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 19-01**

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Effective Date: 04/19/2019

EFFECTIVE DATE		The following policy additions or changes are **effective** 04/19/2019 unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY UPDATES		
5.2.1	Definition of Disability	Added section number.
5.2.2	Disabled Medicaid Applicants and Members Who Convert from Social Security Disability to Social Security Retirement Benefits	*New section.*
5.7.1	Redetermination Introduction	Clarified definition of when to review disability determination.
5.10.2	Medicaid Members Who Convert from Social Security Disability to Social Security Retirement	Renamed section MAPP Members Over Age 65 and added policy clarification from Operations Memo 19-12.
6.9.6	Department of Corrections Pre Release Applications from Offenders	*New Section.*
7.2	Documenting Citizenship and Identity	Renamed, added, removed, and updated subsections with policy changes.
7.3	Immigrants Eligible for Medicaid	Renamed, added, removed, and updated subsections with policy changes.
7.4	Non-Immigrant, Non-Citizens	Deleted section.
8.4	Cooperation Between IM & CSA	*Restored section.*
10.1.1	Social Security Number Requirements	Renamed section Overview of Social Security Number Requirements and updated policy.
15.1.2	Special Financial Tests for Disabled Minors	Updated amounts used in examples.
15.5.10	Census	Updated text.
16.6.5	Special Needs Trust	Clarified when to disregard.
17.4	Exception	Clarified divestment.
17.5.5.4	Changing Divestment Penalty Periods	Removed process information and updated text to refer to Process Help.
18.4.2	Asset Assessment	Clarified date for HCBW applicants.
18.4.3	Calculate the Community Spouse Asset Share	Updated asset amounts.

18.6.2	Community Spouse Income Allocation	Updated maximum amount.
18.10	Dual Spousal Impoverishment Cases	Updated text to clarify policy.
20.3.2	Social Security Number	Updated policy.
20.3.3	Immigration Status	Updated policy.
20.3.5	Assets	Updated text.
20.3.5.2	Reasonable Compatibility for Assets	*New section.*
20.3.6	Medical or Remedial Expenses	Clarified role of care manager for verifying MREs.
20.10	Verification Resources	Updated text to include FDSH.
25.3	Widows and Widowers	Clarified policy.
26.3.2	Disability	Clarified policy for members converting from SSDI to SSRE.
26.5.2	Initial Premium	Moved process to Process Help and referenced the section.
26.5.7	Opting Out	Moved process to Process Help and referenced the section.
27.11	Institutions for Mental Disease	Removed IMD from list.
28	Adult Home and Community Based Waivers Long Term Care Introduction	*Chapter rewritten.*
28.14	Home and Community-Based Waivers Long-Term Care Children's Long-Term Support	Deleted section and moved information to new chapter for CLTS.
30.2	Financial Tests	Updated income limit.
32.6	Medicare Savings Programs Asset Limits	Updated limits.
33	SeniorCare	*Chapter rewritten.*
33.1	Introduction	Updated text.
33.2.1	SeniorCare Application Introduction	Updated text.
33.2.2	Application Processing	Updated text.
33.2.4	Authorized Representative	Updated text.
33.2.5	Guardian and Power of Attorney	Updated text.
33.3	Nonfinancial Requirements	Updated text
33.3.1	SeniorCare Nonfinancial Requirements Introduction	Updated text
33.3.2	Enrollment Fee	Clarified eligibility.
33.3.2.1	Refunds	Updated text.
33.3.2.2	Refunds to Deceased Members	Updated text.
33.3.4	Other Insurance	Clarified eligibility.
33.3.5	Creditable Coverage	*New section.*
33.5.1	SeniorCare Benefit Period Introduction	Clarification of benefit period.
33.5.2	ID Cards	Updated text and image.
33.5.3	Eligibility Begin Date	Clarified begin date.
33.6	Financial Requirements	Updated text.
33.6.2	Income	Clarified spouse's income.
33.6.3	Gross Social Security	Clarified income.
33.6.4	Gross Earnings	Updated text.
33.6.5	Interest and Dividends	Updated links
33.6.6	Self-Employment Earnings	Clarified income.

33.6.6.1	Rental Income	Clarified income.
33.6.7	Gross Retirement Income	Retitled and updated.
33.8.1	SeniorCare Countable Costs Introduction	Clarified costs.
33.9.1	SeniorCare Addition of a Spouse Introduction	Updated links
33.9.2.1	Adding A Spouse, No FTG Change, At Levels 2a and 2b	Clarified deductible.
33.9.4	Addition of a Spouse Summary Table	Updated text.
33.10.1	SeniorCare Changes Introduction	Updated text.
33.10.2	Correction of Errors	Updated text.
33.10.2.2	Applicant or Member Error	Clarified overpayment error.
33.12.1	SeniorCare Early Termination	Updated text and links.
33.13	Notice of Decision	Updated text and links.
33.14.3	Hearing	Updated text.
33.15	Annual Eligibility Review	Retitled and updated.
33.16.1	SeniorCare Benefits Introduction	Updated text.
37.1	Children's Long-Term Support (CLTS) Waiver Program Introduction	New section.
37.2	Agency Roles and Responsibilities	New section.
37.3	HCBW Medicaid CARES Processing for the CLTS Waiver Program	New section.
37.4	Cost Sharing	New section.
37.5	CLTS Parental Payment	New section.
38	Chapter 38	Removed chapter. (Applicable information was moved to Chapter 28.)
39.4.1	Elderly, Blind, or Disabled Assets and Income Table	Updated amounts.
39.4.2	Elderly, Blind, or Disabled Deductions and Allowances	Updated amounts.
39.4.4	Maximum Cost Share	New section.
39.5	Federal Poverty Level Table	Replaced FPL table.
39.6	Cost-of-Living Adjustment	Updated amounts.
39.11.1	SeniorCare Income Limits Introduction	Updated amounts.
39.11.5.1	Level 3: Fiscal Test Group of One	Updated amounts.
39.11.5.2	Level 3: Fiscal Test Group of Two	Updated amounts

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5.2 DETERMINATION OF DISABILITY

5.2.1 Definition of Disability

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

One exception to this is that a MAPP disability determination does not involve the SGA test. See Section 26.1 Medicaid Purchase Plan Introduction for the *MAPP* disability definition.

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

Note that for some long-term care programs, eligibility is based on level of care determinations rather than on a disability determination. For example, there is no disability determination required for children to be eligible for home and community based waivers. The appropriate level-of-care determination as established by the functional screen is used as an indicator of the child's need for services. This is also true for some adults. See Section 28.~~14~~1 Adult Home and Community-Based Waivers Long-~~Term~~term Care ~~Children's Long-term Support~~ Introduction and ~~Section 38.1~~ Chapter 37 Home and Community-Based Services: The Children's Long-Term ~~Care (Non-Institutional Medicaid).~~Support Waiver Program.

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

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

Example 1: Ed is an EBD Medicaid member who was determined disabled ten years ago and has been receiving SSDI since that time. Upon turning 63, his SSDI payments change to SSRE payments. The IM worker can see this change by querying SOLQ-I. By

policy, Ed is considered disabled and will not be required to provide any further verification or go through a re-determination.

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

Example 3: Fred was determined disabled twenty years ago. His SSDI payments recently converted to SSRE. Fred moved to Wisconsin and applied for MAPP. The worker was unable to find evidence of this conversion through SOLQ-I. Fred provided a statement from his “My Social Security” account that shows his SSDI payment stopped and SSRE payments began. This verification is sufficient to consider Fred disabled. He does not need to provide any further verification or go through a re-determination.

5.7 REDETERMINATION

5.7.1 Redetermination Introduction

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

1. The Disability Determination and Transmittal (SSA-831) indicates medical re-examination in item 17 of that form.
2. The person is younger than 65 years old and no longer receives *OASDI* (Social Security) disability benefits. This does not include members who have converted from OASDI benefits to Social Security Retirement benefits (see Section 5.10.2 Medicaid Members Who Convert from Social Security Disability to Social Security Retirement).

   ~~**Note:** Disability determinations should not be done for members older than 65 years old, except in some circumstances for *MAPP* (see Section 5.10.2 MAPP Members Over Age 65 and Section 26.3.2 Disability).~~
3. The medical circumstances have significantly improved (see Section 5.7.2 Members Exceeding the Substantial Gainful Activity Level).
4. The person has returned to work.

Complete and/or forward the following **paper** forms to *DDB* at

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

- Medicaid Disability Redetermination Report (F-10114).
- Signed Confidential Information Release forms.
- The original Disability Determination form (SSA-831) and any subsequent disability determinations and all prior medical evidence and forms.

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

Item 9 (SSA-832) indicates the decision of (A) continuing or (B) ceased.

Item 23B (SSA-832) indicates a medical re-examination date when necessary.

If the member's disability is found to continue, the DDB will send the paper folder, which includes the SSA-832, to the IM agency to be kept until the next redetermination is made.

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

If the member appeals the proposed cessation and DDB is able to reverse the decision to a continuance, a paper folder with a revised SSA-832 will be sent to the IM agency at that time.

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

If the member chooses not to appeal or fails to file the appeal on a timely basis, DDB will send the paper folder that contains the original SSA-832 to the IM agency following the expiration of the 45-day appeal period. DDB will add a **Medicaid Disability Cessation Case** note to the front of the folder to highlight these cases. See Section 5.7.1.1 Example of Medicaid Disability Cessation Case Notice Text for an example.

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

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

Upon receipt of the notification (Medicaid Disability Cessation) from DDB, the IM agency must then redetermine whether or not the member qualifies for some category of Medicaid other than that related to disability. If the member is not eligible for any other Medicaid category, the IM agency would then take the necessary action to discontinue the member's Medicaid eligibility in the normal manner, issuing all required notices. The member would then have another opportunity to appeal the termination of his or her

Medicaid eligibility. The fact that this second potential fair hearing essentially involves the same issue (disability) that was the subject of the first appeal is irrelevant. As stated earlier, this process is required by federal law.

5.10 MEDICAID PURCHASE PLAN DISABILITY

5.10.2 ~~MAPP~~ Medicaid Applicants and Members ~~Over Age 65~~

~~A MAPP member~~ who ~~loses *SSDI* benefits solely because he or she turns 65 does not need a disability re-determination until the next scheduled diary date. If there is no scheduled diary date, check with *SSA* to see if they still consider the person disabled. If not, a MAPP disability determination must be done, and MAPP eligibility must be continued until the MAPP disability determination is made by the *DDB*.~~Convert from Social Security Disability to Social Security Retirement

An EBD Medicaid applicant or member whose SSDI or any other disability-related Old Age, Survivors and Disability Insurance (OASDI or Title II) benefits stopped because he or she began receiving SSRE is considered to have met the disability requirement for all types of EBD Medicaid, including MAPP. A disability re-determination is not required. Refer to 5.2.2 Disabled Medicaid Applicants and Members Who Convert from Social Security Disability to Social Security Retirement Benefits.

For more information on MAPP, see Section. 26.1 Introduction.

6.9 INMATES

6.9.6 Department of Corrections Pre Release Applications from Offenders

Upon release from prison, many offenders are eligible for BadgerCare Plus as parents/caretakers or as childless adults. In order to prevent a gap in medical or pharmacy coverage upon the offender's release, the Department of Health Services (DHS) requires consortia and tribal IM agencies to accept telephonic applications for health care from offenders nearing their date of release.

Inmates who have a definitive release date may apply for health care benefits by calling their income maintenance (IM) agency on or after the 20th day of the month before the month of release. The application must be processed at the time of the initial call. The applicant must be allowed to sign the application telephonically.

Eligibility begins the first of the month in which the applicant is released, but providers are prohibited from billing BadgerCare Plus for any services while the applicant is still incarcerated. The first day that a member can receive BadgerCare Plus-covered services is the day of release.

Most verification can be obtained through current data exchanges, but if additional verification is needed, the applicant must be given 30 days to provide the verification.

When processing applications from applicants whose only source of income is through employment inside a prison in either DOC or Badger State Industries (BSI) jobs, the worker does not need to verify this income. DHS has already received verification that the maximum possible earnings in these positions are below program limits.

Applicants with sources of income in addition to DOC or BSI income are required to verify the income from employment within the prison, in addition to verifying the other income sources.

When processing an application with DOC assistance, the DOC staff may verbally verify the release date of the applicant. If the release date is not verbally confirmed by a DOC staff member as part of an assisted application, the worker will verify the discharge date by searching for the applicant on the WI DOC Offender Locator site.

See Process Help, Section 9.8 Processing Telephonic HC Applications from Offenders for more information on processing these applications.

7.2 DOCUMENTING CITIZENSHIP AND IDENTITY

7.2.1 ~~Documenting~~ Citizenship Verification Introduction

~~Persons~~U.S. citizenship must be verified for persons applying for or receiving Medicaid~~,~~ (MA), BadgerCare Plus, or *FPOS* benefits~~,~~ and who have declared that they are a U.S. citizen, ~~must provide documentation of their U.S. citizenship~~ unless they are exempt from this requirement (See Section 7.2.1.2~~) or their citizenship is verified by~~ Exempt Populations). Citizenship verification for health care must first be attempted using the real-time data exchange with the Social Security Administration before requesting documentation of citizenship from applicants. (See Section 7.2.3 Citizenship Verification through Data Exchange). Only those who are not exempt and for whom verification was not available through a data exchange~~.~~

~~Certain documents, such as a passport, are considered verification of~~ may be required to submit documentation of their citizenship (See Section 7.2.4 Citizenship Verification through Documentation). Once citizenship has been verified for a person, verification may never again be required to receive health care benefits unless previously verified information becomes questionable.

7.2.1.1 Covered Programs

The citizenship and identity documentation requirement covers all non-exempt applicants and members of the following:

- BadgerCare Plus (except for the Prenatal Program)
- Medicaid
- Katie Beckett (Note: Since eligibility for Katie Beckett is determined by staff in the Bureau of Children's Long-Term Support Services, they will ensure citizenship and identity verification.)
- Tuberculosis (TB)-related Medicaid
- Wisconsin Well Woman Medicaid (WWWMA)

Note: TB-related Medicaid and *WWWMA* eligibility are not determined in *CWW*. If citizenship has already been verified for one of these programs, do not require citizenship verification for applicants in CWW.

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
- Anyone who has been eligible for Wisconsin Medicaid or BadgerCare Plus as a Continuously Eligible Newborn (CEN) at any time on or after July 1, 2006. This includes CENs born on or after July 1, 2005

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

Former Supplemental Security Income and Medicare Recipients

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

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

7.2.2 Reserved

7.2.3 Citizenship Verification Through Data Exchange

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

Only persons meeting all of the following criteria will be selected for this data exchange:

- Requesting Medicaid, BadgerCare Plus, or Family Planning Only Services
- Declaring to be a U.S. 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 Medicaid applicants/members who do not provide an SSN or whose SSN cannot be verified, cannot have their citizenship verified through the data exchange. They must meet the citizenship verification requirement by ~~themselves. These are called "stand-alone documents".~~ providing documentation as defined in 7.2.4.

7.2.4 Citizenship Verification Through Documentation

Those who are not exempt from the citizenship verification requirement~~,~~ and have not had their citizenship verified by the Social Security Administration ~~and do not provide a stand-alone document, must provide documentation of citizenship and of identity. 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.~~must provide verification of citizenship. Verification will consist of either stand-alone documentation of citizenship (7.2.4.1) or documentation of both citizenship (7.2.4.2) and identity (7.2.4.3). Whether benefits may be granted while waiting for documentation to be provided and for how long are discussed under the Reasonable Opportunity Period section (7.2.4.4).

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

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

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

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

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

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

7.2.4.1 Stand-Alone Documentation of Citizenship

Stand-alone documentation is a single document that verifies citizenship, such as a United States Passport. Stand-alone documentation of citizenship is the most reliable way to establish that the person is a U.S. citizen. If an individual presents a stand-alone document, no other citizenship verification is required. See the chart below or Process Help Section 68.3 Acceptable Citizenship and Identity Documentation for a list of stand-alone documents.

