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 18-03**

Release Date: 12/14/2018

Effective Date: 12/14/2018

EFFECTIVE DATE		The following policy additions or changes are **effective 12/14/2018** unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY UPDATES		
2.5.1.1	Signatures from Representatives	Updated guardian information.
5.5.2	Reversed Disability Denial Decision	Updated text for SSI and SSDI .
5.5.3	CARES Processing	Updated text for SSI and SSDI.
15.4.22	Income Allocation from Institutionalized Spouse to Community Spouse	New section.
16.1	Assets Introduction	Updated text for SSI.
16.5.1	Burial Trusts	Updated text for irrevocable trusts.
16.5.4	Spaces	Updated with new example.
16.5.6	Wisconsin Funeral Trust Program	Updated text for irrevocable amount.
16.6.5	Special Needs Trust	Updated text for special needs trusts.
18.4.6.1.2	Change in Marital Status During the 12-Month Transfer Period	New section.
18.6.1	Spousal Impoverishment Income Allocation Introduction	Updated text for countable income.
18.8	Spousal Impoverishment Notices	Updated text for allocated amount.
22.1.10	Voluntary Recovery (Not Estate Recovery Program)	Update text for medical refund.
22.4.2	Undue Hardship Waiver Request Process	Update for divestment penalty period.
22.5.1	Authorized Representatives	Updated text for representatives.
24.7.3	Prepaying a Deductible	Updated text for pre-paymenets.
26.3.1	Medicaid Purchase Plan Nonfinancial Requirements Introduction	Updated text for SSI recipients.
26.3.4	Work Requirement	Updated text for services received in error.

	Exemption	
27.7.7.2	Disallowed Expenses	Updated text for medical expense.
27.11	Institutions for Mental Disease	Updated text for additional institution.
32.7.1.1	QMB Applications	Updated for eligibility.
33.2.3	Signing the Application	Updated text for guardian.

2.5.1.1 SIGNATURES FROM REPRESENTATIVES

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

- 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~~ one of the following may sign the application:
  - 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.

If the applicant only has a legal **guardian of the person**, the applicant must sign the application unless the applicant has appointed his or her guardian of the person to be the authorized representative.

- *Authorized Representative*: The applicant may authorize someone to represent him or her. An authorized representative can be an individual or an organization. See Section 22.5 Representatives for more information.

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 Representative form (Person F-10126A or Organization F-10126B).

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.

- 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.

- 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.

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

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

- 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.

5.5.2 REVERSED DISABILITY DENIAL DECISION

When DDB or DHA notifies the IM agency that a disability denial decision has been reversed (approved) as a result of a reconsideration/hearing request or SSI or SSDI appeal, the IM agency must redetermine the individual's Medicaid eligibility.

1. Use the original Medicaid application filing date that was associated with the *MADA* decision that has now been reversed (approved).
2. Re-evaluate the member's Medicaid eligibility for all months between the Medicaid application filing date (and three-month backdate period if appropriate) and the date of the DDB, SSI, or SSDI approval. For this retroactive period, certify the member only for those months for which he or she met all Medicaid eligibility requirements.
3. Send the member a positive notice, advising him or her of the months of retroactive eligibility and current ongoing eligibility, if appropriate. If the member was ineligible for Medicaid for some of the prior months, send the member a negative notice, advising him or her of his or her retroactive ineligibility for those specific months.

For these types of cases, the IM worker is simply doing what ordinarily would have been done if the original DDB, SSI, or SSDI decision had been approved rather than denied.

Note: If an SSI or SSDI disability determination is changed, the new determination is binding for Medicaid. The Medicaid filing date should be preserved as if DDB or DHA had reversed the MADA denial.

5.5.3 CARES PROCESSING

Based on the assumption that the Medicaid CARES case has been closed for more than 30 days since the original denial decision date, you will now have to enter a new application in CARES using the application function. Do not require the member to file a new application. Use the recent DDB, SSI, or SSDI disability approval date as the Medicaid application filing date. You should now be able to use CARES to determine and certify the current month's Medicaid eligibility and up to three backdate months. If you need to go back any further than this, do the eligibility determination and certification manually.

