in each other's FTG~~fiscal group~~. This means that the income and assets of both spouses are counted when determining Medicaid eligibility for either or both spouses. The FTG~~fiscal group~~ size for this ~~situation or~~ living arrangement is two.

There are some exceptions to this Policy:

Blind or disabled minors (or dependent 18-year-olds):~~concept.~~ A blind or disabled *minor* (or *dependent 18-year-old*) living with his or her parents would be a one-person FTG~~fiscal group~~. Special instructions for deeming parental income to the disabled minor are described in Section 28.14 Home and Community-Based Waivers Long-Term Care Children's Long-Term Support. ~~15.1.2 Special Financial Tests for Disabled Minors.~~

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

- Medicaid Purchase Plan (MAPP): The applicant's children are also included in the FTG of a MAPP applicant or member, so the FTG for this program could be greater than two people. See Section 26.2.2 Fiscal Test Group for more information.

An individual applying for Long-term Care Medicaid, including Institutional Medicaid, *HCBW*, Family Care, *PACE*, Partnership, or *IRIS*, would be a one-person fiscal group. If the individual is married, refer to Section 18.1 Spousal Impoverishment Introduction for special instructions regarding spousal impoverishment procedures.

15.1.2 Special Financial Tests for Disabled Minors

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

The disabled minor is a separate fiscal group of one. A child who is an SSI recipient is not considered to be a household member and therefore not included in any of the following procedures. The following procedures are also different from those used to test for HCBW Medicaid eligibility for the Children's Long-Term Support Waiver Program (see Section 28.14 Home and Community-Based Waivers Long-Term Care Children's Long-Term Support).

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

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

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

1. For each ineligible child in the household:

    a. Subtract the ineligible child's unearned and earned income from the EBD Deeming Amount to an Ineligible Minor (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances).
    b. The remainder is the amount to be allocated to the ineligible child from parental gross unearned income. Subtract this amount from the parental unearned income.

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

2. If there was any remaining parental unearned income from step 1(~~.~~ b).~~.~~, subtract $20, the general income exclusion, from the amount.

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

3. Starting from what is left of the parental earned income, first subtract $65, and then subtract half of the remainder.

4. To this remaining parental earned income, add any parental unearned income remaining after steps 1(~~.~~ b).~~.~~ and 2. This is the total parental income.

5. From the total parental income, subtract the appropriate Parental Living Allowance (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances). Use the amount for an individual if one parent lives in the home or the amount for a couple if both parents, or one parent and a spouse, live in the household.

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

6. Divide the parental deemed income equally among the eligible children. Use the EBD-Related Determination Worksheet (Worksheet 06) (see Section 40.1 Worksheets Table of Contents) to calculate each child's Medicaid eligibility.

Example 1: Mr. and Mrs. Darwin have two children. Matthew, eight years old, is disabled, and is the eligible child. Jenny, 10 years old, is the ineligible child. Neither child has income. The Darwins have no unearned income. Parental earned income is $2,775 a month.

EBD deeming amount to an ineligible minor (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances) = -$375

Remaining earned income $2,400
General income exclusion -$20
Remaining earned income $2,380
Earned income exclusion -$65

Remaining earned income $2,315
1/2 remaining earned income -$1,157.50

Parental living allowance -$1,125

Income deemed to eligible child = $32.50

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

Unearned income = $390.00

EBD Deeming Amount for two ineligible minors (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances) -$750.00

After subtracting this from unearned income, there is $360 remaining allocation that can be applied to earned income.

Lawrence's earned income $2,050
Excess allocation -$360

Remaining earned income $1,690
General income exclusion -$20

Remainder $1,670
Earned income exclusion -$65
Remainder $1,605
1/2 remaining earned income -$802.50
Parental living allowance -$750

Income deemed to eligible child $52.50

15.3 EXEMPT AND DISREGARDED INCOME

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

15.3.28 Wisconsin Works Payments

Disregard W-2 stipends and payments, including Case Management Follow-up Plus (CMF+) payments, made directly to a member as part of his or her participation in W-2. Earnings obtained through W-2's subsidized employment programs, such as Trial Jobs or Transform Milwaukee Jobs, are countable earned income.