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

Stand-Alone Document	Description/Explanation
Certificate of Naturalization	Form N-550 or N-570. Issued by the Department of Homeland Security for naturalization.
Certificate of Citizenship	Form N-560 or N-561. The Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.
A State-issued Enhanced Driver's License	A special type of driver's license identified specifically as an "Enhanced Driver's License". It requires proof of U.S. citizenship to obtain. Five states currently issue enhanced driver's licenses (Minnesota, Michigan, New York, Vermont, and Washington), but more states are expected to issue these licenses in the future. Accept an Enhanced Driver's License issued by any U.S. state.
U.S. Passport	The Department of State issues this. A U.S. passport does not have to be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation. Do not accept any passport as evidence of U.S. citizenship when it was issued with a limitation. Passports issued with a limitation may only be used as proof of identity.
Tribal Identification Documents	Documentary evidence issued by a federally recognized Indian tribe, which meets all the following criteria: • Identifies the federally recognized Indian tribe that issued the document • Identifies the individual by name • Confirms the individual's membership, enrollment, or affiliation with the tribe Such Tribal identification documents include, but are not limited

	to: • A Tribal enrollment card; • A Certificate of Degree of Indian Blood; • A Tribal census document; and • Documents on Tribal letterhead, issued under the signature of the appropriate Tribal official A photograph is not required to be part of these documents.

7.2.4.2 Evidence of Citizenship

If an applicant is unable to provide stand-alone documentation of citizenship (7.2.4.1), he or she must provide other documentation proving citizenship. Any document used to establish U.S. citizenship must show either a birthplace in the U.S., or that the person is otherwise a U.S. citizen. (See the chart below or Process Help, Section 68.3 Acceptable Citizenship and Identity Documentation for a list of acceptable documents of citizenship.) If an applicant is unable to provide any of the acceptable documents of citizenship, 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, and place of U.S. birth. The affidavit does not have to be notarized.

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

For any applicant born in Wisconsin, attempt to verify citizenship through the on-line birth query before requesting documentation of citizenship from the applicant.

Acceptable Documentation of Citizenship Only	Description/Explanation
Final Adoption Decree	The adoption decree must show the child's name and U.S. place of birth. Where an adoption is not finalized and the state in which the child was born will not release a birth certificate prior to final adoption, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.
Birth Certificate	A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899),

	, the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986). The birth record document may be recorded (previously 'issued') by the State, Commonwealth, Territory or local jurisdiction. **Note:** A Puerto Rican birth certificate used to verify U.S. citizenship of anyone applying for health care benefits must have been issued on or after July 1, 2010. Older birth certificates that were used to verify citizenship for persons when they previously applied for any IM program before October 1, 2010, are still considered valid.
Birth Query	A birth record query confirms a person's birth in Wisconsin.
U.S. birth record amended more than 5 years after person's birth	An amended U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986). Must show a U.S. birthplace.
Acquired citizenship through parent(s) as outlined in the Child Citizenship Act 2000 (CCA)	An individual demonstrates that s/he has gained his/her U.S. Citizenship through the Child Citizenship Act of 2000.
US Citizen ID Card or Northern Mariana Card	U.S. Citizen ID Card The Immigration and Naturalization Service (INS) issued the I-179 and the I-197 from 1960 until 1983 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Northern Mariana Card Form I-873. Issued by INS for those born in the Northern Mariana Islands before November 4, 1986.
State or Federal census record	Must show birthplace and citizenship. Census records from 1900 through 1950 contain certain citizenship information. To secure this information, the applicant, member, or State should complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested." Also add that the purpose is for Medicaid eligibility. This form requires a fee.

Education Document	The school record must show a U.S. birthplace and the name of the child.
Evidence of civil service employment by U.S. government	The document must show employment by the U.S. government before June 1, 1976. Persons employed with the U.S. Government prior to that date had to be U.S. citizens.
Hospital record	Extract of a hospital record on hospital letterhead established at the time of the person's birth and that indicates a U.S. place of birth. This is not a souvenir "birth certificate" issued by the hospital.
Life, health or other insurance record	Must show a U.S. place of birth.
Medicaid Birth Claim	When the Wisconsin Medicaid program pays the costs associated with the birth of an infant who either: • Did not qualify as a CEN, or • Was a CEN, but born before July 1, 2006, The infant will be considered a U.S. citizen who has met the citizenship documentation requirement. If citizenship is not verified through a data exchange, identity documentation is still required.
Medical record (doctor, clinic, hospital)	The document must show a U.S. birthplace. An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.
Official Military record of service	The document must show a U.S. birthplace.
Admission papers from nursing home, skilled nursing care facility or other institution	The document must show a U.S. birthplace.
Other MA Program Verified Citizenship	An individual has already provided proof of citizenship while they were receiving Wisconsin Medicaid outside of CARES. For example, use this for members previously enrolled through the Katie Beckett program.
Birth Certificate Paid by IM Agency	A U.S. public birth certificate (paid for by the Income Maintenance agency) showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern

	Mariana Islands (after November 4, 1986). The birth record document may be recorded (previously 'issued') by the State, Commonwealth, Territory or local jurisdiction.
Religious Record or Baptismal Certificate	An official religious record. The document must show a US birthplace and either the date of birth or the individual's age at time the record was made.
Certification of Report of Birth	The Department of State issues a DS-1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth.
Certification of Birth Abroad	Form FS-545. Issued by the Department of State consulates prior to November 1, 1990.
Consular Report of Birth Abroad of a US Citizen	Form FS-240. The Department of State consular office prepares and issues this. Children born outside the U.S. to U.S. military personnel usually have one of these.
SAVE database	Using the SAVE system to verify citizenship status for non-citizens who gained US citizenship.
Written Affidavit	If the applicant cannot produce the accepted documents verifying citizenship, then a Written Affidavit may be used. If the documentation requirement needs to be met through an affidavits, the following rules apply: • It must be signed by an individual other than the applicant, who can reasonably attest to the applicant's citizenship, and • That contains the applicant's name, date of birth, and place of U.S. birth. • The affidavit must be signed under penalty of perjury. • The affidavit does not have to be notarized.

7.2.4.3 Evidence of Identity

If an applicant is unable to provide stand-alone documentation of citizenship (7.2.4.1), in addition to providing evidence of citizenship (7.2.4.2), they must also provide evidence of identity. The applicant may provide any documentation of identity listed in the chart below or Process Help, Section 68.3 Acceptable Citizenship and Identity Documentation to prove identity, provided such document has a photograph or other identifying information sufficient to establish identity such as name, age, sex, race, height, weight, eye color, or address.

In addition, you may accept proof of identity from a Federal agency or another State agency, including but not limited to a law enforcement, revenue, or corrections agency,

if the agency has verified and certified the identity of the individual. 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. The applicant may submit a Statement of Citizenship and/or Identity (F-10161) or another affidavit.

Acceptable Documentation of Identity Only	Description/Explanation
State or Territory Driver's license	Driver's license issued by a U.S. State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color.
Education Document	For children under age 19, school records providing the name and other identifying information. School records would include, but not be limited to report cards, daycare or nursery school records.
FoodShare Identification Requirement met	Verifying the identity of the primary person is a requirement for a FoodShare application. Once this requirement is met for FoodShare, it is also met for the identity verification requirement for health care.
Identification card issued by Federal, State, or local government	Must have the same information as is included on driver license.
Institutional Care Affidavit (Form F-10175)	If the applicant cannot produce the accepted documents verifying identity, a signed Statement of Identity for Persons in Institutional Care Facilities (F-10175) may be used. A residential care facility administrator signs this form under penalty of perjury attesting to the identity of a disabled individual in the facility.
U.S. Military card or draft record, Military dependent's identification card, or US Coast Guard Merchant Mariner card	Must show identifying information that relates to the person named on the document.
Medical record	Doctor, clinic, or hospital records for children under age 19 only.
Motor Vehicle Data Exchange	This is a data exchange update with the Division of Motor Vehicles or when verifying an individual's identity

	through the DOT Driver License Status Check website.
Multiple Identity documents	An individual may provide 2 or more corroborating ID documents to verify his/her identity. Examples include marriage license, divorce decree, high school or college diploma, or an employer ID card.
Other MA Program Verified Identity	An individual has already provided proof of identity while they were receiving Wisconsin Medicaid outside of CARES. For example, use this for members previously enrolled through the Katie Beckett program.
State ID Paid by Agency	Must have the same information as is included on driver license.
School Identification card	School identification card with a photograph of the individual and/or other identifying information.
Written Affidavit for Children (Form F-10154)	If the applicant cannot produce the accepted documents verifying identity for children under 18 years of age, a Statement of Identity for Children Under 18 Years of Age (F-10154) is acceptable. The affidavit must be signed under penalty of perjury by a parent, guardian or caretaker relative stating the date and place of birth of the child. The affidavit does not have to be notarized.
Written Affidavit (Form F-10161)	If the applicant cannot produce the accepted documents verifying identity, then a Written Affidavit may be used. If the documentation requirement needs to be met through an affidavit, the following rules apply: • It must be signed by an individual other than the applicant, who can reasonably attest to the applicant's identity, and • That contains the applicant's name, and other identifying information such as, age, sex, race, height, weight, eye color, or address. • The affidavit must be signed under penalty of perjury. • The affidavit does not have to be notarized. A signed Statement of Citizenship and/or Identity (F-10161) may be used for individuals who are unable to obtain any level of acceptable documentation.

7.2.4.4 Reasonable Opportunity Period for Verification of Citizenship

Applicants who are otherwise eligible for Medicaid or other health care benefits and are only 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~~timeframe (30 days from the filing date). They are able to continue receiving health care benefits for which they are eligible, while the IM agency waits for citizenship verification. Applicants have 90 days after receiving a request for citizenship verification to provide the requested documentation. This 90-day period is called the reasonable opportunity period (ROP). The 90-day ROP starts on the date after the member receives the notice informing them of the need to provide citizenship verification by the end of the reasonable opportunity period. Federal regulations require that we assume a minimum five-day time frame for applicants to receive notices. For this reason, we must set the end of the ROP no less than 95 days after the date on the notice, even when the member receives the notice in less than 5 days. If a member shows that a notice was received more than 5 days after the date on the notice, we must extend the deadline to 90 days after the date the member received the notice.

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

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

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

~~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. A person should ordinarily be required to submit evidence of~~ allowed for verification of U.S. citizenship ~~(and identity when needed) only once, unless other information is received causing the evidence to be questionable~~.

Note: Do not reverify 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 requirement must be maintained in the case record.

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

7.2.1.1 Covered Programs

The citizenship and identity documentation requirement covers all non-exempt applicants and members of the following:

- BadgerCare Plus
- Medicaid
- Katie Beckett (Note: Since eligibility for Katie Beckett is determined by staff in the Bureau of Children's Long Term Support Services, they will ensure citizenship and identity verification.)
- *TB*-related Medicaid
- *WWWMA*

Note: TB and WWWMA eligibility is not determined in *CWW*; therefore, it is important to ensure that citizenship and identity verification is done only once.

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
- Anyone who has been eligible for Wisconsin Medicaid or BadgerCare Plus as a Continuously Eligible Newborn (CEN) born on or after July 1, 2005

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

7.2.2 Reserved

7.2.3 Citizenship Verification through Data Exchange

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 or not they are simultaneously applying for other benefits such as FoodShare)
- Declaring to be a US citizen or national

- Provides an SSNIs 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 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). If an applicant or member contacts the agency, work with him or

her to determine if anything on the document list in Process Help is readily available to the applicant or member.

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 of Citizenship

Stand-alone documentation is a single document that verifies citizenship, such as a U.S. Passport. Stand-alone documentation of citizenship is the most reliable way to establish that the person is a U.S. citizen. If an individual presents a stand-alone document, 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.

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

Evidence of Citizenship

If an applicant is unable to provide stand-alone documentation of citizenship, the first thing he or she must provide 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 to provide any of the acceptable 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, 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. Note that a citizenship document is evidence of only U.S. citizenship and must be accompanied by evidence of identity.

Note: Completing an online birth query can be done for all persons born in Wisconsin.

Evidence of Identity

If an applicant is unable to provide stand-alone documentation of citizenship, in addition to providing evidence of citizenship, they must also provide evidence of identity. (See Process Help, Section 68.3.4 Acceptable Documentation of Identity Only for a list.) The applicant may provide any 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.~~

~~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~~

~~7.2.4.3~~An individual may only receive one 95 day reasonable opportunity period for verification of U.S. citizenship or identity in his or her lifetime. When a person is terminated from health care benefits for failure to provide verification of citizenship or identity by the end of the reasonable opportunity period, they are not eligible to have their benefits continued if they request a fair hearing. If a person later reapplies for health care benefits, they must provide citizenship verification within regular verification deadlines and they are not eligible for health care benefits until they provide verification.

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

7.2.5 Agencies Paying for Documentation

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

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

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

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

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

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

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

~~**7.2.4.4 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~~ 7.2.6 Reserved

7.2.~~6~~7 Situations Which Require Special Documentation Processing

7.2.~~6~~7.1 Person Add

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

7.2.~~6~~7.2 Reserved

7.2.7.3 Individuals Without Verification and Effect on Household Eligibility

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

7.2.~~6.3 Individuals Gaining Citizenship Through the~~7.4 Child Citizenship Act of 2000

Certain foreign-born individuals have derivative U.S. citizenship as a result of the Child Citizenship Act. Within the context of the Medicaid citizenship verification requirement, this means that for any applicant or member claiming citizenship through the Child Citizenship Act, IM workers should not request documentation for that person. In these cases, IM workers need to acquire documentation proving the citizenship and identity of at least one U.S. citizen parent. The parent's U.S. citizenship is the basis for the child receiving derivative citizenship.

~~People~~For persons who meet the citizenship verification requirement through the means allowed in the Child Citizenship Act, ~~need~~this is considered evidence of citizenship. Therefore this counts for citizenship only and the individual needs to provide another document to verify identity~~. The code <CA> should be used in the Medicaid Citizenship Verification field~~.

See Section 7.1.2 Child Citizenship Act of 2000.

7.2.~~6.4~~7.5 Non-~~citizens~~U.S. Citizens

As a reminder, do not request or require citizenship and identity documentation from individuals who have not declared that they are U.S. citizens. Non-citizens who apply for IM programs are not subject to this policy. Legal non-citizens are subject to the verification process through *FDSH* and *SAVE* and undocumented non-citizens do not have any status that can be verified. (See Process Help, Section 44.2.2.11 Immigrant/Refugee Verification, for instructions on using FDSH and Process Help, Chapter 82 SAVE, for instructions on using SAVE.) Undocumented non-citizens can apply for Emergency Medicaid or ~~the~~ BadgerCare Plus Prenatal Program and should not be subject to the citizenship and identity 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. These individuals still need to provide proof of identity.

7.2.7.6.~~5~~ Individuals in Institutional Care Facilities

Disabled individuals in institutional care facilities may have their identity attested to by the facility director or administrator when nothing else is available. Use the Statement of Identity for Persons ~~In~~in Institutional Care Facilities ~~form,~~ (F-10175) for this purpose. A medical institution can be, but is not limited to, an *SNF*, *ICF*, *IMD*, and ~~hospital~~hospitals.

7.3 IMMIGRANTS

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

- "Qualified Immigrants" (see Section 7.3.3.1), or
- "Lawfully Present" (see Section 7.3.3.2), and
  - Are under age 19,
  - Are under age 21 and residing in an IMD, or
  - Are pregnant.

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

~~7.3.1 Immigrants Introduction~~

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

Immigrants are persons who reside in the U.S., but are not U.S. citizens or nationals. The immigrants described below, who apply for Medicaid and meet all eligibility requirements, are entitled to receive Medicaid benefits.

7.3.1 Declaration of Satisfactory Immigration Status

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

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

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

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

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

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

7.3.2 Verification

Primary verification of immigration status is done through the Department of Homeland Security (DHS) by use of the Federal Data Services Hub (FDSH) or SAVE, which is an automated telephone and computer database system. A worker processing an application can simply enter the immigrant's alien number and immigration document type into CWW. That information, along with demographic information of the individual, is sent in real time to the FDSH. The FDSH will immediately return verification of the immigrant's status, date of entry, and the date the status was granted if it's available from the Department of Homeland Security, along with other information. If the FDSH cannot provide verification of the immigration status, workers are directed to seek secondary verification though SAVE or take other action.