When the disability denial decision is overturned by DHA, enter the disability approval and disability onset date established by DHA on the Disability page in *CWW* as if it was approved by DDB. Document in the case comments that this disability approval decision was actually made by DHA and not DDB and record the fair hearing case number. Run eligibility to determine Medicaid eligibility for current and future months and also for any past months in which the person was determined disabled.

15.4.22 INCOME ALLOCATION FROM INSTITUTIONALIZED SPOUSE TO COMMUNITY SPOUSE

Income allocated from an institutionalized spouse to a community spouse per Section 18.6 Spousal Impoverishment Income Allocation is counted income to the community spouse if that community spouse is receiving a form of EBD Medicaid.

16.1 ASSETS INTRODUCTION

Children under the age of 19 are not subject to an asset test for any category of EBD Medicaid, including *MAPP*, community waivers, FamilyCare, etc.

SSI MA recipients have already had their assets verified by the Social Security Administration. Assets should not be re-verified for these individuals.

Do not count income as an asset in the month it was received when determining the countable asset amount.

> **Example 1:** Mr. Johnson has $2,600.00 in his checking account for the month of March. This includes his Social Security check of $700.00 that was deposited into the account on March 10. His countable asset amount for March is $1,900.00.

> **Example 2:** Mrs. Jones has $2,400.00 in her checking account for the month of March. She receives Social Security of $1,000.00 each month. She cashed her Social Security check and used the cash to pay her bills. Because her income is not included in the checking account balance, the income should not be deducted from the checking account balance.

Add together all countable, available assets (see Section 16.2 Assets Availability), the fiscal group owns including:

1. Joint accounts (see Section 16.4.1 Joint Accounts)
2. Burial assets (see Section 16.5 Burial Assets)
3. Savings account
4. Checking account
5. Cash available
6. Stocks, bonds, CDs.
7. Loans (see Section 16.7.2 Loans)
8. Life insurance (see Section 16.7.5 Life Insurance)
9. Non-burial trusts (see Section 16.6 Non-burial Trusts)
10. Land contract (see Section 16.7.12 Land Contract)
11. Mortgage (see Section 16.7.13 Mortgage)
12. Trailer home (see Section 16.8.1.2 Non-motorized Trailer Homes)
13. Non-home *real property*. (see Section 16.8 Real Property)
14. Some vehicles (see Section 16.7.9 Vehicles (Automobiles), 18.4 Spousal Impoverishment Assets)

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

16.5.1 BURIAL TRUSTS

Exempt all burial trusts made in Wisconsin that are irrevocable by Wisconsin law, as noted in the trust agreement. If made in another state, exempt all that are irrevocable by the laws of that state. Refer any question about any state's law to your corporation counsel.

Interest and dividends are irrevocable if they accrue to irrevocable trusts and if the trust agreement specifies they are irrevocable. If the interest or dividends are irrevocable, exempt them. If interest or dividends are revocable, they are a countable asset.

In non-*spousal impoverishment EBD* Medicaid cases, each fiscal group member may have one or more irrevocable burial trusts, of which the total *face value* may not exceed $4,500. Any principal amount over $4,500 is a countable asset. Although Wisconsin law allows $3,000 to be irrevocable, Wisconsin's Medicaid state plan allows an additional $1,500 to be considered as though it were irrevocable by law for these burial trusts. This is why $4,500 is allowed. (See Section 18.4 Spousal Impoverishment Assets for information about burial assets for persons with a *community spouse*).)