15.7 INCOME DEDUCTIONS

15.7.2 Special Exempt Income

15.7.2.2 Plan to Achieve Self-Support ~~Plan~~

A member whose eligibility is based on blindness or *disability* may deduct income that is received under an approved plan to achieve self-support (PASS). A PASS~~plan. This~~ allows qualifying blind or disabled individuals~~a handicapped person~~ to receive income and accumulate resources for training or purchasing equipment necessary for reaching employment goals that will lead to self-~~self~~ support. Where all requirements are met, income from any source, earned or unearned, is deducted and allowed to accumulate to the extent specified in the plan.

To qualify for this deduction, the member must perform in accordance with the plan. The plan must:

- Be specific, current, and in writing.
- Be approved by the Social Security Administration as verified by submission of the plan and the Social Security Administration's approval letter~~county or tribal agency~~.
- Specify the amount to be set aside and the expected cost and time required to accomplish the objective.
- Provide for identification and segregation of goods and money accumulated and conserved.

16.4 ACCOUNTS

16.4.1 Joint Accounts

Account means a deposit of funds with a financial institution (bank, savings and loan, credit union, insurance company, investment~~brokerage~~ firm, etc).~~.)~~.

Apply the following policy to accounts where the account holders have equal access to the funds.

Note: The following policy does not apply to joint ownership of securities such as stocks and bonds. Shares of stock represent ownership in a business, and their value shifts. Absent evidence to the contrary, assume each owner owns an equal share of the value of the security. For example, two owners would each own 50% of the value. The individual's stock certificate or statement of account should indicate their ownership percentage.

17.5 PENALTY PERIOD

17.5.2 Calculating the Penalty Period

For divestments on or after January 1, 2009, the divestment penalties are calculated by~~in~~ days using the average daily nursing home private pay rate. The rate effective July 1, 2018~~2017~~ is $286.15~~278.05~~. This rate may be updated annually (see Section 39.4.3 Institutional Cost of Care Values).

CWW will calculate the penalty period once a worker enters the appropriate information into the Transfer/Divestment of Assets page, runs eligibility, and confirms.

Example 1: Jeff applied for Family Care. One month earlier, Jeff had transferred $18,500 in cash to his son. At the time of application, Jeff is otherwise eligible for Family Care. Since $18,500 divided by $286.15~~278.05~~ equals 64.65~~66.53~~ days, CWW will calculate a divestment penalty period of 64~~66~~ days for Jeff.

17.14 BOTH SPOUSES INSTITUTIONALIZED

If the *community spouse* made a divestment that resulted in a penalty period for the institutionalized *spouse* (see Section 17.4 Exceptions), ~~2. b.),~~ split the remaining penalty period between the spouses at the time the community spouse enters an institution, applies for Medicaid, and is found otherwise eligible.

Example ~~1~~: Joe is in a nursing home. Joe's wife, Mildred, is his community spouse. Joe inherited $84,000 and immediately transferred it to Mildred. Mildred gave it to her church. This divestment resulted in a penalty period ~~of 26 months~~ for Joe. Now Mildred is entering the nursing home and applying for Medicaid. The time that remains on Joe's penalty period must be apportioned to both spouses.

The penalty period must be apportioned follows:

1. Find the *divested amount* that was used to calculate the original penalty period.
2. Calculate how much of the divested amount remains to be satisfied by:
   a. Multiplying the average nursing home private pay rate used to calculate the original divestment penalty period times the number of days of the penalty period already served.
   b. Subtracting the result from the original divested amount.
3. Calculate the penalty period for the remaining divested amount by using the current average nursing home private pay rate.
4. Divide the new penalty period equally between the two spouses.

CARES will calculate the new penalty period and amount left to be served for workers to apportion to the spouse's case.

If either spouse leaves the institution or dies, add the remainder of his or her penalty period to the other spouse's penalty period.

18.4 SPOUSAL IMPOVERISHMENT ASSETS

18.4.6.2.2 Loses Medicaid Eligibility but Remains Institutionalized

If the institutionalized spouse remains in the institution and remains Medicaid eligible after the 12-month transfer period but subsequently becomes ineligible and remains institutionalized, spousal impoverishment asset rules would not be applicable if he or she should reapply.

If the institutionalized spouse reapplies for Medicaid, his or her asset limit would be $2,000~~,~~ and the community spouse's assets would not be counted.

If eligible, the institutionalized spouse would still be allowed to allocate some of his or her income to the community spouse.