The verification query via the FDSH or SAVE most likely results in returning the latest date of any qualified alien status update for an individual, not his or her original date of arrival. The only way to obtain an accurate date of arrival for those who do not meet an exemption category and who report a date of arrival prior to August 22, 1996, is through the secondary verification procedure. The FDSH or SAVE will describe the immigrant's current status which may have changed from the original status. In some situations described later workers will need to maintain the original status in CARES.

It may be necessary to complete a secondary or third level verification procedure with the U.S. Citizenship and Immigration Services (USCIS), including confirming the date of arrival, in the following situations:

- The applicant does not fall into any of the categories of non-citizens who are exempt from the five-year ban (e.g., refugees, asylees, those with military service).

- An IM worker has made an initial or primary verification inquiry using the SAVE database. The information from the inquiry conflicts with information on the applicant's immigration documents or what he or she is telling the IM worker.
- A non-citizen applicant tells an IM worker that he or she came to the U.S. prior to August 22, 1996. If he or she arrived in a legal or documented status, the IM worker needs to verify the date of arrival to ensure that the correct alien eligibility rules are being applied.
- The FDSH or SAVE returns the message "Institute Secondary Verification."
- The IM worker finds any questionable information in the initial verification process.

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

Consult the SAVE manual for more information.

Additional verifications from sources other than the Department of Homeland Security are sometimes required as well. For example, persons who are in an immigration status subject to the 5-year bar and who indicate that they, their spouse or parent is in the military service or is a veteran, that military status must also be verified.

The following documents are considered valid verification of military service:

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

Immigration statuses for most immigrants are permanent and most often change when the immigrant become a U.S. citizen. For this reason, immigration status for most members should only be verified once, unless the status for an individual is questionable or it's a status subject to reverification (see Section 7.3.2.1). Even if an immigrant loses health care eligibility for a period of time, his or her immigration status does not need to be re-verified unless the status is subject to reverification.

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

7.3.2.1 Reverification of Immigration Status

The following persons with a Registration Status Code of 20 – Lawfully Residing are required to verify their immigration status at application and renewal, even if they have previously verified their immigration status:

- Immigrant children under age 19

- Youths under age 21 in an Institution for Mental Disease (IMD)
- Pregnant women

Typically, these persons will be labelled with a “Non-immigrant” status by the United States Citizenship and Immigration Services. Reverifications are not to be done for children and pregnant women with other Registration Status Codes, as those statuses are permanent. The reverification requirement is only to be applied at the time of subsequent applications, renewals, or when an agency receives information indicating that the member may no longer be lawfully residing in the U.S. For pregnant women, the reverification is not to occur until the renewal is done to determine the woman’s eligibility after the end of the 60-day postpartum period.

7.3.2.2 Reasonable Opportunity Period for Verification of Immigration Status

Applicants who have declared that they are in a satisfactory immigration status, are otherwise eligible and are only pending for verification of immigration status must be certified for health care benefits within the normal application processing timeframe (30 days from the filing date). They are to continue receiving health care benefits for which they are eligible, while the IM agency waits for immigration status verification. Applicants who are otherwise eligible and are only pending for verification of immigration will have 90 days after receiving a request for immigration verification to provide the requested documentation. This 90-day period is called the Reasonable Opportunity Period (ROP). The 90-day ROP starts on the date after the member receives the notice informing the member of the need for the member to provide immigration verification by the end of the reasonable opportunity period. Federal regulations require that we assume a minimum five-day time frame for applicants to receive notices. For this reason, we must set the end of the ROP no less than 95 days after the date on the notice, even when the member receives the notice in less than 5 days. It also means that if a member shows that a notice was received more than 5 days after the date on the notice, we must extend the deadline to 90 days after the date the member received the notice.

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

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

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

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

Applicants who fail to provide verification of immigration status and later reapply for health care benefits are not eligible for another ROP. If verification of immigration status is still needed, eligibility may not be granted until verification is provided. The regular verification deadlines apply.

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

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

- The person was not a U.S. citizen when first applying for benefits and received a reasonable opportunity period to verify immigration status. Later, the person became a U.S. citizen and applied for benefits. The person may receive a reasonable opportunity period to verify U.S. citizenship.
- The person is an immigrant who must reverify his or her immigration status at renewal (see Section 7.3.2.1 Reverification of Immigration Status). This person may receive an additional reasonable opportunity period for each subsequent renewal, as long as he or she provided the requested verification during the previous reasonable opportunity period.

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

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

7.3.3 Immigrants Eligible for Medicaid

Immigrants may be eligible for BadgerCare Plus if they meet all other eligibility requirements and are either Qualifying Immigrants or are Lawfully Present as described below.

7.3.3.1 Qualifying Immigrants

Immigrants of any age meeting the criteria listed below are considered Qualifying Immigrants.

1. A refugee admitted under Immigration and Nationality Act (INA) Section 207.

   A refugee is a person who flees his or her country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group.

   An immigrant admitted under this refugee status may be eligible for Medicaid even if his or her immigration status later changes.

2. An asylee admitted under INA Section 208.

   Similar to a refugee, this is a person who seeks asylum and is already present in the U.S. when he or she requests permission to stay.

   An immigrant admitted under this asylee status may be eligible for Medicaid even if his or her immigration status later changes.

3. An immigrant whose deportation is withheld under INA Section 243(h) and such status was granted prior to April 1, 1997, or an immigrant whose removal is withheld under INA Section 241(b)(3) on or after April 1, 1997.

   An immigrant admitted under this status may be eligible for Medicaid even if his or her immigration status later changes.

4. A Cuban/Haitian entrant.

   An immigrant admitted under this Cuban/Haitian entrant status may be eligible for Medicaid even if his or her immigration status later changes.

5. An American Indian born in Canada who is at least 50 percent American Indian by blood or an American Indian born outside the U.S. who is a member of a federally recognized Indian tribe.

6. Victims of a severe form of trafficking in accordance with 107(b)(1) of the Trafficking Victims Protection Act of 2000 (P.L. 106-386).

7. Lawfully admitted for permanent residence under the INA~~.~~.*

8. Paroled into the U.S. under INA Section 212(d)(5~~).~~).*

9. Granted conditional entry under immigration law in effect before April 1, 1980 [INA Section 203(a)(7~~)~~])]*

10. An immigrant who has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements~~.~~.*

11. An immigrant whose child has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements~~.~~.*

12. An immigrant child who resides with a parent who has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements~~.~~.*

~~**7.3.1.1 Special Provisions for Immigrants in items 7-12~~

~~**~~
*If these immigrants ~~(from items 7-12)~~ lawfully entered the U.S. on or after August 22, 1996, they must also be one of the following:

- ~~Lawfully~~Be lawfully residing in Wisconsin and an honorably discharged veteran of the U.S. Armed Forces~~, or~~ (see Section 7.3.10 Military Service)
- ~~Lawfully~~Be lawfully residing in Wisconsin and on active duty (other than active duty for training) in the U.S. Armed Forces~~, or~~ (see Section 7.3.10 Military Service)
- ~~Lawfully~~Be lawfully residing in Wisconsin and the spouse , unmarried dependent child, or surviving spouse of either an honorably discharged veteran or a person ~~described in "a" or "b" or~~on active duty in the U.S. Armed Forces
- ~~An~~Be an Amerasian~~, or~~
- ~~Resided~~Have resided in the U.S. for at least five years since his or her date of entry~~.~~
  ~~-~~ (see Section 7.3.6 Continuous Presence).

~~Beginning, October 1, 2009, children under the age of 19 and pregnant women who are either:~~

~~Lawfully~~7.3.3.2 Lawfully Present Immigrant Children, Young Adults, and Pregnant Women

Children younger than 19 years old, adults younger than 21 years old who are residing in an IMD, and pregnant women do not have to wait five years to be eligible for full-benefit Medicaid and BadgerCare Plus if they meet one of the following:

- Are lawfully Admitted for Permanent Residence (CARES TCTZ Code #1 in the Immigration Status Chart ~~below~~in Section 7.3.8),
- ~~Lawfully~~Are lawfully present under Section 203(a)(7) (Code #3 in the Immigration Status Chart ~~below~~in Section 7.3.8),
- ~~Lawfully~~Are lawfully present under Section 212(d)(5) (Code #6 in the Immigration Status Chart ~~below~~in Section 7.3.8), or
- ~~Who suffer~~Have suffered from domestic abuse and are considered to be a battered immigrant (Code #16 in the Immigration Status Chart ~~below~~in Section 7.3.8),

~~no longer~~Women who have ~~to wait 5 years to be~~an immigration status requiring a five-year waiting period before being eligible for ~~full benefit Medicaid and~~ BadgerCare Plus~~. This policy applies to both persons in existing open cases and new applicants. Women~~ will have the ~~5-year ban~~waiting period lifted when their pregnancy is ~~verified and~~reported to the agency. The lift on the five-year waiting period continues for an additional 60 days after the last day of pregnancy and through the end of the month in which the 60th day occurs.

Children younger than 19 years old, young adults younger than 21 years old who are residing in an IMD, and pregnant women may qualify for BadgerCare Plus or Medicaid if they are lawfully present in the U.S. under any of the nonimmigrant statuses listed in the table below and are otherwise eligible.

Eligible Nonimmigrant Statuses for Children, Young Adults in an IMD, and Pregnant Women	
Description	**Class of Admission Code or Section of Law Citation**
Aliens currently in temporary resident status pursuant to section 210 or 245A of the Act.	S16, S26, W16, W25, W26, W36 or 8 CFR 103.12(a)(4)(i)
Aliens currently under Temporary Protected Status (TPS)pursuant to section 244 of the Act. Child accompanying or	TPS, 8 CFR 103.12(a)(4)(ii)

following to join a K-3 alien.	
Family Unity beneficiaries pursuant to section 301 of Pub. L.101-649. (These are the spouses and unmarried children of individuals granted temporary or permanent residence under Section 210 or 245A above.)	FUG, 8 CFR 103.12(a)(4)(iv)
Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President.	8 CFR 103.12(a)(4)(v)
Aliens currently in deferred action status pursuant to Service Operations Instructions at OI 242.1(a)(22).	8 CFR 103.12(a)(4)(vi)
Aliens who are the spouse or child of a United States citizen whose visa petition has been approved and who have a pending application for adjustment of status	8 CFR 103.12(a)(4)(vii)
Legal non-immigrants from the Compact of Free Association states (Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau) who are considered permanent non-immigrants.	NA
Spouse/dependent of a non-immigrant foreign government official, dependent of foreign government official	A-2
Attendant, servant, or personal employee of A-1 or A-2 and members of immediate family.	A-3
Domestic servant of certain non-immigrants or US Citizens	B-1, B-2
Treaty Trader/Investor, spouse and children	E-1, E-2, E-3; 8 USC 1101(a)(15)(E)

Students; their spouse and children	F-1, F-2, F-3; 8 USC 1101(a)(15)(F)
Spouse/dependent of foreign government official or representative of international organization and their dependents, servants or employees	G-1, G-2, G-3, G-4, G-5; 8 USC 1101(a)(15)(G)
Spouse of a temporary worker (other than registered nurse) with "specialty occupation" admitted on the basis of professional education, skills, and/or equivalent experience	H1-B, H4
Spouse or children of an exchange visitor	J-2
An alien who is the fiancée or fiancé of a U.S. citizen entering solely to conclude a valid marriage contract.	K-1
Child of K-1	K-2
Spouse of a U.S. citizen who is a beneficiary of a petition for status as the immediate relatives of a U.S. citizen (I-130).	K-3
Child accompanying or following to join a K-3 alien.	K-4
Individuals in the U.S. who have been transferred from a subsidiary, affiliate, or branch office overseas to the U.S. to work in an executive, managerial, or specialized knowledge capacity; or their spouse and children.	L-1, L-2, L-3
Student pursuing a full course of study at an established vocational or other recognized nonacademic institution (other than in a language training program); their spouse and children	M-1, M-2
Parent of an alien classified SK3 or SN3	N-8

Child of N-8 or of an alien classified SK1, SK2, SK4, SN1, SN2, SN4.	N-9
Temporary worker to perform work in religious occupations.	R1
Spouse and children of R1	R2
An alien who is in possession of critical reliable information concerning a criminal organization or enterprise, is willing to supply or has supplied such information to Federal or State law enforcement authorities or a Federal or State court; and whose presence in the United States the Attorney General determines is essential to the success of an authorized criminal investigation or the successful prosecution of an individual involved in the criminal organization or enterprise	8 U.S.C. 1101(a)(15)(S)(i)
An alien who the Secretary of State and the Attorney General jointly determine is in possession of critical reliable information concerning a terrorist organization, enterprise, or operation; is willing to supply or has supplied such information to Federal law enforcement authorities or a Federal court; will be or has been placed in danger as a result of providing such information; and is eligible to receive a reward from the State Department.	8 U.S.C. 1101(a)(15)(S)(ii)
An alien who is the spouse, married and unmarried sons and daughters, and parents of an alien in possession of critical reliable information concerning either criminal activities or terrorist operations.	8 U.S.C. 1101(a)(15)(S)
Individuals who have suffered substantial physical or mental abuse as victim of criminal activity.	U-1
An alien who is the spouse, child, unmarried sibling or parent of the victim of	U-2, U-3, U-4, U-5

the criminal activity above.	
An alien who are the spouses or children of an alien lawfully admitted for permanent residence and who have been waiting since at least December 2000 for their visa application to be approved.	V-1, V-2, V-3

Immigrants~~,~~ who do not appear in the lists above~~,~~ (for example, someone with a status of *DACA* and who apply for Medicaid and meet all eligibility requirements except for citizenship are entitled to receive Medicaid Emergency Services only (see ~~the BadgerCare Plus Eligibility Handbook).~~ Chapter 34 Emergency Services).

Pregnant immigrants who do not appear in the list above~~,~~ and who apply for the BadgerCare Plus Prenatal Program ~~(BC+PP) (see the BadgerCare Plus Eligibility Handbook) and who~~ and meet the eligibility requirements except for citizenship are entitled to receive ~~those~~BadgerCare Plus Prenatal Program benefits~~.~~ and/or BadgerCare Plus Emergency Services (see BadgerCare Plus Eligibility Handbook, Chapter 41 BadgerCare Plus Prenatal Program and Chapter 39 Emergency Services).

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

~~Verify immigration status using the procedures in the SAVE Program Guide.~~

7.3.~~2~~4 Public Charge

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

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

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

7.3.~~5~~ 5 ~~3 INS Reporting~~ Immigration and Naturalization Service (INS) Reporting

Do not refer an immigrant to *INS* unless information for administering the Medicaid program is needed. For example, if Medicaid needs to determine an individual's location for repayment or fraud prosecution, or to determine his or her immigration status.

7.3.~~4 Immigration Status Chart~~6 Continuous Presence

Certain non-citizens who arrived in the U.S. on or after August 22, 1996, are subject to a five-year ban on receiving federal benefits (including BadgerCare Plus and Medicaid), other than emergency services. For these immigrants, the five-year ban is calculated beginning on the day on which they gain qualified immigrant status. However, certain applicants who alleged an arrival date in the U.S. before August 22, 1996, and obtained legal qualified immigrant status after August 22, 1996, are not subject to the five-year ban and may be eligible to receive federal BadgerCare Plus enrollment. The immigrants described below, who apply for BadgerCare Plus and meet all eligibility requirements, are entitled to receive BadgerCare Plus benefits:

- A non-citizen who arrived in the U.S. before August 22, 1996, in a legal, but non-qualified, immigration status and changed his or her status to a qualified immigrant on or after August 22, 1996. This individual would not be subject to the five-year ban if he or she remained continuously present from his or her date or arrival in the U.S. until the date he or she gained qualified immigration status.
- A non-citizen who arrived in the U.S. before August 22, 1996, in undocumented status or who overstayed his or her original visa is treated the same as someone who arrived and remained in the U.S. with valid immigration documents. Therefore, if this individual remained continuously present from his or her date of arrival in the U.S. until the date he or she gained qualified immigration status, he or she would not be subject to the five-year ban.
- For those non-citizens who arrived in the U.S. with or without documentation on or after August 22, 1996, or for those whose continuous presence cannot be verified, the five-year ban applies from the date the individual obtained qualified immigrant status.