16.5.4 SPACES

Burial space exemptions apply only to EBD fiscal group members. Burial space exemptions include all the following, if they have been paid for:

- Plots, vaults, caskets, crypts, mausoleums, urns, or other repositories customarily used for the remains of deceased persons
- Necessary and reasonable improvements upon the burial space with items such as headstones, markers, plaques
- Arrangements for opening and closing the ~~gravesite~~grave site

Exempt multiple spaces of any value under the following conditions:

- The space(s) must be owned by the elderly, blind, or disabled person, that person's *spouse*, or, when the EBD person is a *minor*, by the minor's parents.
- Both a plot and a mausoleum space cannot be exempted for the same person.
- Each person may have more than one type of space.
- The space(s) must be for the use of the elderly, blind, or disabled member or one of the following:
    - Spouse.
    - Minor or *adult* natural, adoptive, or stepchild.
    - Brother or sister.
    - Natural or adoptive parent.
    - Spouse of any of the above.

Example 5: Bob, who is 12 years old, lives with his parents and is tested for EBD Medicaid. His father owns five burial plots and spaces: the first is for Bob, the second and third are for his parents, the fourth is for his older brother, who does not live at home, and the fifth is for Bob's uncle. All the plots and spaces are exempt except for the fifth.

Example 6: Harry is applying for HCBW. Last year he used his life insurance policy with a face value of $10,000 and a cash value of $8,000 to set up a LIFBC for his son. On the Statement of Goods and Services, $4,000 is designated for a casket, $1,000 for a vault, and $500 for the cemetery plot, for a total of $5,500 that is exempt burial space expenses. The remaining $2,500 that was put in to the LIFBC is considered divestment.

16.5.6 WISCONSIN FUNERAL TRUST PROGRAM

The Wisconsin Funeral Trust is a single trust owned and operated by the *WFDA*. It was established and maintained according to the rules of the Wisconsin Department of Financial Institutions. It is available for use by all WFDA members statewide. Funds placed in the Trust will be invested in accordance with applicable state law.

WFDA has created two preneed funeral contracts: one is for a guaranteed price and the other is for a non-guaranteed price. These contracts are available to all individuals, not just those who are or may be EBD Medicaid applicants or members.

The agreement by the purchaser with the funeral home constitutes a purchase, even if revocable in whole or part. The contract nearly always includes burial spaces, which are excluded assets. The contract is not:

- An installment burial contract.
- An insurance funded burial contract.
- Divestment as the funds transferred are in exchange for equal amounts of goods and/or services.

In determining countable asset value:

1. Deduct first the amount ~~identified~~considered as irrevocable under Wisconsin law and the Medicaid state plan (see Section 16.5.1) up to a maximum of $4,500.
2. Deduct next the amount equal to the value of all burial spaces purchased by the contract. Remember that "burial spaces" includes caskets and outer burial containers, vaults, liners, etc.
3. Deduct any amount that can be included in the applicant's or member's burial fund.
4. The remainder is the countable asset.

Example ~~8~~9:

Total Contract Value	=	$~~5,200~~6,700
Amount Designated as Irrevocable	=	- $~~3,000~~4,500
		$2,200
Value of Excluded Burial Spaces	=	- $1,300
		$900
Amount of Excluded Burial Funds*=		- 0
Countable Asset	=	**$900**

* The amount of funds that may be excluded as the $1,500 "burial fund" is reduced by any amount of cash value in his or her life insurance and the amount of

irrevocable burial trust. Whenever the burial contact specifies $1,500 or more as irrevocable, no funds can be excluded as "burial fund."

Example ~~9~~10:

Total Contract Value	=	$4,200
Amount Designated as Irrevocable	=	- $1,300
		$2,900
Value of Excluded Burial Spaces	=	- $1,300
		$1,600
Amount of Excluded Burial Funds*	=	- 200**
Countable Asset	=	**$1,400**

**This example assumes that the person has not identified another insurance or irrevocable burial funds toward his or her "burial fund." The $1,500 maximum burial fund allowance, less the $1,300 this contract makes irrevocable, leaves room for an additional $200 to be allocated to the "burial fund". Note that in Example 1, the purchaser was able to achieve a higher exemption.