Example 4: Gregory was institutionalized in December 2007. Gregory and his wife, Marcia, who remained in the community, passed the joint asset test. Gregory was found eligible and had until November 2008 to get under the $2,000 asset limit. By November 2008, Greg had transferred enough assets to Marcia to get under the asset limit.

In March 2009, while Gregory remained institutionalized, he refused to sign over to Medicaid a health insurance payment check. His Medicaid eligibility was discontinued March 31, 2009~~2005~~, for failure to cooperate with *TPL* requirements. Greg has never left the institution and now reapplies for Medicaid on June 3, 2009. Since Greg did not leave the institution for 30 days or more since his original Medicaid spousal impoverishment application was approved (December 2007), the assets of his community spouse are not counted when determining eligibility for the application filed June 2009. Greg's asset limit for this application is $2,000.

18.6 SPOUSAL IMPOVERISHMENT INCOME ALLOCATION

18.6.2 Community Spouse Income Allocation

To determine how much of the institutionalized spouse's income to allocate:

1. The community spouse maximum income allocation is one of the following:
   a. $2,~~706.66~~743.34 plus excess shelter allowance (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances) up to a maximum of $3,090.00.

      "Excess shelter allowance" means shelter expenses above $~~812~~823.00. Subtract $~~812~~823.00 from the community spouse's shelter costs. If there is a remainder, add the remainder to $2,~~706.66~~743.34 (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances).

      Community spouse shelter costs include the community spouse's expenses for:

      - Rent~~.~~
      - Mortgage principal and interest~~.~~
      - Taxes and insurance for principal place of residence. This includes renters insurance.
      - Any required maintenance fee if the community spouse lives in a condominium or cooperative.
      - The standard utility allowance established under FoodShare:

If the community spouse pays:	Add:
Heat and utilities	Heating Standard Utility Allowance*
Utilities only	Limited Utility Allowance*
Telephone only	Phone Utility Allowance*
If the community spouse lives in a condominium or cooperative where the maintenance fee includes utility expenses, reduce the standard utility allowance by the amount of utility expenses included in the maintenance fee. * See the FoodShare Wisconsin Handbook Section 8.1.3 Deductions for the current standard utility allowance amounts.	

      For *HCBW* cases, follow these rules to determine when to add the excess shelter cost to the community spouse income allocation:

      - If the waiver person's community spouse lives with him or her, do not add the excess shelter cost to the income allocation.
      - If the waiver person's community spouse does not live with him or her, add the excess shelter cost to the income allocation.

b. A larger amount ordered by a fair hearing decision or a court order. A court or fair hearing can increase the community spouse income allocation if it determines the spouse is not able to provide for his or her necessary and basic maintenance needs with the amount allocated.

2. The maximum allocated amount is the difference between the allowable community spouse income allocation and the community spouse's monthly gross income. Use the *EBD* income rules, but do not give earned income, unearned income, and work-related deductions.

   The institutionalized spouse may choose to allocate less than the maximum amount.

18.6.3 Family Member Income Allowance

The institutionalized person can allocate up to $~~676.66~~685.83 per month to each dependent family member who lives with the community spouse.

The allocated amount is the difference between $~~676.66~~685.83 and the actual monthly income of the dependent family member.

20.3 MANDATORY VERIFICATION ITEMS

20.3.5 Assets

Verification of countable assets is mandatory.

Example 1: An EBD Medicaid member's burial plot is not counted in determining his or her Medicaid eligibility. Do not require verification of its value in determining the group's Medicaid eligibility.

If reported assets exceed the asset limit, do not pursue verification.

Do not verify cash on hand.

Verify assets using the Asset Verification System (AVS) integrated within CARES Worker Web. If current asset information is not available through AVS, the applicant/member is required to verify their assets through other sources (for example, bank statements). Assist the applicant/member in obtaining verification if he or she has difficulty in obtaining it.

20.7 WHEN TO VERIFY

20.7.1 Application and Renewal

20.7.1.3. Late Renewals

Effective December 22, 2014, agencies must accept and process health care renewals and renewal-related verifications up to three calendar months after the renewal due date. Late renewals are only permitted for individuals whose eligibility has ended because of lack of renewal and not for other reasons. *Members* whose health care benefits are closed for more than three months because of lack of renewal must reapply.