An individual meets the "continuous presence" test if he or she:

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

To establish continuous presence, require a signed statement from the *applicant* stating he or she was continuously present for the period of time in question. The signed statement will be sufficient unless a worker believes the information is fraudulent or further information received now indicates that it is questionable.

Below is one example of a signed statement:

> I, *first and last name*, hereby declare that I have continuously resided in the United States between the day I arrived in the United States, *date here*, and the date I received qualified alien status, *date here*. I have not left the United States in that time for any single period of time longer than 30 days or for multiple periods totaling more than 90 days.
>
> *Applicant/authorized representative Signature, Date*

7.3.7 Undocumented Non-Citizens

In cases in which it is known that the applicant originally arrived in the U.S. in undocumented status, do not attempt to verify his or her status with the USCIS. Undocumented immigrants do not have any official documentation regarding their date of arrival. Therefore, if a worker needs to establish a date of arrival for a qualified immigrant who originally arrived as an undocumented immigrant prior to August 22, 1996, alternative methods need to be used. In such cases, the applicant must provide at least one piece of documentation that shows his or her presence in the U.S. prior to August 22, 1996. This may include pay stubs, a letter from an employer, lease or rent receipts, or a utility bill in the applicant's name.

~~**Arrived on or after 8-22-96**~~**Example 2:** The legal status conferred on a non-citizen by immigration law—Toshi entered the U.S. February 2, 2004, with qualified immigrant status. She is applying for Medicaid in February 2008. The IM worker should first determine if she is in one of the immigrant categories exempt from the five-year ban. If Toshi is not exempt, then she must wait five years before qualifying for Medicaid. She can be enrolled in Medicaid after February 2, 2009 if she meets other financial and non-financial criteria.

~~01~~	~~Lawfully admitted for permanent residence~~	~~Eligible~~	~~Eligible~~	~~Ineligible for 5 years~~	~~Eligible~~	~~Eligible effective 10-01-09~~
~~02~~	~~Permanent resident under color of law (PRUCOL)~~	~~Ineligible~~	~~Ineligible~~	~~Ineligible~~	~~Ineligible~~	~~Ineligible~~
~~03~~	~~Lawfully present under Section 203(a)(7)~~	~~Eligible~~	~~Eligible~~	~~Ineligible for 5 years~~	~~Eligible~~	~~Eligible effective 10-01-09~~
~~04~~	~~Lawfully present under~~	~~Eligible~~	~~Eligible~~	~~Eligible~~	~~Eligible~~	~~Eligible~~

	Section 207(c)					
05	Lawfully present under Section 208	Eligible	Eligible	Eligible	Eligible	Eligible
06	Lawfully present under Section 212(d)(5	Eligible	Eligible	Ineligible for 5 years	Ineligible for 5 years	Eligible effective 10-01-09

Example 3: Shariff arrived as a student in June 2002. On June 5, 2006 he was granted asylum. The five-year ban does not apply because asylees are exempt from the ban. Secondary verification is not necessary. Shariff is eligible to be enrolled in Medicaid if he meets other financial and non-financial criteria.

Example 4: Katrin entered the U.S. March 3, 1995, and gained qualified immigrant status June 20, 1995. She is applying for Medicaid in February 2008. She is a qualified immigrant who entered the U.S. prior to August 22, 1996. There is no need to apply the five-year ban. She is eligible for Medicaid if she meets other financial and non-financial criteria.

Example 5: Juan entered the U.S. as an undocumented immigrant on April 1, 1996. He applied for Medicaid on February 1, 2008. His immigration status changed to lawful permanent resident on March 3, 2005. He has signed a self-declaration stating he remained continuously present in the U.S. between April 1, 1996, and March 3, 2005. Additionally, Juan provided a copy of a lease showing a date prior to August 1996. He is eligible for Medicaid if he meets other financial and non-financial criteria.

Example 6: Elena entered the U.S. on July 15, 1999, on a temporary work visa and obtained qualified immigration status on October 31, 2004. She applied for Medicaid February 1, 2008, and has been in the U.S. for over five years. Elena is not in one of the immigrant categories exempt from the five-year ban. Therefore, the five-year ban would have to be applied since Elena's original entry date is after August 22, 1996. The five-year clock starts from the date she obtained qualified immigration status, so she would be able to apply for Medicaid after October 31, 2009.

Example 7: Tomas entered the U.S. on April 8, 1996, on a visitor's visa. He obtained qualified alien status on September 22, 2003. Tomas applied for Medicaid on May 5, 2008. The IM worker completed primary verification and USCIS responded with the date of entry as September 22, 2003, since that was the last updated date on his status. The IM worker needs to confirm with the applicant that this is the original date he arrived in the U.S. Tomas explained that he arrived in 1996; therefore, the IM worker needs to

conduct secondary verification. USCIS responds and confirms that the original date of arrival was April 8, 1996. Additionally, the IM worker needs to confirm that the applicant was continuously present between April 8, 1996, and September 22, 2003. Tomas signs a self-declaration confirming this and is found eligible. If the IM worker had used September 22, 2003, as the date of entry in CARES, Tomas would have been incorrectly subject to the five-year ban and not eligible until September 22, 2008.

7.3.8 Immigration Status Chart

CARES TCTZ Code	Immigration Status	Arrived Before 08/22/96	Veteran* Arrived before August 22, 1996	Arrived on or after August 22, 1996	Veteran* Arrived on or after August 22, 1996	Children under 19 and pregnant women; Arrived on or after August 22, 1996
01	Lawfully admitted for permanent residence	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009 Eligible
02	Permanent resident under color of law (PRUCOL)	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
03	Lawfully present under Section 203(a)(7)	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009 Eligible
04	Lawfully present under Section 207(c)	Eligible	Eligible	Eligible	Eligible	Eligible
05	Lawfully present under Section 208	Eligible	Eligible	Eligible	Eligible	Eligible
06	Lawfully present under Section	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009 Eligible

	212(d)(5					
07	IRCA (No longer valid)	N/A	N/A	N/A	N/A	N/A
08	Lawfully admitted - temporary	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
09	Undocumented ~~Alien~~Immigrant	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
10	Illegal ~~Alien~~ -Immigrant	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
11	Cuban/Haitian Entrant	Eligible	Eligible	Eligible	Eligible	Eligible
12	Considered a Permanent Resident by USCIS	Ineligible	Ineligible	Ineligible	Ineligible	~~Ineligible~~Eligible
13	Special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
14	Additional special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
15	Withheld deportation - Section 243(h)	Eligible	Eligible	Eligible	Eligible	Eligible
16	Battered ~~Alien~~Immigrant	Eligible	Eligible	Ineligible for 5 years	~~Ineligible for 5 years~~Eligible	Effective October 1, 2009 Eligible ~~effective 10-01-09~~

17	Amerasian	Eligible	Eligible	Eligible	Eligible	Eligible
18	Foreign-~~born~~Born Native American ~~Indian~~	Eligible	Eligible	Eligible	Eligible	Eligible
19	Victims of Trafficking**	Eligible	Eligible	Eligible	Eligible	Eligible
20	~~Lawfully Residing - to be used for all persons admitted under one of the Class of Admission Codes found in the table in section 7.4.4~~Lawfully Residing	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
21	Victims of Trafficking Subject to 5 Year Bar	Eligible	Eligible	Ineligible for 5 years	Eligible	Eligible

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

~~7~~

**Some victims of trafficking may need to provide certain verification to be exempt from the five-year bar. See Section 4.3.~~5~~10 Victims of Trafficking for more information.

7.3.9 Iraqis and Afghans with Special Immigrant Status

~~Some Afghan and Iraqi aliens have been granted special immigrant status. Individuals and family members granted this special status are eligible for resettlement assistance, entitlement programs and other benefits the same as refugees admitted under section 207 of the INA. These groups have been admitted to the U.S. in Lawful Permanent Resident status; however for a limited time upon arrival they are treated as if they are in Refugee status for public benefits purposes.~~

~~Though treated like refugees, the individuals in this special immigrant status category are only able to access benefits for a limited time:~~

- ~~Afghan special immigrants are eligible for Medicaid benefits for up to six months from the date they enter the country.~~
- ~~Iraqi special immigrants are eligible for Medicaid benefits for up to eight months from the date they enter the country.~~

~~At the end of the six or eight month period, the immigration status for these populations becomes Lawful Permanent Resident (LPR). According to federal law, LPRs are subject to the five year bar on receiving public benefits. See Section 7.3.4 Immigration Status Chart.~~

~~Spouses and unmarried children under age 21, who accompany or follow-to-join the principal special immigrant *applicant* are eligible for the same benefits as the principal applicant.~~

~~Any Iraqi or Afghan immigrant granted the special status, who applied after 12/26/2007 and was denied Medicaid benefits due to citizenship or immigration status, may request Medicaid benefits back to the original application filing date.~~

~~7.3.5.1 End of Temporary Benefit Period~~

~~Medicaid eligibility for special immigrants and family members must end within six or eight months after their US entry as special immigrants or conversion to special immigrant status, regardless of rules that are otherwise applied for their eligibility group (e.g., coverage of pregnant women until the end of their postpartum period).~~

~~These individuals would not be able to receive benefits until they have been here for five years from the date of entry. The five year clock begins from the individual's original date of entry and it does not start over once the limited special status benefits expire.~~

~~Iraqi and Afghan special immigrants and their families may qualify for Medicaid coverage of emergency services, until they meet the 5-year bar for qualified immigrants.~~

~~**Note:** An infant born in the U.S to a woman who was Medicaid eligible as an Iraqi or Afghan special immigrant on the baby's date of birth, is a U.S. citizen and deemed Medicaid eligible as a newborn until turning age one.~~
Beginning December 19, 2009, Special Immigrants from Iraq or Afghanistan (Class of Admission Codes SI-1, 2, 3, 6, 7, and 8) are to be treated like they are refugees when determining their eligibility for BadgerCare Plus for as long as they have this Special Immigrant status. This policy applies to these immigrants regardless of when they received this status.

Class of Admission Code	Description	CARES Alien Registration Status Code
SI1	Nationals of Iraq or Afghanistan serving as interpreters with the U.S. Armed Forces	Code 04
SI2	Spouses of an SI1	Code 04
SI3	Children of an SI1	Code 04
SI6	Nationals of Iraq or Afghanistan serving as interpreters with the U.S. Armed Forces	Code 04
SI7	Spouses of an SI6	Code 04
SI8	Children of an SI6	Code 04

7.3.~~5.2~~9.1 Counting Refugee Related Income

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

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

7.3.~~5.3~~9.2 Refugee Medical Assistance

If an individual does not meet the other eligibility requirements for Medicaid, he or she may apply for Refugee Medical Assistance (RMA), which is not funded by Medicaid. ~~RMA~~Refugee Medical Assistance is considered a separate benefit from Medicaid but provides the same level of benefits ~~as these programs. RMA~~. Refugee Medical Assistance is available only in the first eight months after a special immigrant's date of entry. If it is not applied for in that eight-month period, it cannot be applied for later. Iraqi immigrants may be eligible for ~~RMA~~Refugee Medical Assistance for eight months and Afghan immigrants may be eligible for ~~RMA~~Refugee Medical Assistance for six months.

While W-2 agencies have contractual responsibility for providing ~~RMA~~Refugee Medical Assistance, they need to coordinate with economic support agencies to ensure eligibility for all regular Medicaid subprograms is tested first.

More information about this program is in ~~Chapter 18 of the~~ Wisconsin Works (W-2) Manual, Section 18.3 Refugee Medical Assistance.

Note: The federal Medicaid eligibility for all other refugees admitted under Alien Status Code 04 remains the same.

7.3.10 Military Service

Applicants with an immigration status that requires them to be in that immigration status for five years before being eligible for health care benefits are exempt from this five-year bar if they meet any of the following criteria related to military service:

- Honorably discharged veterans of the U.S. Armed Forces. This is defined as persons who were honorably discharged after any of the following:
  - Serving for at least 24 months in the U.S. Armed Forces.
  - Serving for the period for which the person was called to active duty in the U.S. Armed Forces.
  - Serving less than 24 months but was discharged or released from active duty for a disability incurred or aggravated in the line of duty.
  - Serving less than 24 months but was discharged for family hardship.
  - Serving in the Philippine Commonwealth Army or as a Philippine Scout during World War II.
- On active duty (other than active duty for training) in the U.S. Armed Forces.
- The spouse, unmarried and non-emancipated child under age 18, or surviving spouse of either an honorably discharged veteran or a person on active duty in the U.S. Armed Forces. A surviving spouse is defined as meeting all of the following criteria:
  - A spouse who was married to the deceased veteran for at least one year.
  - A spouse who was married to the deceased veteran either:
    - Before the end of a 15 year time span following the end of the period of military service, or
    - For any period of time to the deceased veteran and a child was born of the marriage or was born before the marriage.
  - A spouse who has not remarried since the marriage to the deceased veteran.

7.3.11 Victims of Trafficking

Applicants claiming to be victims of trafficking (or have a Class of Admission (COA) code indicating that they are a victim – ST6 or T1), have not resided in the United States for at least five years, and are at least 18 years of age, must have a victim certification from the federal Office of Refugee Resettlement (ORR) in the Department

of Health and Human Services to be treated like a refugee and be exempt from the five-year bar.

Persons with a COA code indicating they are a child, spouse, or parent of a trafficking victim (Codes ST0, ST1, ST7, ST8, ST9, T2, T3, T4, T5, or T6) are exempt from the five-year bar and do not need certification from the ORR. Victims of trafficking who are under 18 at the time they apply do not require a certification from the ORR. Victims of Trafficking who are 18 or older and do not have the certification will be subject to the five-year bar.