16.6.5 SPECIAL NEEDS TRUST

Disregard special needs trusts, also called supplemental needs trusts, whose sole beneficiary is under age 65 and totally and permanently disabled (under *SSI* program rules) if ~~it meets both~~ they meet all of the following conditions:

- For trusts established prior to December 13, 2016, the trust must be established for the sole benefit of the disabled person by his or her parent, grandparent, legal guardian, or a court.
  Note: For any special needs trusts established on or after December 13, 2016, the trust does not have to be established by a third party. The disabled person under age 65 may also set up the trust.
- Established with the resources of the disabled individual.
  Note: If a legally competent, disabled adult does not establish the trust, a parent or grandparent may establish a seed trust using a nominal amount of his or her money (e.g., $10). After the seed trust is established, the disabled adult's assets can be transferred into the trust.
- Contain a provision that, upon the death of the beneficiary, Wisconsin Medicaid will receive all amounts remaining in the trust not in excess of the total amount of Medicaid paid on behalf of the beneficiary.

Trusts that meet the above criteria but are not called a special or supplemental needs trust are treated as special needs trusts for Medicaid purposes. Trusts that are called special or supplemental needs trusts but do not meet the above criteria are not treated as special needs trusts for Medicaid purposes and availability must be determined according to the criteria in 16.6.3 Revocable Trusts or 16.6.4 Irrevocable Trusts.

The funds deposited in, contributions to, and distributions from the special needs trust are disregarded. The exception continues after the person turns 65, provided he or she continues to be disabled. However, a grantor cannot add to the trust after the beneficiary turns 65. Anything added to the trust after the beneficiary turns 65 is a divestment. Money added before the beneficiary turns 65 is not a divestment.

18.4.6.1.2 CHANGE IN MARITAL STATUS DURING THE 12-MONTH TRANSFER PERIOD

If the community spouse passes away or is no longer married to the institutionalized person, then spousal impoverishment rules no longer apply and the institutionalized person is subject to the $2,000 asset limit.

Example 3: Sue was institutionalized in July 2017 and was married to Tom, who resided in the community. Sue was eligible for Medicaid in July 2017 and had until June 2018 to get under the $2,000 asset limit. On September 20, 2017, Sue reports that Tom passed away. Because spousal impoverishment rules no longer apply for ongoing eligibility, Sue would be subjected to the $2,000 asset limit beginning November 2017.

18.6.1 SPOUSAL IMPOVERISHMENT INCOME ALLOCATION INTRODUCTION

After an institutionalized person is found eligible, he or she may allocate some of his or her income to the *community spouse* and dependent family members living with the community spouse. Income that is allocated for the community spouse must actually be given to the community spouse each month in order for it to be allowed as a post-eligibility income deduction for the institutionalized spouse. However, income that is allocated for a dependent family does not have to be actually given to the dependent family member.

Dependent family members include:

- Dependent *minor* children (natural, adopted, step) of either parent who live with the community spouse.
- Children (natural, adopted, step), 18 years old or older, of either parent, who are claimed as dependents for tax purposes under the *IRC* and who live with the community spouse.
- Siblings of either the institutionalized person or the community spouse who are claimed as dependents and who live with the community spouse.
- Parents of either the institutionalized person or the community spouse who are claimed as dependents and who live with the community spouse.

An institutionalized person must decide how much income to allocate. He or she may allocate an amount that brings the community spouse's and family members' income up to the maximum allocation, or he or she may choose to allocate a lesser amount.

Since he or she may have medical costs that are not covered by Medicaid, he or she may wish to keep some income and not allocate it all.

Note: Income allocated to the community spouse is countable income for him or her and must be added to the community spouse's case.

Example 1: Caroline has monthly income of $400. She transfers $310 to her community spouse, keeping only her personal needs allowance (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances) and $45 to pay as her monthly patient liability. She incurs $80 in noncovered medical expenses each month. Those expenses will be charged first to her patient liability, but she must pay the remaining $35.00 out of her personal needs allowance. If the personal needs allowance does not cover her expenses, the provider will try to obtain the balance from the community spouse.