This policy will apply to the following programs:

- BadgerCare Plus (BC+)~~+).~~
- Family Planning Only Services (FPOS))~~).~~
- SSI-related~~Elderly, Blind or Disabled~~ Medicaid ~~(EBD MA).~~
- Home and Community-Based Waivers (HCBW))~~).~~
- Institutional Medicaid~~.~~
- MAPP~~.~~
- MSP (QMB/SLMB/SLMB+/QDWI))~~).~~

The policy will apply to members receiving health care benefits based on a met deductible, but not to members with an unmet deductible.

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

> **Example 3:** Jenny's renewal is due on January 31, 2015. She submits an online renewal via ACCESS on March 15, 2015. If the renewal is processed on the same day and verification is requested, the verification will be due on March 25, 2015. If she provides verification on or before this due date and meets all other eligibility criteria, her eligibility and certification period will start on March 1, 2015. Her next renewal will be due February 28, 2016.
>
> The three-month period starts from the month the renewal was due. It does not restart when a late renewal has been submitted.

Example 4: Jenny's renewal is due on January 31, 2015. She submits an online renewal via ACCESS on March 15, 2015. If the renewal is processed on the same day, and verification is requested, the verification will be due on March 25, 2015. If Jenny does not provide verification until May, she will need to reapply after the three-month period that started with her January renewal date.

If a member has a gap in coverage because of his or her late renewal, he or she may request coverage of the past months in which the gap occurred and must provide all necessary information and verifications of income and assets for the current month and the gap months and must pay any required premiums to be covered for those months.

Because QMB coverage is not retroactive, the ability to request coverage for past months does not apply for this program.

Example 5: Jenny's renewal is due on January 31, 2015. She completes her renewal on January 20, 2015, and a VCL is generated requesting income verification for the 30 days prior to January 20. Jenny does not submit the requested verification, and her BadgerCare Plus eligibility is terminated as of January 31, 2015. On April 27, 2015, she submits her paystubs for April 10 and April 24. If she meets the eligibility criteria for BadgerCare Plus, her certification period will start on April 1, 2015, and her next renewal will be due March 31, 2016. If she had submitted the verification of her income for January, a new VCL should be generated asking for verification of her current income for April.

20.7.3 Date of Death Matches

When a Social Security Administration data exchange indicates that an eligible member or applicant has died and the IM agency has not received any other information to confirm the death, the member, another family member, or the member's representative must be allowed 10 days to correct any misinformation prior to benefits being impacted. For ongoing cases, the member for whom a death match was received will still be considered to be alive and benefits for the member or others on the case will not be changed or pended during this time. The case should be pended when verifications, such as earned income, are needed. Benefit changes due to changes in eligibility will still need to be processed. However, for an application, person add or renewal, it means allowing at least the minimum 10 days for a response before a worker confirms eligibility for the application, renewal or person/program add.

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

- A member, family member, or his or her representative, confirms the date of death.
- A worker verifies a date of death through a third party source, such as a local newspaper obituary.

At the end of the refutation period, if no response is received from the member/applicant or the household, the date of death is considered verified and eligibility for the household must be redetermined and a notice of decision issued.

20.10 VERIFICATION RESOURCES

Workers can verify many sources of information, such as income, Social Security, *UC*, and birth records, through data exchanges. See Process Help Handbook Chapter 44 Data Exchange for instructions.

Verification of liquid assets can ~~also~~ be obtained electronically using the Asset Verification System (~~at renewal via IntegriMatch, Wisconsin's *AVS*~~). For instructions on using AVS, see Process Help Section 50.4~~3~~ Asset Verification System (AVS).

Verification of immigration status can be obtained through the SAVE system. For instructions on using the SAVE system, see Process Help Handbook Chapter 82 SAVE.

21.4 COVERED SERVICES

21.4.2.4 Transportation Coordination

NEMT is coordinated by the *DHS* NEMT manager, Medical Transportation Management Inc. (MTM Inc.). As the NEMT manager, MTM Inc. arranges and pays for rides to covered Medicaid services for members who have no other way to receive a ride. Rides can include ambulance, SMV, or common carrier transportation depending on a member's medical and transportation needs. Members must schedule routine rides at least two business days before their appointment.

The NEMT manager does not coordinate transportation for the following members:

- Members residing in a nursing home. Members residing in a nursing home have their NEMT services coordinated by the nursing home.

- Members enrolled in Family Care. Members enrolled in Family Care receive NEMT services from the Family Care *MCO*.