7.4 ~~NON-IMMIGRANT, NON-CITIZENS~~RESERVED

~~7.4.1 Introduction~~

~~Section 214 of the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3), offers states the option to cover children and pregnant women under the federal Medicaid and State Children's Health Insurance Programs who are not Qualified Aliens.~~

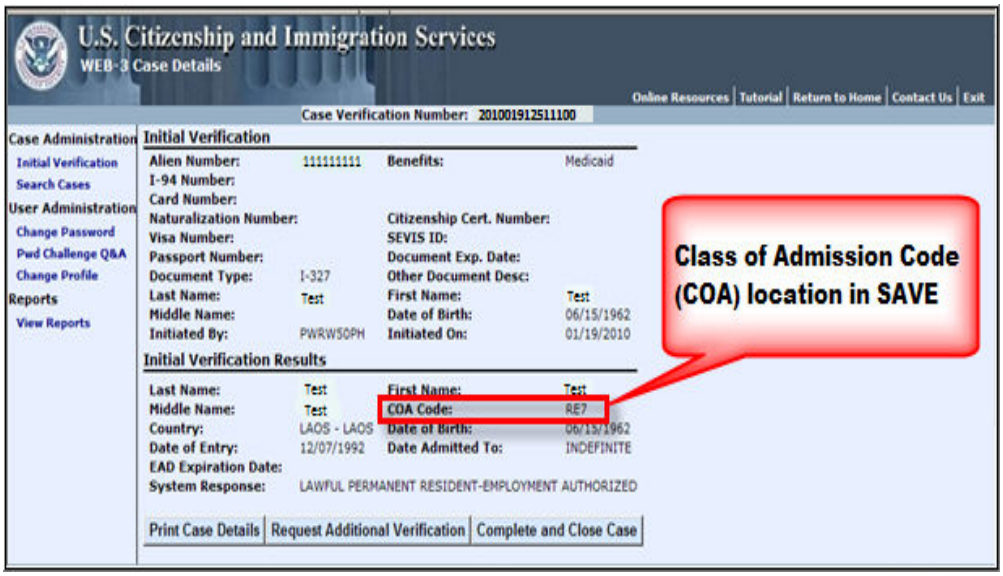
~~The law also affects children and pregnant women in a number of non-immigration statuses/classes (see table below) who are lawfully residing in the country for an indefinite period. This policy clarification allows children and pregnant women admitted to the United States in these statuses/classes to qualify for Medicaid and BadgerCare Plus, if they are otherwise eligible, starting October 1, 2009.~~

~~7.4.2 New Age Group~~

~~*CMS* requires that the new policies that apply to children also be applied to persons under age 21 who are institutionalized, including residents of *IMD*s). These changes are effective October 1, 2009.~~

~~7.4.3 VIS SAVE Verification Responses~~

~~All non-immigrants admitted legally to the United States for any reason will have some type of *USCIS* document, for example, a Non-immigrant Visa, Employment Authorization card, Passport, etc. The USCIS document proof provided by the non-immigrant individual will usually include a two to three digit code called the "Class of Admission Code" (COA) or the Section of Federal Law citation. The COA code is also found in the SAVE response when doing a SAVE query.~~



~~A table of the COA codes or the Section of Law citation for this new non-immigrant population is included below. The non-immigrant children and pregnant women with the admission code or Federal law citation found in this table who are otherwise eligible are now able to receive full benefit Medicaid or BadgerCare Plus.~~

~~7.4.4 Class Of Admission (COA) Codes~~

~~USCIS Class of Admission Code or Section of the Federal Law Citation Authorizing Class~~	
~~Description~~	~~Class of Admission Code (COA)/Section of Law Citation~~

Aliens currently in temporary resident status pursuant to section 210 or 245A of the Act.	S16, S26, W16, W25, W26, W36 or 8 CFR 103.12(a)(4)(i)
Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the Act. Child accompanying or following to join a K-3 alien.	8 CFR 103.12(a)(4)(ii)
Family Unity beneficiaries pursuant to section 301 of Pub. L. 101-649. (These are the spouses and unmarried children of individuals granted temporary or permanent residence under Section 210 or 245A above.)	8 CFR 103.12(a)(4)(iv)
Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President.	8 CFR 103.12(a)(4)(v)
Aliens currently in deferred action status pursuant to Service Operations Instructions at OI 242.1(a)(22).	8 CFR 103.12(a)(4)(vi)
Aliens who are the spouse or child of a United States citizen whose visa petition has been approved and who have a pending application for adjustment of status	8 CFR 103.12(a)(4)(vii)
Legal non-immigrants from the Compact of Free Association states (Republic of the Marshall Islands, the Federated States of Micronesia and the Republic of Palau) who are considered permanent non-immigrants.	NA
An alien who is the fiancée or fiancé of a U.S. citizen entering solely to conclude a valid marriage contract.	K-1
Child of K-1	K-2
Spouse of a U.S. citizen who is a beneficiary of a petition for status as the immediate relatives of a U.S. citizen (I-130).	K-3

~~Child accompanying or following to join a K-3 alien.~~	~~K-4~~
~~Parent of an alien classified SK3 or SN3~~	~~N-8~~
~~Child of N-8 or of an alien classified SK1, SK2, SK4, SN1, SN2, SN4.~~	~~N-9~~
~~Temporary worker to perform work in religious occupations.~~	~~R1~~
~~Spouse and children of R1~~	~~R2~~
~~An alien who is in possession of critical reliable information concerning a criminal organization or enterprise, is willing to supply or has supplied such information to Federal or State law enforcement authorities or a Federal or State court; and whose presence in the United States the Attorney General determines is essential to the success of an authorized criminal investigation or the successful prosecution of an individual involved in the criminal organization or enterprise~~	~~8 U.S.C. 1101(a)(15)(S)(i)~~
~~An alien who the Secretary of State and the Attorney General jointly determine is in possession of critical reliable information concerning a terrorist organization, enterprise, or operation; is willing to supply or has supplied such information to Federal law enforcement authorities or a Federal court; will be or has been placed in danger as a result of providing such information; and is eligible to receive a reward from the State Department.~~	~~8 U.S.C. 1101(a)(15)(S)(ii)~~
~~An alien who is the spouse, married and unmarried sons and daughters, and parents of an alien in possession of critical reliable information concerning either criminal activities or terrorist operations.~~	~~8 U.S.C. 1101(a)(15)(S)~~
~~Individuals who have suffered substantial~~	~~U-1~~

physical or mental abuse as victim of criminal activity.	
An alien who is the spouse, child, unmarried sibling or parent of the victim of the criminal activity above.	U-2, U-3, U-4, U-5
An alien who are the spouses or children of an alien lawfully admitted for permanent residence and who have been waiting since at least December 2000 for their visa application to be approved.	V-1, V-2, V-3

- For a complete table of the USCIS Class of Admission (COA) Codes log into the SAVE system and click on the "Online Resources" tab.

Note: There is no change in Medicaid or BadgerCare Plus eligibility policy for individuals in any other status or for those who are undocumented.

8.4 COOPERATION BETWEEN IM & CSA

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

8.4.1 Information

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

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

8.4.2 Medicaid Discontinued

The CSA is notified through CARES when Medicaid is discontinued.

8.4.3 Fraud

When the CSA has knowledge of possible fraud, they will refer the case back to the IM agency. For example, if in the process of collecting support the CSA establishes that a parent is in fact not absent, the CSA will give that information to the IM agency for appropriate action (Income Maintenance Manual Section 11.1 Public Assistance Fraud Program).

10.1 SSN REQUIREMENTS

10.1.1 ~~Overview of~~ Social Security Number Requirements

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

~~Do not deny benefits pending issuance of an SSN if you have any documentation that an SSN application was made.~~ If an SSN application was made in good faith and the applicant cooperated fully with the application process, do not deny benefits if the SSN application was denied for reasons beyond the applicant's control. See Section 20.3.2 Social Security Number for more information on health care eligibility without a verified SSN.

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

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

Verify the SSN only once.

15.1 INCOME INTRODUCTION

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 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.

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~~3,000 a month.

EBD deeming amount to an ineligible minor (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances) = -$~~375~~386

Remaining earned income $2,~~400~~614
General income exclusion -$20
Remaining earned income $2,~~380~~594
Earned income exclusion -$65

Remaining earned income $2,~~315~~529
1/2 remaining earned income -$1,~~157~~264.50

Parental living allowance -$1,~~125~~157

Income deemed to eligible child = $~~32~~107.50

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~~772.00

After subtracting this from unearned income, there is $~~360~~ 382 remaining allocation that can be applied to earned income.

Lawrence's earned income $2,050
Excess allocation -$~~360~~382

Remaining earned income $1,~~690~~668
General income exclusion -$20

Remainder $1,~~670~~648
Earned income exclusion -$65
Remainder $1,~~605~~583
1/2 remaining earned income -$~~802~~791.50
Parental living allowance -$~~750~~771

Income deemed to eligible child $~~52~~20.50

15.5.10 CENSUS

Disregard all wages paid by the Census Bureau for temporary employment related to the Census ~~2010~~.

16.6 NON-BURIAL TRUSTS

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 they meet all of the following conditions:

~~For trusts established prior to December 13, 2016, the trust must be established~~

- Established for the sole benefit of the disabled person.
  - Trusts established prior to **December 13, 2016 may not** be set up by ~~his or her~~the member. They may only be established by the following:
    - the member's parent~~,~~
    - the member's grandparent~~,~~
    - the member's legal guardian~~, or a~~
    - the court~~.~~
      ~~**Note:** For any special needs trusts~~ on the member's behalf
  - 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 be set up by the member.** They may also ~~set up~~be established by the ~~trust.~~following:
    - The member's parent,
    - The member's grandparent
    - The member's legal guardian
    - The court on the member's behalf
- 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.

17.4 EXCEPTIONS

A divestment that occurred in the look-back period or any time after does not affect eligibility if any of the following exceptions apply:

1. The person who divested shows that the divestment was not made with the intent of receiving Medicaid.

   The person must present evidence that shows the specific purpose and reason for making the transfer, and establish that the resource was transferred for a purpose other than to qualify for Medicaid. Verbal assurances that he or she was not trying to become financially eligible for Medicaid are not sufficient. Take into consideration statements from physicians, insurance agents, insurance documents, and bank records that confirm the person's statements.

   Any of the following circumstances are sufficient to establish that the *applicant*/*member* transferred resources without an intent to qualify for Medicaid.

   - The applicant/member had made arrangements to provide for his or her long term care needs by having sufficient financial resources and/or long term care insurance to pay for long term care services for at least a five-year period at the time of the transfer.

   An exception to this requirement is allowed if the individual had a life expectancy of less than five years at the time of transfer. If the individual's life expectancy was less than five years at the time of the transfer, a divestment penalty is not applied if resources and/or insurance were sufficient to pay for his or her long term care services for his or her remaining life expectancy.

   To measure "sufficient resources," use the average monthly nursing home cost of care in effect at the time of the divestment multiplied by 60. Compare that number to the income, assets, and insurance held by the individual at the time of the divestment, **or**

   - Taking into consideration the individual's health and age at the time of the transfer, there was no expectation of long-term care services being needed for the next five years. For example, someone who was gainfully employed and 50 years old at the time of the divestment is not expected to have set aside sufficient resources for five years of long-term care, **or**

   - If an individual or couple had a pattern of charitable gifting or gifting to family members (i.e., birthdays, graduations, weddings, etc.) prior to the

look-back period, similar transfers during the look-back period would not be considered to have been given with the intent to divest as long as the total yearly gifts did not exceed 15 percent of the individual's or couple's annual gross income. If the yearly gifted amount exceeds 15 percent of the individual's or couple's annual gross income, and/or there is a gap in the years the gifts occurred, the total amounts gifted for the years in the look-back period shall be considered divestment. This exception is not limited to gifts made on traditional gift-giving occasions and does not preclude a pattern of giving to assist family members with educational or vocational goals, or

- Resources spent on the current support of dependent relatives living with the individual are not considered to be divestments. The individual must either claim the relative as a dependent for *IRS* tax purposes, or otherwise provide more than 50 percent of the cost of care and support for the dependent relative.

This list is not intended to be all inclusive when describing divestments which are permissible because the transfer was made without the intent to qualify for Medicaid. Other situations will arise and in those instances, the person's "intent" must be evaluated on a case-by-case basis to determine whether or not a divestment occurred. The fact that a person does not meet the criteria for a specific exception does not create a presumption that the person cannot show that the transfer was made for a purpose other than qualification for Medicaid. For example, a person may be able to show that a transfer to a dependent relative not living at home was made for a purpose other than qualifying for Medicaid.

2. The community spouse divested assets that were part of the community spouse asset share **and** this transfer occurred more than five years after the institutionalized spouse was determined eligible. If it is more than five years after the institutionalized person is determined eligible, the community spouse can divest assets.

Example 1: When Ralph went into a nursing home and applied for Medicaid, Edith's community spouse asset share was $42,000. Six years after Ralph became eligible, Edith gave $30,000 of the community spouse asset share to a favorite nephew. This divestment did not affect Ralph's eligibility. Edith is allowed to divest all or any part of the community spouse asset share, as long as it is more than five years after Ralph was determined eligible. If Edith applies for long-term care services within five years though, the gift to her nephew may be considered divestment when determining her eligibility.

Example 2: When Ralph went into the nursing home and applied for Medicaid, Edith's community spouse asset share was $42,000. One year after Ralph became eligible, Edith gave $30,000 to a favorite nephew. This divestment will result in a divestment penalty period for Ralph because it occurred within the first five years of his eligibility.

The transfer of *homestead* property to the community spouse and then to another person is treated as a divestment depending on when the transfers occur. If the institutionalized person transfers the homestead to the community spouse, and then the community spouse transfers it to someone else within five years of the institutionalized person becoming eligible for long-term care Medicaid, this would be considered a divestment, and it would affect the institutionalized person's eligibility. However, if five years have passed since the institutionalized person became eligible for long-term care Medicaid, the community spouse can transfer the homestead property without affecting the institutionalized person's eligibility.

Example 3: When Ralph applied for Institutional Medicaid, he and Edith owned a home together. After Ralph became eligible, he signed his 1/2 share of the home over to Edith. After five years have passed, Edith can transfer the part of the homestead Ralph gave her without Ralph's eligibility being affected.

Note: While these examples show that in some circumstances the community spouse's divestments occurring more than five years after the determination do not affect the institutionalized person's eligibility, they may affect the community spouse's eligibility if he or she later enters an institution and applies for Medicaid.

3. The ownership of the property is returned to the person in the fiscal group who originally disposed of it.

4. Division of property as part of a divorce or separation action, and loss of property due to foreclosure or repossession are not divestment. An exception to this is if someone voluntarily signs the property deed over to the bank rather than trying to sell the property or foreclosing due to defaulting on their loan. Banks may refer to this as a "voluntary foreclosure," which would be considered divestment.

5. The person intended to dispose of the asset either at fair market value or other valuable consideration.

Example 4: Gary had a lucky 3-cent postage stamp that he carried in his wallet. A friend admired it, so Gary sold it to him for $0.03, unaware that it was worth more. The friend sold it to a stamp dealer for $7,300. When Gary applies for Medicaid, this divestment will be disregarded.

6. The agency determines that denial of eligibility would result in undue hardship for the person (see Section 22.4 Undue Hardship).

7. The institutionalized person or his or her spouse divests homestead property to his or her:

    a. Spouse
    b. Child who meets at least **one** of the following conditions/situations:

        - Is younger than 21 years old
        - Is blind
        - Is permanently and totally disabled
        - Has been residing in the institutionalized person's home for at least two years immediately before the person moved to a medical institution, and provided care to him or her which permitted him or her to reside at home rather than in the institution. This care must have been provided for the entire two years immediately before the person moved to a medical institution. Get a notarized statement that the person was able to remain in his or her home because of the care provided by the child.

            Note: The statement must be from his or her physician or from someone else who has personal knowledge of his or her living circumstances. A notarized statement from the child does not satisfy these requirements.

    c. Sibling who:

        - Was residing in the institutionalized person's home for at least one year immediately before the date the person moved to a medical institution.

        Verify that the sibling was residing in the institutionalized person's home for at least one year immediately before the person moved to a medical institution. Do not require a specific type of verification. Some examples of verification are written statements from nonrelatives, social services records, tax records, and utility bills with the address and the sibling's name on them.

        and

        - Has a verified equity interest in the home.

        "Equity interest" means an ownership interest in a homestead.

Ask to see a copy of the *deed* or the land contract or some other document to verify the sibling's equity interest in the homestead. Since the sibling's name on the document is not sole proof, you may need to require other documentation such as canceled checks and receipts.

8. The institutionalized person or his or her community spouse divests a non-homestead asset or assets to:

   a. A spouse
   b. A child of any age of either spouse who is either blind or permanently and totally disabled or both.

17.5 PENALTY PERIOD

17.5.5.4 Changing Divestment Penalty Periods

If it is necessary to change an existing penalty period, IM workers must update the information in CARES and confirm. However, if the divestment penalty period has been shortened or removed (for example, it was cured), IM workers must also notify the fiscal agent. ~~IM workers can email the change to VEDSDivestmentReport@wisconsin.gov or call 608-421-6340. IM workers need to provide the fiscal agent with the new divestment penalty period end date. If the divestment penalty period was completely removed, workers need to provide the effective date of the member's eligibility for LTC service coverage~~See Process Help 72.1.3.10 for instructions.

~~IM workers should also contact the appropriate person at the member's nursing home or institution, so he or she can submit bills for the period that is now covered by Institutional Medicaid.~~

18.4 SPOUSAL IMPOVERISHMENT ASSETS

18.4.2 Asset Assessment

The *IM* agency must make an assessment of the total countable assets of the couple at one of the following, whichever is earlier:

- The beginning of the person's first continuous period of institutionalization of 30 days or more.
- ~~The date of the first request for *HCBWs*.~~

- ~~**Note:** The date of the first request is the~~The date a functional screen was completed and the person was determined functionally eligible for *HCBW*s.

Complete an asset assessment when a person applies, even if he or she had one done in the past, to get the most current asset share.

If a member was not married on the first date of institutionalization or waivers request, apply the policy from the point he or she is married. If he or she has remarried since the first date of institutionalization or waivers request, apply the policy from the date he or she married his or her current spouse.