18.8 SPOUSAL IMPOVERISHMENT NOTICES

After the institutionalized person has been determined Medicaid eligible, the worker must send the following manual notices to both spouses:

1. Notice of Medicaid Income Allocation (F-10097). This notice contains the amount of income allocated to the *community spouse* and the amount of the institutionalized person's cost of care contribution. This notice must also be completed any time there is a change in the allocated amount.
2. Medicaid Recipient Asset Allocation Notice (F-10098). This notice specifies the amount of assets the member must transfer to the community spouse in order to retain Medicaid eligibility. It also specifies the date by which the transfer must be made.

22.1.10 VOLUNTARY RECOVERY (NOT ESTATE RECOVERY PROGRAM)

Accept payments from a member under age 55 made for purposes of Medicaid eligibility or prepaying a Medicaid deductible.

Instruct the member to make the payment payable to your IM agency. Report the receipt on the Community Aids Reporting System (CARS) ~~on Line 909~~labeled as a Medical Refund.

22.4.2 UNDUE HARDSHIP WAIVER REQUEST PROCESS

If an applicant or member is denied long-term care services as a result of ~~one~~any of the situations listed in Section 22.4.1, except a divestment penalty period, *IM* workers are required to manually send the applicant or member the following:

- Undue hardship letter (F-10187).
- Undue Hardship Waiver Request form (F-10193).

These forms must be mailed the same day that CWW or the IM worker mails the Notice of Denial of Benefits/Negative Change in Benefits (F-16001) informing the applicant or member that long-term care services will be terminated or denied.

Note: Because the forms listed above are completed and mailed manually for all situations, except a divestment penalty period, workers should document in case comments that undue hardship forms were sent and scan a copy of the forms into the *ECF*.

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

If an applicant or member is represented by a legal guardian of the person and the estate, legal guardian of the estate, legal guardian in general, or conservator, the legal guardian or conservator must appoint the authorized representative. If the applicant or member only has a legal guardian of the person, the applicant or member must appoint the legal guardian of the person as an authorized representative if the applicant or member would like the legal guardian of the person to act on his or her behalf. If the applicant or member has a power of attorney, the applicant or member can still appoint an authorized representative.

A valid authorized representative appointment requires all contact information of the authorized representative and the signatures of the applicant or member, the authorized representative, and a witness. If the applicant or member is signing with an “X,” a valid appointment requires 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. Authorized representatives can also request in writing (for example, a signed statement) to be removed if they no longer want to act as the authorized representative. If an authorized representative is requesting to be removed, a signed statement is not needed by the member. An authorized representative designation is valid on a case until a written and signed request is received for removal.

Example 1: Penny is due for renewal of her BadgerCare Plus benefits on August 31. In July, she receives her case summary as part of the administrative renewal process. Penny's case summary lists her mom, Darlene, as her authorized representative. Penny no longer wants Darlene to be her authorized representative.

Penny crosses out the authorized representative information on the case summary, signs it, and mails it to the IM agency. The IM agency receives the case summary on August 3. Based on Penny's handwritten update on the case summary, the IM agency removes Darlene as Penny's authorized representative effective on August 3.

24.7.3 PREPAYING A DEDUCTIBLE

Anyone can prepay a deductible for himself/herself or for someone else. It can be paid in installments or all at once. A prepaid deductible may be refunded if the member requests a refund of the prepayment **prior** to the begin date of the corresponding deductible period.

If the member is **55 or older**, forward the payment to:

ForwardHealth
Estate Recovery/Casualty Collections
313 Blettner Blvd
Madison WI
53714-2405

Prepayment checks or money orders should be made payable to: "~~;~~The Department of Health~~ and Family~~ Services."

With the payment, include:

1. Documentation that the payment is voluntary.
2. The member's name and Medicaid ID number.

If he or she is **under 55**, instruct the member to make the payment payable to your *IM* Agency. Report the receipt on the Community Aids Reporting System (CARS) ~~on Line 909.~~labeled as a Medical Refund.