21.5 COPAYMENT

An EBD Medicaid *member* may be required to pay a part of the cost of a service. This payment is called a “copayment” or “copay.”

The following members do not have to pay a copayment:

- Children eligible for BadgerCare Plus who are:
  - Under age 16 with income at or below 150 percent of the FPL
  - Age 1 through 5 with income at or below 191 percent of the FPL
  - Age 6 through 18 with income at or below 133 percent of the FPL
- Children under age 18 who are eligible for SSI
- Children eligible for Katie Beckett
- Pregnant women
- People who are eligible to receive services from Indian Health Services or an Urban Indian Health Center, members of a federally recognized tribe, or the child or grandchild of a tribal member
- Nursing home residents

The following are medical services that are exempt from copayments:

- Emergency hospital and ambulance services and emergency services related to the relief of dental pain.
- Services related to pregnancy.
- Family planning services and supplies.
- Home health services
- Personal care services.
- Case management services.
- Outpatient psychotherapy services received that exceed 15 hours or $500, whichever occurs first, during one calendar year.
- Occupational, physical, or speech therapy services received that exceed 30 hours or $1,500 for any one therapy (, whichever occurs first, during one calendar year).
- Hospice care services.
- Substance abuse (alcohol and other drug abuse) day treatment services.
- Respiratory care for ventilator-assisted members.
- *CSP* services.

Providers are required to make a reasonable effort to collect the copayment. Copayments range from $0.50 to $3.00 for each procedure or service. Providers may not refuse services to an EBD Medicaid member who fails to make a copayment.

21.6 HMO ENROLLMENT

21.6.1 HMO Enrollment Introduction

Most Medicaid members who are eligible for BadgerCare~~Badger Care~~ Plus, MAPP, or SSI-related Medicaid and reside in a Medicaid HMO service area must enroll in an~~a~~ HMO.

Members may choose their own HMO or work with the HMO enrollment specialist to choose the best one for their needs. They may choose at any time during the enrollment process. All eligible members of the member's family must choose the same HMO. However, individuals within a family may be eligible for exemption from enrollment.

This is the enrollment process:

1. Members residing in an~~a~~ HMO service area receive an~~a~~ HMO enrollment packet. The packet has an enrollment form, a list of available HMOs, instructions on how to choose an~~a~~ HMO and how to find out if a provider is affiliated with an~~a~~ HMO.
2. If the member does not choose an~~a~~ HMO within two weeks of receiving the enrollment packet, he or she receives a reminder card. Members in areas with only one available HMO will stop here in the process. They do not have to enroll in an~~a~~ HMO.
3. If the member has not chosen an~~a~~ HMO after four weeks and lives in an area covered by two or more HMOs, he or she will be assigned an~~a~~ HMO. A letter explaining the assignment will be sent to him or her. He or she will receive another enrollment form and have an opportunity to change the assigned HMO.
4. He or she will then receive a notice confirming enrollment in the assigned or chosen HMO for the following month. The member has up to three months to change HMOs, once enrolled. This is the open enrollment period. After the initial three months, the member is locked into the HMO and cannot change for nine months. If your member has questions about HMO enrollment, he or she should contact the enrollment specialist at 1-800-291-2002.

22.1 ESTATE RECOVERY

22.1.2 Recoverable Services

Not all services provided by Medicaid are recoverable. Recoverability depends on what was provided and the *member's* age and residence when he or she received the benefit.

The following are the services for which ERP may seek recovery:

1. All Medicaid services received while living in a nursing home on or after October 1, 1991.

2. All Medicaid services received while institutionalized in an inpatient hospital on or after July 1, 1995.

3. Home health care services received by members age 55 or older on or after July 1, 1995, consisting of:

    a. Skilled nursing services.
    b. Home health aide services.
    c. Home health therapy and speech pathology services.
    d. Private duty nursing services.
    e. Personal care services received by members age 55 or older on or after April 1, 2000.

4. All *HCBW* services (*COP-W*, *CIP* 1A, CIP 1B, CIP II, Brain Injury Waiver, Community Opportunities and Recovery, and Community Supported Living Arrangements) received by members age 55 or older between July 1, 1995, and July 31, 2014:

    a. Prescription/legend drugs received by waiver participants.
    b. Benefits paid associated with a waiver participant's inpatient hospital stay. These include inpatient services that are billed separately by providers and services that are noncovered hospital services.