The IM agency should inform the person for whom an assessment is being made what documentation is required. He or she must document ownership interest in and the value of any available assets the couple had at the time of his or her first period of continuous institutionalization. The same documentation procedures are used as when an application is filed (see Section 20.1 Verification Introduction).

18.4.3 Calculate the Community Spouse Asset Share

The community spouse asset share is the amount of countable assets greater than $2,000 that the community spouse, the institutionalized person, or both, can possess at the time the institutionalized person applies for Medicaid.

IF the total countable assets of the couple are:	**Then the community spouse asset share is:**
$~~247,200~~252,840 or more	$~~123,600~~126,420
Less than $~~247,200~~252,840 but greater than $100,000	½ of the total countable assets of the couple
$100,000 or less	$50,000

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. $2,743.34 plus excess shelter allowance (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances) up to a maximum of $3,~~090.00~~160.50.

"Excess shelter allowance" means shelter expenses above $823.00. Subtract $823.00 from the community spouse's shelter costs. If there is a remainder, add the remainder to $2,743.34 (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.

18.10 DUAL SPOUSAL IMPOVERISHMENT CASES

When both *spouses* are applying for community waivers, Family Care, or *PACE*/Partnership, and neither spouse resides in a medical institution, both eligibility determinations are done using spousal impoverishment policies.

The eligibility determination for both spouses is done on one case if the couple resides together.

Since income allocated to a *community spouse* is counted as income for that spouse, the couple should decide which spouse should allocate to the other spouse and how much to allocate.

One spouse may have more income or less expenses, so he or she could allocate to the other spouse with less income or more expenses. Each case will have to be assessed individually and the income allocation adjusted to meet the needs of the couple.

~~After determining how much~~For instructions on entering income ~~to allocate,~~allocated paid out and ~~which~~allocated income received, see Process Help 11.1.2 Income Allocation

Asset Eligibility for Dual Spousal Cases

When both spouses are applying for Waivers and neither spouse ~~is allocating,~~resides in a medical institution, an asset assessment should be done for both spouses using the ~~allocated amount must be entered on~~ couple's combined assets. Both are tested using the ~~*CWW*~~ Community Spouse ~~page for~~ Asset Share calculated with the asset assessment plus $2,000.

Asset Transfer Period

Both spouses have 12 months from the time of application to decrease their countable assets to less than $2,000. The assets can be transferred from one spouse ~~that is allocating as the Court Ordered/Fair Hearing amount to let CWW know~~ to ~~allocate that amount~~the other and used to purchase other exempt assets such as burial assets. The assets can also be used on other necessary living expenses for either spouse. Both spouses must have their countable assets below $2,000 at the next regularly scheduled renewal to remain eligible.

~~Do not create a Community Spouse page for the spouse that is not allocating income.~~

~~If the eligibility is determined for both spouses on one case, the income allocated must be entered as OTMA on the Unearned Income page for the spouse receiving the allocation. If the eligibility is determined on separate cases, the income should be entered as OT on the Unearned Income page for the spouse receiving the income allocation.~~

20.3 MANDATORY VERIFICATION ITEMS

20.3.2 Social Security Number

Social security numbers (SSNs) need to be furnished for household members requesting Medicaid unless they are exempt from the SSN requirement (see Section 10.1.1 Social Security Number Requirements). SSNs are not required from non-applicants.

An *applicant* ~~does~~is not ~~need~~required to provide a document or social security card. He or she only needs to provide a number, which is verified through the ~~data exchange with Social Security~~*CARES* SSN validation process.

If the SSN validation process returns a mismatch record, ~~then~~ the *member* must provide the social security card or another official government document with the SSN displayed. If an applicant does not yet have a SSN, he or she must be willing to apply for one.

Agencies must assist any household that requests help with applying for an SSN for any applicant or member who does not have one. “Assisting the applicant” may include helping with filing the SS-5 SSN Application form, obtaining a birth certificate on behalf of the applicant, or assisting with obtaining another document needed to apply for the SSN.

Health care eligibility may not be delayed if the person is otherwise eligible for benefits and any of the following are true:

- The person has provided an SSN, even if the SSN has not yet been verified.
- The person has requested assistance with applying for an SSN.
- The person has verified that he or she has applied for an SSN.

In cases where an application for SSN has been filed with the Social Security Administration, an SSN must be provided by the time of the next health care renewal for the case or health care eligibility will be terminated for that individual. In addition, if eligibility for another program pends for provision of an SSN and the SSN application date on file is six months or older, eligibility for health care will also pend. Members must be given a minimum of 10 days to provide an SSN, but if they do not, health care eligibility must be terminated.

Even when citizenship cannot be verified due to a lack of a verified SSN, health care benefits should not be pended for lack of an SSN during the reasonable opportunity period for verification of citizenship (see Section 7.2.1.1 Reasonable Opportunity Period).

20.3.2.1 Fraudulent Use of SSN

The member should be informed if the SSN validation process indicates another individual is using the same SSN. The member should contact the Social Security Administration and request they conduct an investigation. The IM worker cannot provide the member with any information that would identify the individual who is using the member's SSN.

If the Social Security Administration finds that the SSN has been used fraudulently it may:

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

Verify the SSN only once.

20.3.3 Immigration Status

~~A member who indicates he or she is not a citizen must provide an official government document that lists his or her immigration registration number. Verify~~Verification of the individual's immigration status ~~by using~~is done through the *FDSH* or the Systematic Alien Verification for Entitlement (SAVE) system. Women applying for ~~BCPP~~BadgerCare Plus Prenatal Program (see ~~the~~ BadgerCare Plus Handbook, Chapter 41 BadgerCare Plus Prenatal Program) and ~~persons~~people applying for ~~EMA who~~ Emergency Services (see Chapter 34 Emergency Services do not ~~provide proof~~have to verify their immigration status.

Applicants who are otherwise eligible and are only pending for verification of immigration status ~~can still qualify for those benefits~~must be certified for health care benefits during the reasonable opportunity period (see Section 7.3.2.2 Reasonable Opportunity Period for Verification of Immigration Status.

~~An immigrant that presents documentation of his or her immigration status and meets all other eligibility criteria is presumptively eligible. Begin benefits and determine, through SAVE, that he or she is in a satisfactory immigration status.~~

~~Do not re-verify immigration status unless the member reports a change in citizenship or immigration status.~~

20.3.5 Assets

Verification of *countable assets* 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.~~

Note: The value of exempt assets, such as an EBD Medicaid member's burial plot, may not be verified unless the worker has information that deems the member-reported amount to be questionable.

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

Do not verify cash on hand.

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

20.3.5.2 Reasonable Compatibility for Assets

As defined in federal regulations, information from an electronic data source (in this case, AVS) is reasonably compatible if it results in the same eligibility outcome as self-reported information.

- If the individual reports assets that are above a given asset limit, the self-reported asset information will be used to deny or terminate health care benefits, regardless of what the outcome would be from using AVS information. Verification is not required.
- If both AVS and the self-reported information put the individual's total countable assets below a given asset limit, the two data sources are considered to be reasonably compatible and further verification may not be requested or required.
- If AVS puts the individual's total countable assets above a given asset limit, but the self-reported information puts his or her total countable assets below that same limit, the two data sources are not reasonably compatible and further verification is required as a condition of eligibility.

The reasonable compatibility test will only be applied to AVS liquid assets that have not otherwise been verified (for example, if a member submits bank statements as part of their initial application, or if the asset has been verified by another program). It can only be applied when asset information is available through the Asset Verification System.

20.3.5.2.1 Determination of Reasonable Compatibility

The reasonable compatibility test will be performed during the eligibility determination for EBD Medicaid if there is an AVS-returned amount for at least one unverified liquid

asset. To determine reasonable compatibility, CARES will perform the following calculations:

Calculation	Description
1: Total Countable Assets (Self-Reported)	Sum of all the self-reported amounts for all countable assets. If the self-reported countable assets are over the asset limit, eligibility will fail right away and no reasonable compatibility test will be performed.
2: Total Countable Assets (AVS and/or Self-Reported)	Sum of the following: • All verified, countable asset amounts. • For all countable AVS assets, if an AVS amount was returned for an asset and that asset has not been verified: the higher of the AVS-returned or the unverified self-reported amounts. • All unverified, self-reported countable asset amounts with no AVS match, including non-AVS assets. • All countable AVS assets that were not reported.

CARES will compare the results of calculations 1 and 2 to determine reasonable compatibility.

- **If reasonably compatible**, verification of the AVS-matched asset amounts will not be requested, and eligibility will not pend for verification of these assets, even when there is a ?, Q?, WN, NV, or QV in the verification field. If otherwise eligible, the individual will receive a Notice of Decision listing the self-reported asset amounts. If eligibility is pending for other assets, a Verification Checklist will be sent.
- **If not reasonably compatible**, a Verification Checklist will be sent to the individual to request verification for all assets for which the individual has not already provided verification. If the individual does not provide the requested verification by the due date, eligibility will be denied or terminated for lack of verification.

Note: When there is an MSP request in addition to a request for EBD Medicaid, an additional, separate reasonable compatibility determination will be performed for MSP. In situations where the assets are reasonably compatible for MSP but exceed the asset limit for other programs, the individual may enroll in MSP without being required to provide further verification of assets for that program.

If an individual is applying for health care and has also requested MAPP, the reasonable compatibility test may provide different results based on the EBD Medicaid

and MAPP asset limits. Because CARES considers these two programs to be part of the same health care request, the reasonable compatibility test will be performed using the MAPP asset limits only if the individual is found ineligible for EBD Medicaid because of excess assets or failure to provide verification of assets. This means an individual can still be eligible for MAPP based on the reasonable compatibility test for assets, even if they failed to submit verification of assets as required for EBD Medicaid (see Example 2 below).

If the worker is running with dates and an AVS amount is entered for a given asset, the reasonable compatibility test will be performed as long as the eligibility month is June 2018 or later.

The following examples show various results of the reasonable compatibility test.

Example 1: Lauren applies for EBD Medicaid and reports the following asset amount, without providing verification:

A. Checking account: $5

AVS returns the following information and the worker processes the information as shown:

- Savings account: $200 | Match with A
- Undisclosed checking account: $800 | Add as new information

Reasonable Compatibility Determination

- EBD Medicaid Asset Limit: $2,000
- 1. Total Countable Assets (Self-Reported): **$5**
- 2. Total Countable Assets (AVS and/or Self-Reported): $200 + $800 = **$1,000**
- Result: **Reasonably Compatible**, because the sum of both calculations is less than the asset limit.

No further verification is requested from Lauren. A Notice of Decision is sent, listing only the self-reported amount.

Example 2: Mike applies for EBD Medicaid with a MAPP request and reports the following asset amounts, without providing verification:

A. Checking account: $500

B. Savings account: $700
C. Savings bond" $300 (non-AVS asset)

AVS returns the following information and the worker processes the information as shown:

- Checking account: $800 | Match with A
- Savings account: $400 | Match with B
- Undisclosed checking account: $900 | Add as new information

Reasonable Compatibility Determination for EBD Medicaid

- EBD Medicaid Asset Limit: $2,000
- 1. Total Countable Assets (Self-Reported): $500 + $700 + $300 = **$1,500**
- 2. Total Countable Assets (AVS and/or Self-Reported): $800 + $700 + $900 + $300 = **$2,700**
- Result: **Not Reasonably Compatible**, because the sum of countable assets from data sources is above the EBD Medicaid asset limit.

In this case, the $700 savings account amount is used when calculating the total countable assets based on data sources, as it is the higher of the self-reported and AVS-returned information. A Verification Checklist is sent to Mike. All self-reported assets and the undisclosed checking account returned by AVS are included in the Proof Needed section.

If Mike provides verification of his assets and is found to be over the $2,000 asset limit for EBD Medicaid, CARES will then consider his MAPP eligibility without a reasonable compatibility test because all assets have been verified. If he meets all financial and non-financial rules for MAPP, his MAPP eligibility will be approved.

However, if Mike provides verification of his savings bond (the non-AVS asset) but fails to verify his checking and savings accounts, CARES will consider his MAPP eligibility using a reasonable compatibility test based on the MAPP asset limit.

Reasonable Compatibility Determination for MAPP

- MAPP Asset Limit: $15,000
- Total Countable Assets (Self-Reported): $500 + $700 + $300 = **$1,500**
- Total Countable Assets (AVS and/or Self-Reported): $800 + $700 + $900 + $300 = **$2,700**

- Result: **Reasonably Compatible**, because the sum of countable assets from data sources is below the MAPP asset limit.

No further verification is requested from Mike. A Notice of Decision is sent, listing only the self-reported amounts.

Example 3: Tasha applies for EBD Medicaid and MSP and reports the following asset amounts, without providing verification:

A. Checking account: $1,000
B. Savings account: $500

AVS returns the following information and the worker processes the information as shown:

- Checking account: $2,000 | Match with A
- Savings account: $2,500 | Match with B

Reasonable Compatibility Determination for EBD Medicaid

- EBD Medicaid Asset Limit: $2,000
- 1. Total Countable Assets (Self-Reported): $1,000 + $500 = **$1,500**
- 2. Total Countable Assets (AVS and/or Self-Reported): $2,000 + $2,500 = **$4,500**
- Result: **Not Reasonably Compatible for EBD Medicaid** because the sum of countable assets from data sources is above the EBD Medicaid asset limit.

Reasonable Compatibility Determination for MSP

- MSP Asset Limit: $7,730
- 1. Total Countable Assets (Self-Reported): $1,000 + $500 = **$1,500**
- 2. Total Countable Assets (AVS and/or Self-Reported): $2,000 + $2,500 = **$4,500**
- Result: **Reasonably Compatible for MSP** because the sum of countable assets from data sources is below the MSP asset limit.

A Verification Checklist is sent to the Tasha to request verification of the checking and savings account for EBD Medicaid. However, if Tasha does not return verification of these accounts, she will remain eligible for MSP.

20.3.5.2.2 Programs for Which Reasonable Compatibility Will Apply

The reasonable compatibility test will be performed as part of any eligibility determination for all EBD Medicaid programs with asset tests.

Populations not subject to an asset test (for example, children under age 19 and children who are members of the Children's Long-Term Support Waiver Program) will not have a reasonable compatibility test.

20.3.6 Medical or Remedial Expenses

Medical or remedial expenses used to meet a deductible or calculate patient liability, cost share, or premium amounts must be verified. The expense amount, any third party liability amount, and date of service must all be verified. If verification is not provided, do not include the expense to determine when a deductible has been met or in the liability, cost share, or premium calculation. Do not deny or terminate eligibility for failure to provide the requested verification.

For HCBW, Family Care, Family Care Partnership, PACE, and IRIS members, Care Managers, ADRC staff, and IRIS Consultant Agencies (ICAs) calculate medical and remedial expenses. Because care managers, ADRC staff, and ICAs already verify all medical and remedial expenses before reporting those expenses to IM, additional verification is not needed. Refer to 28.6.4.5 Medical/Remedial Expenses.

20.10 VERIFICATION RESOURCES

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

Verification of some liquid assets can be obtained electronically using the Asset Verification System (*AVS*). For instructions on using AVS, see Process Help Section 50.4 Asset Verification System (AVS).

Verification of immigration status can be obtained through the Federal Data Services Hub (FDSH) or the SAVE system. For instructions on using the SAVE system, see Process Help Handbook Chapter 82 SAVE.

25.3 WIDOWS AND WIDOWERS

A widow ~~or~~, widower, or surviving ex-spouse who lost *SSI* remains eligible for Medicaid if he or she meets all of the following conditions:

- Is considered elderly, blind, or disabled.

- ~~Is between the ages of 50 and 65.~~
- ~~Was either married to the deceased person at the time of his or her death or was married to the deceased person~~ at least ~~ten~~50 years~~, divorced from him or her, and is now unmarried~~ of age.
- Is receiving *OASDI* benefits as a widow or widower (Section 202, Title II, Social Security Act).
- Received SSI or a State Supplementary Payment (SSP) (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables) in the month before the month in which he or she began to receive Widow/Widower OASDI payments.
- Became ineligible for SSI or SSP due to the receipt of the Widow/Widower benefits.
- Would be eligible for SSI or SSP except for the receipt of the Widow/Widower OASDI payment. *Disregard* the entire OASDI amount.
- Is not entitled to Medicare Part A.