26.3.1 MEDICAID PURCHASE PLAN NONFINANCIAL REQUIREMENTS INTRODUCTION

Members must:

- Meet general Medicaid nonfinancial requirements (see Section 4.1 Who is Nonfinancially Eligible for Medicaid?).
- Be at least 18 years old (there is no maximum age limit).
- Be determined disabled, presumptively disabled, or *MAPP*-disabled by the *DDB*, regardless of age (see Section 5.2 Determination of Disability and Section 5.10 Medicaid Purchase Plan Disability).
- Be working in a paid position or participating in an *HEC* program (see Section 26.3.4 Work Requirement Exemption).

Note: People who are receiving Medicaid through *SSI*'s 1619(b) program are nonfinancially eligible for MAPP. People who are *SSI*-eligible under 1619(b) can be on SSI Medicaid and MAPP at the same time. These people are not receiving an SSI cash benefit because they are working, but they meet certain specific SSI requirements that allow them to keep their categorical eligibility for Medicaid. SSI MA recipients have already had their assets verified by the Social Security Administration. Assets should not be re-verified for these individuals. Because this group is the most likely to move from SSI Medicaid to MAPP, *DHS* has decided to allow them to be eligible for both at the same time.

26.3.4 WORK REQUIREMENT EXEMPTION

If there is a serious illness or hospitalization that causes the member to be unable to work, the work requirement can be suspended for up to six months. He or she can continue to be MAPP eligible. The member must contact the *IM* agency to request the exemption. Have the member complete the Medicaid Purchase Plan (MAPP) Work Requirement Exemption form (F-10127). This provision is not available unless he or she:

- Has been enrolled in MAPP for six months and has paid any applicable premiums prior to the request of an exemption.
- Is expected to return to work in the next six months.
- Provides an expected date of recovery.
- Provides the reason that an exemption is needed (e.g., illness or hospitalization).
- Has had no more than two exemptions (maximum of six months each) to the work requirement in a three-year time period. The two exemptions cannot be consecutive.

Based on the criteria outlined above, the IM agency will approve or deny the request. If a work exemption request is denied, the member has appeal rights in accordance with the Medicaid program.

If the member has received MAPP services in error, due to failure to report a change or other reason that would have made the member ineligible he or she is not able to receive a work requirement exemption.

In the sixth month of an exemption, mail the member a notice indicating the date the medical work exemption will end as well as steps the member may take to continue MAPP eligibility.

27.7.7.2 DISALLOWED EXPENSES

Do not allow payments that an institutionalized person is making, or requests to make, as a need item or as a cost share adjustment if the medical or remedial expense meets any of the following exception reasons:

- Remains unpaid but was previously used to meet a Medicaid deductible.
- Was incurred as the result of imposition of a divestment penalty period.
- A patient liability or cost share from a previous budget period, whether paid or unpaid, cannot be used as an incurred medical or remedial care expense in a subsequent budget period.
- Incurred medical and remedial care expenses deducted from income to determine patient liability or cost share in a month cannot be used to determine patient liability or cost share in a subsequent month.

Example 4: On September 17, Alice was hospitalized for injuries she sustained in a fall. Alice was uninsured at the time and incurred a $2,000 hospital bill. Before leaving the hospital, she set up a payment agreement to pay $100 per month until the debt was paid. Alice used the outstanding expense to satisfy a deductible in the amount of $1,800 and was determined Medicaid-eligible from September through February.

In May, Alice was determined to be functionally eligible for *HCBW*s and was determined eligible for Medicaid under Group B waiver rules. Without a medical or remedial expense, Alice's cost share would be $100. Alice's care manager verified that Alice still owes $1,200, but only $200 of the expense is allowable because $1,800 was already used to satisfy a deductible. Her care manager will include the $100 payment in the medical or remedial expense amount submitted to the *IM* worker for determining her cost share, but will reevaluate Alice's medical or remedial expense amount in two months.