5. Family Care services received by members age 55 or older between February 1, 2000, and July 31, 2014:

    a. Prescription/legend drugs received by waiver participants.
    b. Benefits paid associated with a waiver participant's inpatient hospital stay. This includes inpatient services that are billed separately by providers and that are non-covered~~noncovered~~ hospital services.

6. All Family Care Partnership HCBW services, prescription/legend drugs and benefits associated with an inpatient hospital stay that are received by members age 55 or older between March 1, 2009, and July 31, 2014.

7. All *IRIS* services, prescription/legend drugs and benefits associated with an inpatient hospital stay that are received by members age 55 or older before August 1, 2014.

8. All Medicaid services received by members age 55 or older participating in a LTC program on or after August 1, 2014. LTC programs include all HCBW programs (including COP-W, CIP 1A, CIP 1B, CIP II, Brain Injury Waiver, Community Opportunities and Recovery, Community Supported Living Arrangements, FamilyCare, FamilyCare Partnership, IRIS, and *PACE*). The capitation payment made to the *MCO* on or after August 1, 2014, will be recovered for members receiving LTC program services through managed care.

9. Costs that may be recovered through a lien are:

    a. Medicaid costs for services received on or after October 1, 1991, during a nursing home stay or services received while institutionalized in a hospital on or after July 1, 1995.
    b. Medicaid costs of all other recoverable services as listed in Items 1-5 that are received on or after April 1, 2000, by members age 55 or older as of the date of the service.

22.5 REPRESENTATIVES

22.5.1 Authorized Representatives

Applicants or members can appoint either an individual or an organization as authorized representative. An authorized representative can be appointed through any of the following means:

- ACCESS, when applying
- Federally Facilitated Marketplace (Note: When a Marketplace application is processed by the agency and an applicant has appointed an authorized representative in the application, the agency must honor this appointment of an authorized representative.)
- Paper form:
    - Appoint, Change, or Remove an Authorized Representative: Person, F-10126A
    - Appoint, Change, or Remove an Authorized Representative: Organization, F-10126B

A valid authorized representative appointment requires all contact information of the authorized representative and the signatures of the applicant or member, the authorized representative, and a witness. If the applicant or member is signing with an "X," a valid appointment requires a witness signature. If any of the required signatures are missing, the following three conditions apply:

- The authorized representative appointment is not valid.
- This authorized representative cannot take action on behalf of the applicant or member.
- The agency cannot disclose information about the case to the invalid authorized representative.

There can be only one authorized representative at a time on a case. There is no time limit on how long a person or organization can act as authorized representative. The appointment of the authorized representative is valid until the applicant or member notifies the agency of a change or removal in writing. Once appointed, the authorized representative has ability to act for all open programs on the case.

Organizations acting as authorized representatives must provide the name and contact information of a person from the organization. Once the organization has been appointed as the authorized representative, anyone from the organization will be able to take action on behalf of the applicant or member (not just the person who signed the form on behalf of the organization). If an organization is only changing the contact person for the organization, the member is not required to complete a new Appoint, Change or Remove Authorized Representative form if the organization is going to remain as the authorized representative.

The authorized representative should be familiar with the applicant or member's household situation and is expected to fulfill their responsibilities to the same extent as the individual being represented. An authorized representative is limited to doing any or all of the following on behalf of the applicant or member:

- Apply for or renew benefits
- Report changes in the applicant or member's circumstances or demographic information
- Receive copies of the applicant or member's notices and other communications from the agency
- Work with the IM agency on any benefit related matters
- File grievances or appeals regarding the applicant or member's eligibility

To change an authorized representative, the member must complete and submit the Appoint, Change, or Remove an Authorized Representative form (Person F-10126A or (Organization F-10126B) to his or her IM agency. To remove an authorized representative, the member needs to let the agency know of the removal in writing. For example, by completing Section One of the Appoint, Change, or Remove an Authorized Representative form or submitting a signed letter indicating the removal. The member does not need to gather additional signatures from the authorized representative or a witness to complete the removal of an authorized representative.