Note: In some cases a Widow/Widower, who loses eligibility for the Widow/Widower Medicaid benefit due to receipt of Medicare, may be eligible as a "503" case. See Section 25.1 "503" Eligibility.

26.3 ~~NONFINANCIAL~~NONFINANCIAL REQUIREMENTS

26.3.2 Disability

Disability is a non-financial eligibility requirement for MAPP, even for members who are age 65 and older. DDB must certify disability (see Section 5.10 Medicaid Purchase Plan Disability). There is no requirement that a member be a current or former SSI or *SSDI* beneficiary to qualify for MAPP. Earned income is not used as evidence in MAPP disability determinations.

If ~~a~~an applicant or member does not have a disability determination from ~~*SSA*~~*DDB*, complete the disability application process outlined in Section 5.3 Disability Application Process~~.~~ even if the applicant or member is age 65 or older (unless the applicant or member fits the policy on converting from SSDI to SSRE). The rest of the MAPP application must be completed at this time, and MAPP eligibility can only be pending for the disability determination before the *MADA* will be sent to DDB through the automated process (see Process Help Chapter 12 Automated Medicaid Disability Determination).

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

Redeterminations
Follow the rules in Section 5.7 Redetermination on when to review disability determination.

Members Who Have Lost Their SSDI Due to Exceeding Substantial Gainful Activity
A current MAPP member who loses SSDI because he or she exceeds the Substantial Gainful Activity level remains MAPP-eligible until a MAPP disability determination is done by DDB. If DDB determines the individual is not disabled using the MAPP criteria, the MAPP eligibility will terminate with *adverse action* notice for the reason "not MAPP disabled."

~~***Members Turning 65***~~
~~A current MAPP member who loses SSDI benefits solely due to turning 65 years old does not need a disability redetermination until the next scheduled diary date. If there is no scheduled diary date, check with SSA to see if they consider the person disabled. If not, a MAPP disability determination must be done, and MAPP eligibility continued until the MAPP disability determination is made by the DDB.~~

26.5 MAPP PREMIUMS

26.5.2 Initial Premium

There are no free premium months. Before eligibility confirmation, the member must pay applicable premiums for the initial benefit month and for any backdate months for which the member elects coverage. If determining eligibility in the month after application, the premium for the second month also must be paid before confirming eligibility.

Example 2: Eric applies for MAPP on January 29, but his application is not processed until February 11. The *IM* agency determines that he owes a $50 premium per month. Before eligibility is approved (confirmed), Eric must pay a $50 premium for January and a $50 premium for February.

Example 3: Eric applies for MAPP on January 29. Eric is requesting MAPP for February but not January. CARES will not pend the case for February's premium because you are processing it in January. Confirm the case. The Medicaid fiscal agent will pursue collection of the premium for February.

CARES will send premium information to MMIS, but the IM worker continues to be responsible for collecting the premium due for initial month(s) and any backdated months for which the member elects coverage. Complete the premium Medicaid Purchase Plan Premium Information/Payment (F-00332) and record receipt of the premium payment in CARES. Refer to Process Help 25.1.6 Processing a MAPP Application Requiring a Premium.

~~Send MAPP premium payments separate from BadgerCare premium payments and other agency funds. Send premium payments to the following address:~~

~~Medicaid Purchase Plan~~
~~P.O. Box 6738~~
~~Madison, WI 53716-0738~~

~~The check or money order should be made payable to the Medicaid Purchase Plan.~~

26.5.7 Opting Out

If a MAPP member chooses to de-request MAPP coverage, or opt out, any time prior to the beginning of the next benefit month, close the case in CARES for the next possible month~~. If the case cannot be closed in CARES at the end of the current benefit month, do not impose an RRP. Close the case in CARES. Submit a Medicaid/BadgerCare Plus Eligibility Certification form (F-10110 [formerly DES 3070]) by fax to 608-221-8815 or by mail to:~~ and do not impose an RRP. Refer to Process Help 25.1.9 Opting Out~~.~~.

~~ForwardHealth~~

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

~~Enter "MAPP OPT OUT" in red in the Comments section of the Medicaid/BadgerCare Plus Eligibility Certification form.~~

~~**Example 7:** Sally calls her worker on July 25 to de-request MAPP for August. Since Sally opted out prior to the benefit month, Sally should not owe a premium for August. The worker will need to change the request for MAPP on the MAPP page in *CWW* and zero out the premium due for August.~~

~~To zero out the premium, the worker has to alter the income for the process month. The altered income should be low enough that MAPP still passes with no premium and high enough that Sally does not qualify for another Medicaid subprogram. At this point, the worker runs the eligibility with appropriate dates and confirms the results. An RRP should not be imposed because Sally de-requested August MAPP coverage prior to the beginning of the benefit month.~~

~~Sally's worker must override the RRP on the Restrictive Reenrollment page in CWW by entering an override RRP end date using the reason code SY, system problem. Change the request for MAPP on the MAPP page in CWW to N, and suppress the CARES notice stating that Sally's MAPP eligibility will end August 31. Send a manual negative notice indicating that Sally's MAPP eligibility ends July 31.~~

A MAPP applicant's decision to opt out does not affect other family members' eligibility for Medicaid or Medicaid-related programs.

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.

28.1 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE INTRODUCTION

Medicaid-eligible adults who meet the LOC requirements can receive their LTC services through enrollment in an MCO or through the fee-for-service program IRIS.

Managed LTC programs include ~~the following programs~~:

- ~~*CIP* I (CIP 1A and CIP 1B).~~
- ~~CIP II.~~
- ~~*CLTS* Waiver Program. This program serves children with physical disabilities, developmental disabilities, and severe emotional disturbance or mental health needs.~~
- ~~*COP-W*.~~

- Family Care~~.~~
- Family Care Partnership~~.~~
- *PACE*

Medicaid Eligibility

IM workers are responsible for determining Medicaid eligibility as well as cost share amounts, if applicable. If a member disenrolls from the managed LTC program for any reason and does not enroll in IRIS or a managed LTC program, his or her Medicaid eligibility must be tested under non-HCBW rules. Eligibility for HCBW would end following adverse action logic once the IM worker has been notified by the *ADRC* that the member has disenrolled from the managed LTC program or IRIS.

Managed Long-Term Care or IRIS Enrollment

Enrollment in managed LTC or IRIS is completed by the ADRC. The ADRC will submit the following information to IM workers:

- ADRC Referral to Income Maintenance for Managed Long-Term Care Services, F-02053, which lists the anticipated program start date for HCBW
- Medicaid application, if the ADRC is assisting the applicant with the Medicaid application process or establishing a Medicaid filing date
- Functional Screen Eligibility Results page
- Medical and Remedial Expenses: checklist For Medicaid Long-Term Care Waiver Programs, F-00295, or other communication of the total expenses
- Housing expenses and any other verification items the ADRC has received from the applicant to support the Medicaid application
- Estate Recovery Program (ERP) Disclosure, F-13039, if completed by the ADRC
- Declaration Regarding Transfer of Resources Long-Term Care Medicaid Waiver Program and/or Community Options Program, F-20919D, if any potential divestment was reported to the ADRC
- Disenrollment from the managed LTC program or IRIS, if applicable
- ~~*IRIS*.~~
- ~~*PACE*.~~

28.1.1 Adult Home and Community Based Waivers Long-Term Care Disability Policy

To be eligible for ~~these waivers~~*EBD* Medicaid or LTC Medicaid, a person must ~~meet all of the following:~~be elderly, blind, or disabled.

Adults over age 18 and younger than 65 years old must have a disability determination unless the person is eligible for BadgerCare Plus, *WWWMA*, Foster Care, or Adoption Assistance. If a person later loses eligibility for that program and must be tested for EBD Medicaid or LTC Medicaid, he or she must then be elderly, blind, or disabled to remain enrolled in Family Care, Family Care Partnership, PACE, or IRIS.

- ~~Meet Medicaid *LOC* requirements for admission to nursing homes.~~
- ~~Meet nonfinancial requirements for Medicaid.~~
- ~~Meet financial requirements for Medicaid.~~
- ~~Reside in a setting allowed by community waivers policies.~~
- ~~Have a need for *LTC* services.~~
- ~~Have a *disability* determination if he or she is younger than 65 years old. Exceptions to this include the following:~~

A ~~finding of~~ disability finding made prior to the person's 18th birthday, which remains in effect on the person's 18th birthday, will be considered to meet the disability ~~requirement until either an adult disability determination can be done or the child's disability determination is no longer in effect, whichever occurs first).~~requirements for managed LTC or IRIS until the first of the following:

- An adult disability determination can be completed
- The child disability determination is no longer in effect

Managed LTC or IRIS eligibility will not be denied solely because the disability determination in effect at application was made prior to applicant's 18th birthday.

28.1.2 Family Care

Family Care is a managed long-term care program for adults with disabilities and frail elders.

To enroll in Family Care the individual must meet the following criteria:

- Be 18 years of age or older.
- Meet financial and non-financial eligibility criteria for:
    - A full benefit category of EBD Medicaid, including Long Term Care Medicaid (see 28.1.1 Disability Policy),
    - BadgerCare Plus (BCP),
    - *WWWMA*,
    - Adoption Assistance (AA), or

- Foster Care Medicaid; and
- Meet the nursing home or non-nursing home functional level of care.

28.1.3 Family Care Partnership

The Family Care Partnership program is a managed long-term care program integrating health and long-term support services for adults with disabilities and frail elders.

To participate in the Family Care Partnership program the individual must meet the following criteria:

- Be 18 years of age or older,
- Meet financial and non-financial eligibility criteria for:
  - A full benefit category of EBD Medicaid, including Long Term Care Medicaid (see 28.1.1 Disability Policy),
  - BadgerCare Plus (BCP) Standard Plan,
  - *WWWMA*,
  - Adoption Assistance (AA), or
  - Foster Care Medicaid; and
- Meet the nursing home functional level of care.

28.1.4 PACE

PACE is a program that provides comprehensive community-based services, including both acute and chronic care for frail elderly individuals. Most services are provided in a day health center, and members must receive medical services from a PACE physician. PACE is only available in select counties.

- ~~Children determined by functional screening to meet an institutional level of care and who meet all other eligibility requirements are eligible for the Children's Long-Term Support Waiver Program without a disability determination (see Section 28.14 Home and Community-Based Waivers Long-Term Care Children's Long-Term Support).~~
- ~~Adults younger than 65 years old who meet both of the following criteria may be enrolled in Family Care, Family Care Partnership, PACE, or IRIS without first obtaining a disability determination from *DDB*:~~
  - ~~Functionally eligible for Family Care, Family Care Partnership, PACE, or IRIS at a nursing home level of care~~
  - ~~Eligible for one of the following Medicaid or BadgerCare Plus categories: BadgerCare Plus Standard Plan, Wisconsin Well~~

~~Woman Medicaid, Medicaid through adoption assistance, or Foster Care Medicaid~~

~~Note:~~ To enroll in PACE, ~~a person~~the individual must ~~be~~meet the following criteria:

- Be 55 years of age ~~55~~ or older~~.~~,

~~The Eligibility Results page of the long-term care functional screen indicates Family Care, Family Care Partnership, PACE, or IRIS eligibility for people who meet this criteria. Because CARES requires that they have a disability determination, these eligible Family Care Partnership or PACE members should be coded as presumptively disabled as long as they qualify for one of the Medicaid or BadgerCare Plus categories listed above.~~

~~Note:~~ ~~A person who is *MAPP* disabled may be eligible as a Group A participant even if a regular disability has not been determined by *DDB*.~~

- Meet the nursing home functional level of care,
- Reside in a county that offers PACE.

PACE participants who are ~~-~~

~~To be eligible for *LTC* waiver services, applicants must be both Medicaid eligible and functionally eligible. All waiver applicants must complete a Medicaid application unless they are already open for another program of assistance.~~

~~Adult waiver applicants receive level of care assessment, long-term care options, and enrollment counseling services from the *ADRC*. Once the level of care assessment is complete and the applicant is determined functionally eligible, the ADRC will submit the waiver program start (enrollment) date to the *IM* agency along with the waiver functional eligibility determination.~~

~~If an applicant is~~ not ~~functionally~~ eligible~~, the ADRC~~ for Medicaid will ~~send~~pay a premium to the PACE organization. If the PACE Participant is eligible for Medicaid, the ~~appropriate correspondence~~participant is subject to the ~~applicant regarding their~~ requirements in this chapter, including cost sharing.

28.1.5 IRIS

IRIS (Include, Respect, I Self-Direct) is a fee-for-service long-term care support program available to individuals who meet the functional and financial eligibility requirements. IRIS participants receive a budget amount that is calculated based on the results of their long-term care functional screen that can be used to purchase long-term care supports and services related to the participant's needs.

To participate in ~~, which may include the Notice~~the IRIS program, individuals must meet the following criteria:

- Be 18 years of ~~Denial of Functional Eligibility, Notice of Non-Nursing Home Level of Care, and Appeal Rights.~~age or older;
- Meet the nursing home level of care;
- Meet the financial and non-financial eligibility criteria for one of the following:
  - A full-benefit category of EBD Medicaid, including Long-Term Care Medicaid
  - ~~28.~~BadgerCare Plus
  - *WWWMA*
  - Adoption Assistance
  - Foster Care Medicaid; and
- Reside in an IRIS eligible living setting:
  - Individual's own home or apartment;
  - 1-2~~.1~~ or 3-4 bed Adult Family Home (AFH);
  - Residential Apartment Care Complex (RCAC).

28.1.6 Changing Programs

Individuals who want to change long-term care programs must complete this request through their Aging and Disability Resource Center (ADRC).

28.1.7 Spousal Impoverishment

Spousal impoverishment policy applies to group B and B Plus waiver participants with a community spouse~~, with the exception of *MAPP* waiver participants~~ (see Section ~~18.2.3 Institutionalized and Section~~ 26.3.7 Spousal Impoverishment).

~~28.2.2 Tentative Approval~~

~~Persons who apply for waivers may receive tentative waiver approval while their Medicaid eligibility is being determined.~~

~~The tentative approval process begins when the care manager refers the waiver *applicant* to the IM agency with accompanying information about the type of waiver, waiver begin date, and medical/remedial expenses.~~

28.~~3~~2 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE FISCAL ~~TEST GROUP~~TEST GROUP

Form the fiscal test group as follows:

1. Single person = a fiscal test group of one.
2. Married couple, when one *spouse* is applying for community waivers, and the other is a *community spouse* . This is a *spousal impoverishment* situation. Combine the assets (18.4.3 Calculate the Community Spouse Asset Share) and apply the spousal impoverishment asset test (18.4.4 Asset Test). The income limit is the same as for institutionalized persons who do not have a community spouse.
3. Married couple, ~~-~~both applying for HCBW, are in two separate fiscal test groups. Spousal impoverishment policies may apply.

Example 1: Cathy and Bob, a married couple, are both applying for community waivers. Both are each other's community spouse. Combine the assets and apply the spousal impoverishment asset test. Calculate asset shares and asset limits for each. Cathy and Bob each have one year to spend assets down to $2,000, based on their individual application dates.

28.3 ADULT HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE ~~FISCAL TEST GROUP~~DIVESTMENT

~~Form the fiscal test group as follows:~~

1. ~~Single person = a fiscal test group of one.~~
2. ~~Married couple, when one spouse is applying for community waivers, and the other is a community spouse . This is a spousal impoverishment situation. Combine the assets (18.4.3 Calculate the Community Spouse Asset Share) and apply the spousal impoverishment asset test (18.4.4 Asset Test). The income limit is the same as for institutionalized persons who do not have a community spouse.~~
3. ~~Married couple, both applying, are in two separate fiscal test groups. Spousal impoverishment policies may apply.~~

~~**Example 1:** Cathy and Bob, a married couple, are both applying for community waivers. Both are each other's community spouse. Combine the assets and apply the spousal impoverishment asset test. Calculate asset shares and asset limits for each. Cathy and Bob each have one year to spend assets down to $2,000, based on their individual application dates.~~

~~-~~IM determines divestment for adult home and community-based waivers applicants. For Group A applicants, the care manager completes F-20919D for IM to investigate and determine divestment. See 17.1 Divestment Introduction.