Example 5: On August 1, Alice moved to a nursing home. Her eligibility for HCBWs ended and she was determined eligible for Nursing Home Medicaid beginning August 1. She is still making the $100 payments to the hospital, and has an outstanding balance of $900. However, Alice used $1,800 to meet a deductible and already received a deduction of $200 from her community waiver cost share. The payment cannot be used as a medical expense deduction from her income when calculating the monthly patient liability.

Example 6: In January, Lyle was institutionalized and applied for Medicaid. Due to a previous divestment, Lyle has a three-month divestment penalty period, beginning in December. During this three-month period, Medicaid will not cover the cost of Lyle's institutional care, but will only cover his card

services. In March, the divestment penalty period expired, and Lyle is eligible for Medicaid payment of his institutional cost share. He would like to use $2,000 of his monthly income to pay for the nursing home bills that he incurred in January and February and deduct this amount from his cost share. The request to allow an adjustment in Lyle's cost share must be denied because the medical expense that he wants deducted from his income is to pay for the cost of institutional care incurred during a prior Medicaid divestment penalty period.

- The expense is unverified.

CARES Process

~~Until changes in CARES can be made to accommodate this policy and process change for institutional cases, enter the allowable medical and remedial expenses as a court-ordered support payment on the Support Obligations/Payments page in CWW. Be sure to document detailed information about the expense and cost share calculations in case comments.~~

~~Remember, medical or remedial expenses for Group B waiver cases are still entered on the Medical Expense page. There are no CARES processing changes or overrides required for community waiver or Family Care cases.~~

Enter allowable expenses on the Medical Expense Page for Institutional and Group B Waivers cases. See Process Help Section 18.2 Medical Expenses.

27.11 INSTITUTIONS FOR MENTAL DISEASE

Brown
Bellin Psychiatric Center, Green Bay
Brown County Mental Health Center, Green Bay
Libertas Center, Green Bay (aka St. Joseph's)
Willow Creek Behavioral Health, Green Bay

Dane
Mendota Mental Health Institute, Madison

Fond du Lac
Fond du Lac County Health Care Center

Milwaukee
Aurora Psychiatric Hospital, Milwaukee
Rogers Memorial Hospital, Milwaukee
Milwaukee County Behavioral Health, 144 bed psychiatric hospital - license #229, Milwaukee

Trempealeau
Trempealeau County Health Care Center IMD, Whitehall - license # 2961
Trempealeau County IMD, Whitehall - license # 5001

Waukesha
Rogers Memorial Hospital,Oconomowoc
Waukesha County Mental Health Center, Waukesha

Winnebago
Winnebago Mental Health Institute, Winnebago

Note: The Milwaukee County Behavioral Health and the Trempealeau County Health Care Center are multi-purpose complexes which include Nursing Homes, Facilities for the Developmentally Disabled and IMD's. In order to make a correct Medicaid eligibility determination for the residents of these 2 complexes, it will be necessary to accurately identify the type of facility in which the Medicaid *applicant* /member resides.

32.7.1.1 QMB ~~APPLICATIONS~~BEGIN DATE

For initial ~~applications~~eligibility, *QMB* benefits begin on the first of the month after the month in which the person is determined to be eligible, and the case is confirmed in CARES.

Example 1: Henry has been in the same nursing home since 2013. He applied for Medicaid on January 23, 2017, and also requested QMB. His application was processed and confirmed for both programs on January 23, 2017, and he was determined eligible for both. His Medicaid begin date is January 1, 2017. His QMB begin date is February 1, 2017.

33.2.3 SIGNING THE APPLICATION

The applicant must sign the application form in Section V of F-10076) (Section VI of the 07/02 version of F-10076) with his or her signature, a mark or an "X", unless one of the following signs for him or her:

~~1. A guardian.~~

1. A guardian of the estate, a guardian of the person and the estate, or a guardian in general.

~~1.~~2. An authorized representative .

~~2.~~3. A power of attorney/durable power of attorney. (Health Care Power of Attorney is not accepted as proof of authority.)