22.5.2 Additional Responsibilities

The applicant or member can choose to appoint the person who is acting as his or her authorized representative to receive the member's ForwardHealth card and is also be allowed to do the following tasks:

- Enroll the applicant or member in an HMO
- Contact Member Services or the HMO about a bill, service or other medical information, including Protected Health Information (PHI)

An authorized representative who is appointed by the member to have these additional functions is coded in CARES as a Medicaid (MA) Payee. The authorized representative and the MA Payee must be the same person, and the MA Payee cannot be an organization. If the member's authorized representative is an organization and the member wants to appoint a MA Payee, the member will need to change the authorized representative to a person and authorize that person to have the MA Payee functions.

The applicant or member can appoint his or her authorized representative to fulfill the additional responsibilities listed on Section 1 Part C of the Appoint, Change or Remove Authorized Representative: Person form (F-10126A). The applicant or member acknowledges that he or she is authorizing the disclosure of PHI to the authorized representative since the authorized representative will have access to medical information such as health care services or treatments, medical bills, etc.

There is no time limit on the MA Payee designation. An applicant or member can request removal of the MA Payee in writing at any time. For example, the applicant or member can submit the Appoint, Change or Remove Authorized Representative form or write a letter indicating the MA Payee removal.

28.8 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE INSTRUCTIONS

28.8.1 Home and Community-Based Waivers Long-term Care Instructions Introduction

Eligibility for Group A, B, and B Plus community waivers cases are determined in CARES.

Katie Beckett cases are Group A, and, because of the small number of these cases, are processed manually outside CARES by ~~care managers and~~ Katie Beckett staff.

~~Care managers will determine and certify community waiver eligibility for children already eligible for Medicaid through the Katie Beckett Program.~~

28.8.2 Group A

Group A members are waiver functionally eligible and Medicaid eligible via *SSI* (including *SSI-E* Supplement and *1619A* and B) or a full-benefit Medicaid subprogram (see Section 21.2 Full-Benefit Medicaid) other than a HCBW LTC program or Family Care (i.e., not Group B or B Plus). This does not include someone solely eligible for any of the limited benefit Medicaid subprograms (see Section 21.3 Limited Benefit Medicaid).

Members who have met a deductible are eligible for community waivers as a Group A. The member remains eligible as a Group A until the end of the deductible period. At the next review the member will be able to make a choice between meeting the deductible to receive Medicaid (remaining a Group A) or becoming eligible for community waivers as a Group B or B Plus with a potential cost share.

Group A members are financially eligible with no cost share.

Note: Group A members do not have an asset limit if they are Group A eligible via BadgerCare Plus, Adoption Assistance Medicaid, Foster Care Medicaid, Katie Beckett Medicaid, or Wisconsin Well Woman Medicaid since these programs do not have an asset test. All Group A members, including those who are eligible for Group A through BadgerCare Plus eligibility, are subject to the divestment policy described in Chapter 17 Divestment.

28.14 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE CHILDREN'S LONG-TERM SUPPORT

28.14.1 Children's Long-Term Support Waiver Program Introduction

The *CLTS* Waiver Program includes the following three target population groups:

- Developmental disabilities
- Physical disabilities
- Severe emotional disturbance or mental health disabilities

The CLTS Waiver Program is entered in *CWW* as a waiver type when a child or young adult is applying for HCBW. The~~. All~~ Medicaid eligibility criteria for HCBW for children and young adults in the CLTS Waiver Program are similar to the *CIP* IB Waiver except there is no disability determination required in order to qualify. Instead, the CLTS Functional Screen determination of institutional *LOC* meets the *HCBS* Waiver eligibility requirement.

County waiver agencies (CWAs) complete the level of care assessment and determine eligibility for the CLTS Waiver Program. Being enrolled in any form of full benefit Medicaid (see Section 21.2 Full-Benefit Medicaid), is a prerequisite for participation in the CLTS Waiver Program. ~~**28.14.2 Children's Long-Term Support Waiver Program CARES Processing**~~

~~The child should first be tested with his or her family to see if there is eligibility for BadgerCare Plus and the Group A Waiver.~~

If the child is eligible for a type of non-CARES Medicaid such as Foster Care Medicaid, Adoption Assistance Medicaid, *SSI* Medicaid, or Katie Beckett Medicaid, the child will be eligible as a Group A Waiver and will not be referred to IM. ~~(see Section 28.8 Home and Community-Based Waivers Long Term Care Instructions for waiver processing instructions).~~

CLTS Waiver Program applicants and participants who are not open for a type of non-CARES Medicaid must complete a health care application, and they must first be tested for eligibility using HCBW rules (see Section 28.14.2 HCBWLTC CARES Processing for the Children's Long-Term Support Waiver Program).

Individuals can be eligible for the CLTS Waiver Program and HCBW Medicaid through age 21. When a CLTS Waiver Program applicant or member reaches 18 years old and their source of Medicaid is HCBW, they must apply for HCBW Medicaid as the primary person. Federal and state privacy and confidentiality protections prevent the parents of

adults from automatically having access to protected information; therefore, these young adults must apply as the head of their own IM case.

When individuals ages 18-21 require HCBW Medicaid, CWA staff submits the following to IM:

- Wisconsin Medicaid, BadgerCare Plus, and Family Planning Only Services Registration Application, F-10129
- Home and Community-Based Waiver Medicaid Enrollment for the Children's Long-Term Support Waiver Program Form, F-02319
- Medicaid Waiver Eligibility and Cost Sharing Worksheet, F-20919
- Verification of the young adult's income, if any.

To be eligible for HCBW, the child must be both Medicaid-eligible and functionally eligible. To determine eligibility for HCBW, only the child's income is counted. There is no asset test. Since assets are disregarded, there can be no divestment in a HCBW Medicaid case for a child.

If an applicant or participant is ineligible for HCBW, he or she must then be tested for BadgerCare Plus.

28.14.2 HCBW LTC CARES Processing for the Children's Long-Term Support Waiver Program

To facilitate the application and renewal process and reduce the duplication of verification requests that could cause a burden to families who are applying for multiple programs, CWA staff working with a family whose child is functionally eligible and requesting HCBW will submit the following information to the IM agency.

For applications, CWAs work with families to complete and submit:

- A valid application for health care (see Section 2.4 Valid Application), including the Wisconsin Medicaid, BadgerCare Plus, and Family Planning Only Services Registration Application, F-10129
- Home and Community-Based Waiver Medicaid Enrollment for the Children's Long-Term Support Waiver Program, F-02319
- Medicaid Waiver Eligibility and Cost Sharing Worksheet, F-20919
- Verification of the child's income, if any

For annual HCBW renewals, the family must submit a completed health care renewal (for example, a PPRF) and CWA staff will submit:

- Home and Community-Based Waiver Medicaid Enrollment for the Children's Long-Term Support Waiver Program, F-02319

- Medicaid Waiver Eligibility and Cost Sharing Worksheet, F-20919
- Verification of the child's income, if any

Eligibility should not be discontinued if the CWA has not yet made the level of care review. ~~If the child is not eligible for other categories of Medicaid or BadgerCare Plus, CARES will test the child for a Group B or B Plus Waiver, based on the child's income.~~

~~Since a disability determination is not required for these members, IM workers should update the "Is Disability Determination Required?" question on the Community Waivers page to **No**.~~

HCBW requests must be processed differently depending on whether there are any other people on the case who are requesting health care. See Process Help Section 9.7 Home and Community-Based Waiver Medicaid for Children's Long-Term Support for processing instructions.

39.4 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLES

39.4.2 Elderly, Blind, or Disabled Deductions and Allowances

The cost-of-living adjustments in the following table were effective January 1, 2018.

Description		Amount
Personal Needs Allowance (effective 7/1/01)		$45.00
EBD Maximum Personal Maintenance Allowance		$2,250.00
EBD Deeming Amount to an Ineligible Minor		$375.00
Community Waivers Basic Needs Allowance		$930.00
Parental Living Allowance for Disabled Minors	**1 Parent** **2 Parent**	$750.00 $1,125.00
MAPP Standard Living Allowance Standard Living Allowance = SSI + State Supplement + $20		$853.00

The spousal impoverishment values in the following table were effective July 1, 20182~~2017~~.

Description	Amount
Community Spouse Lower Income Allocation Limit	$2,743.34~~706.66~~
Community Spouse Excess Shelter Cost Limit	$823~~812~~.00
Family Member Income Allowance	$685.83~~676.66~~

39.4.3 Institutional Cost of Care Values

The values in the following table were effective July 1, 2018~~2017~~.

Description	Amount
Daily Average Private Pay Nursing Home Rate	$286.15~~278.05~~
Monthly Average Private Pay Nursing Home Rate	$8,703.73~~457.35~~
Monthly Rate for State Centers for Persons with Developmental Disabilities	$25,329.48~~23,124.27~~