28.4 RESERVED

28.5 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE EFFECTIVE DATE

The ~~applicant cannot choose a~~ begin date of waiver eligibility is the program start date submitted to the IM agency by the care manager or the *ADRC*.

28.5.1 Urgent Services

Applicants who have been determined functionally eligible for Family Care or Family Care Partnership may receive services from the MCO while Medicaid financial eligibility is being determined if they have been determined by the ADRC to be in need of urgent services.

For such individuals, the ADRC will send IM a referral for a "priority" Medicaid eligibility determination along with:

1. A copy of a signed Family Care Program Enrollment (F-00046) or PACE/Partnership Programs Enrollment (F-00533) form; and
2. A copy of a signed Urgent Services Agreement (F-02140).

IM will then (1) confirm with the ADRC that it has received the Urgent Services referral; (2) conduct the financial eligibility determination on a priority basis; and (3) notify the ADRC and MCO of the outcome of the financial eligibility determination as soon as possible. A financial eligibility determination for Medicaid must be made within 30 calendar days from the date an individual, or their legal guardian, conservator, or activated power of attorney, signs the Urgent Services Agreement.

The effective date of enrollment into Family Care or Family Care Partnership shall be no earlier than the date the Urgent Services Agreement is signed and the Medicaid application is submitted.

28.6 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE ELIGIBILITY GROUPS AND COST SHARING

28.6.1 Home and Community-Based Waivers Long-Term Care Instructions Introduction

Financial eligibility for home and community-based waivers cases is determined in CARES.

Although Katie Beckett cases are Group A, these cases are processed manually outside of CARES by Katie Beckett staff.

28.6.2 Group A

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

Group A members do not have a cost share.

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

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

28.6.3 Group B and B Plus

Group B members are defined as those not in Group A, but who have gross income at or below the nursing home institutions categorically needy income limit (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables).

Group B Plus members are defined as those not in Group A, who have gross income above the nursing home institutions categorically needy income limit, but whose income does not exceed the cost of the appropriate institutional care by more than the medically

needy income limit (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables).

28.6.4 Cost Share Amount

The cost share amount is the monthly amount Group B and B Plus members must pay toward the cost of their waiver services. The cost share amount is calculated in CARES by applying the cost share deductions to Group B and B Plus members' gross income.

IRIS, Family Care, Family Care Partnership, or PACE members institutionalized in a medical institution pay a patient liability calculated according to Chapter 27 Institutional Long-Term Care rather than cost share under this section.

28.6.4.1 Personal Maintenance Allowance

A personal maintenance allowance for room, board, and personal expenses must be deducted from income when calculating cost share. Do not give the special housing amount to waiver participants under age 18.

The personal maintenance allowance (Line 6 and Page 2 of the worksheet) is the total of the following:

1. Community Waivers Basic Needs Allowance (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances).
2. Sixty-five dollars and ½ earned income deduction (see Section 15.7.5 $65 and ½ Earned Income Deduction).
3. Special housing amount equal to monthly housing costs over $350. If the waiver applicant's housing costs are over $350, add together the following costs and subtract $350 to get the special housing amount:
    - Rent.
    - Home or renters insurance.
    - Mortgage.
    - Property tax (including special assessments).
    - Utilities (heat, water, sewer, electricity).
    - "Room" amount for members in a CBRF, Residential Care Apartment Complex, or an Adult Family Home. The case manager determines and provides this amount.

If ~~which includes a month in which, if he or she had applied, he or she would have been ineligible due to excess assets~~both spouses are applying and both have income, divide the special housing amount equally between them.

~~**Example 2:** Doyle applies for Medicaid in July. He has excess income in July. He wants a Medicaid deductible period that goes from April through September. In~~

~~addition to having excess income in April, Doyle had $5,000 in his savings account on April 30. He cannot include April in his Medicaid deductible period. He no longer had the $5,000 on May 31, so he can begin his Medicaid deductible period in May.~~**Example 1:** Two spouses applying with income:
$600 rent
- 350
= 250/2 spouses = $125 that each can set aside

If only one *spouse* has income and both spouses are applying, allocate the full special housing amount to the spouse with income.

When one spouse has income and both are applying:

1. And they reside together in the same residence, allocate the full special housing amount to the spouse with income.
2. And they reside in separate rooms in a substitute care facility, but there is only one room and board contract for both, allocate the full housing amount to the spouse with income.
3. And they reside in separate rooms in a substitute care facility, but each has an individual room and board contract, only the spouse with income gets a deduction for the special housing amount, and it is based on their individual "rent" costs that are obtained from the care manager.

~~**Example 3:** Clarice applies for Medicaid in July. She has excess income in July. She wants a Medicaid deductible period that goes from April through September.~~

~~In addition to having excess income in April and May, Clarice had an inheritance of $5,000 in May. She still retained it on May 31. Therefore, she cannot include May or any months prior to May in her Medicaid deductible period. She no longer had the $5,000 on June 30, so she can begin her Medicaid deductible period in June.~~**Example 2:** Emma and Herbert are living in the same residence. Herbert has income of $1,000 per month. Emma does not have any income. The total housing costs are $650 for both of them. Allocate the full special housing amount to Herbert ($650-$350 = $300 special housing amount).

~~The applicant can choose a Medicaid deductible period which includes a month in which, if he or she had applied, he or she would have been ineligible for a non-financial reason. Although excess income is still calculated over a six month period, the individual can only be certified for Medicaid during the dates when he or she was non-financially eligible.~~

Example 4: Marion applies for Medicaid in July. She has excess income in July. She wants a Medicaid deductible period that goes from April through September.

Marion was incarcerated from April 30th through May 18th. She meets the deductible with a countable expense from April 10th, so she should be certified from April 10th through April 29th, and May 19th through September 30th.**Example 3:** Bert and Ingrid live in separate rooms in a substitute care facility, but there is only one room and board contract for both. Bert has income of $1,000 per month. Ingrid does not have any income. The total rent amount is $650 for both of them. Allocate the full special housing amount to Bert ($650-$350 = $300 special housing amount).

Example 5: Janet applies for Medicaid in July and requests a Medicaid deductible period from April through September. She gave birth on June 30th. Janet paid the full deductible amount, so is certified from April 1st through June 30th. **Example 4:** Ned and Maria live in separate rooms in a substitute care facility, and each of them has an individual room and board contract. Ned has income of $1,000 per month. Maria does not have any income. Ned's "rent" from the room and board amount is $550 and Maria's "rent" from the room and board amount is $400. Calculate Ned's special housing amount ($550-$350 = $200 special housing amount). Do not consider Maria's room and board amount when calculating Ned's special housing amount.

For backdate months, when a person had excess assetsWhen both spouses have income and both are applying:

1. And they reside together in any of the three months prior tosame residence, divide the month of application,special housing amount equally between them.
2. And they reside in separate rooms in a substitute care facility, but there is only one room and board contract for both, divide the special housing amount equally between them.
1.3. And they reside in separate living arrangements (e.g., they reside in two different substitute care facilities OR they reside in the same substitute care facility but each has a private room and his or her eligibility in the backdate month is determined by whether or not he or she had excess assetsown individual room and board contract) then calculate a separate special housing amount for each, based on the last day oftheir individual "rent" costs that are obtained from the monthcare manager.

Example 6: Jack applies for Medicaid in July. He wants a Medicaid deductible period that goes back two months to include May and June. In May, he would have

been eligible except for excess income. In June he had received a $10,000 gift. On June 29 he went to the track and lost the $10,000. Had he applied on June 30 he would have been eligible. Jack can include both May and June in his Medicaid deductible period.**Example 5:** Emma and Herbert are living in the same residence. Herbert has income of $1,000 per month, and Emma has income of $500 per month. The total housing cost for both of them is $650. Divide the special housing amount equally between them ($650-$350 = $300 special housing amount, so the special housing amount for Emma and Herbert is $150 each).

Example 7: Mansour applies for Medicaid in July. He is found to be eligible. He had medical bills in April and May. He also had excess income in April and May. He wants a Medicaid deductible period that includes April and May. Unfortunately, he was the recipient of a $5,000 cash gift on June 29. It was several days before he was able to spend it on groceries and other legitimate purchases. Mansour will not be able to include April or May in the deductible period because on June 30, had he applied, he would have been determined ineligible.**Example 6:** Bert and Ingrid live in separate rooms in a substitute care facility, but there is only one room and board contract for both. Bert has income of $1,000 per month, and Ingrid has income of $500 per month. The total "rent" from the room and board amount for both of them is $650. Divide the special housing amount equally between them ($650-$350 = $300 special housing amount, so the special housing amount for Bert and Ingrid is $150 each).

An individual can establish a new deductible period at any time if they file an application for Medicaid. This includes situations where someone has already established a deductible period, hasn't yet met the deductible, and wishes to establish a new deductible period.

Example 8: Jeff applies for Medicaid on 1/1/14 and his monthly excess income is $100.00. His Medicaid deductible is $600.00 and his deductible period is January 01, 2004 through June 30, 2014. In April 2014, Jeff's monthly excess income decreases to $10.00 a month. Jeff reports the decreased income in April and now has a choice between two different deductible recalculations. He can either have his worker recalculate the original $600.00 deductible which would then become a $330.00 deductible (three months of $100.00 excess income and three months of $10.00 excess income) or since he hasn't yet met that deductible, he can file a new application in April and establish a new deductible period of April 2014 through September 30, 2014 with a $60.00 deductible obligation ($10.00 x 6 = $60.00). If Jeff hasn't already incurred any substantial medical expenses, he may want to file a new application, set a new deductible period, and be in a better position to meet a much smaller deductible. (See 24.6.1 Changes During the Deductible Period> Income Changes)**Example 7:** Ned and Maria live in separate rooms in a substitute care facility, and each of them has an individual room and board contract. Ned has

income of $1,000 per month, and Maria has income of $500 per month. Ned's "rent" from the room and board amount is $550 and Maria's "rent" from the room and board amount is $400. Calculate the special housing amounts separately. Ned's is calculated as follows: $550-$350 = $200 special housing amount. Maria's is calculated as follows: $400- $350= $50 special housing amount.

The total of 1, 2, and 3 must not be greater than the EBD Maximum Personal Maintenance Allowance (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances).

28.6.4.2 Family Maintenance Allowance

A family maintenance allowance, an amount to be used for the support of the applicant's family members, should only be deducted from income when calculating cost share in certain cases. The family maintenance allowance may not be used for a deduction when *spousal impoverishment* policies apply or if the member is a disabled child.

28.6.4.2.1 Family Maintenance Allowance Calculation - Minor Child

When the waiver participant is the custodial parent of a *minor* child living in the home, and there's no spouse in the home, calculate the following:

1. Minor children's gross earned income.
2. -$65 and ½ of gross earned income (see Section 15.7.5 $65 and ½ Earned Income Deduction).
3. =_____.
4. + Minor Children's total unearned income.
5. =_____Add (3) and (4).
6. AFDC Related med needy income limit _____ (see Section 39.3 AFDC-Related Income Table). (Do not include the waiver *applicant* in the group size.)

If (5) is greater than (6), there's no family maintenance allowance. If (5) is less than (6), the family maintenance allowance is the difference between (5) and (6).

28.6.4.2.2 Family Maintenance Allowance Calculation - EBD-Related

If there are no minor children in the home, and spousal impoverishment policies do not apply, calculate the following:

1. Spouse's gross earned income.
2. -$65 and ½ of total gross earned income (see Section 15.7.5 $65 and ½ Earned Income Deduction).
3. =_____.

4. +Spouse's total unearned income.
5. = (3)+(4).
6. -$20 disregard .
7. = (6)-(5).
8. Enter the SSI Payment Level Plus the E Supplement for one person (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables).

If ~~Individuals who have been certified for Medicaid after meeting a deductible, will have to complete a review to establish a new deductible period. CARES does not send a review notice to the member regarding the new deductible period if he or she did not meet the deductible for the current period.~~

(7) is greater than (8), there is no family maintenance allowance. If (7) is less than (8), the family maintenance allowance is the difference between (7) and (8).

28.6.4.3 Special Excempt Income

Special exempt income (see Section 15.7.2 Special Exempt Income) must be deducted from income when calculating cost share.

28.6.4.4 Health Insurance

All health and dental insurance premiums covering the waiver person and for which he or she is responsible and pays a premium must be deducted from income when calculating cost share. This includes any Medicare Premium obligation including Medicare Part D. See Section 9.6.2 Policies Not To Report for a list of insurance types for which premium deductions are not allowed.

If the waiver participant is part of a covered group but not responsible for the premium, find his or her proportionate share by dividing the premium by the number of people covered. If both members of a couple apply, but only one pays the premium, divide the premium equally. Prorate premiums over the months payment covers.

~~**Example 1:** Horace applies for Medicaid in July. He has no income and does not expect any income in the future. He is financially eligible in July. He also wants Medicaid eligibility for April to cover some medical expenses he had in April. In April he would have been eligible because he had no income or assets.~~

~~But in May and June he had excess income of $20 each month. He has 2 choices:~~

~~Choose a Medicaid deductible period of April through September. After meeting the Medicaid deductible of $40 he would be certified for Medicaid from April through September.~~

~~Not choose a Medicaid deductible period. He would not have to meet a Medicaid deductible. He could be certified immediately for April and July. But he would have to forego Medicaid for May and June because of the excess income in May and June.~~**Example 8:** Sally pays a $600 premium quarterly for her Medicare supplement policy. Six hundred dollars divided by three equals $200. Enter $200 as her monthly health insurance premium payment on the Medical Coverage page.

28.6.4.5 Medical/Remedial Expenses

The dollar amount of the applicant's medical and remedial expenses, as reported by the MCO care manager, ICA, or ADRC, must be deducted from income when calculating

cost share. See Section 15.7.3 Medical/Remedial Expenses and Section 20.3.6 Medical or Remedial Expenses.

Note: Care managers should refer to the limitations associated with allowable medical or remedial expenses that are described in Section 27.7.8 Medical/Remedial Expenses and Payments for Non-Covered Services.

28.6.5 Maximum Cost Share Amount

For Family Care, Family Care Partnership, and PACE, see Section 39.4.4 for maximum cost share amount.

28.6.6 Waiver or Reduction Cost Share

Family Care, Family Care Partnership, or PACE members may request a waiver or reduction of their cost share from the Department. Members indicating that they are having difficulty paying cost share should be informed of this right, directed to complete the Application for Reduction of Cost Share form (F-01827), and referred to the Bureau of Adult Programs and Policy (1-855-885-0287).

~~If the applicant has excess income in the month of application, but no excess income in the 3 months prior to the month of application, he or she does not have to include them in a deductible period. He or she can be certified for them immediately, and can begin the Medicaid deductible period with the month of application.~~

~~**Example 2:** Roslyn applies for Medicaid in July. She is ineligible because she has excess income. She had no income in April, May, or June. She can be certified immediately for April, May, and June. She begins her Medicaid deductible period in July.~~

28.7 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE MEDICAL CODES

See the Process Help Section 81.5 Med Stat Code Chart for Community Waiver medical status codes. These are not the same codes as nursing home medical status codes. A medically needy Medicaid member could be eligible as a categorically needy waiver member (Group B), thus requiring a change in the medical status code from medically needy to categorically needy.

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

IM reviews financial eligibility annually. The care manager reviews level of care eligibility annually. Eligibility should not be discontinued if the care manager has not yet made the level of care review.

The care manager informs the *IM* agency if the person is no longer level of care eligible. IM must notify the care manager if the person is no longer Medicaid eligible.

28.9 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE COMMUNITY SPOUSE'S MEDICAID APPLICATION

When a community waivers person and his or her *community spouse* are both applying for Medicaid ~~deductible for a regular Medicaid~~, they are one case, but separate AGs.

Both spouses are in the non-waiver spouse's fiscal test group~~:~~ (*FTG*). Since the waiver *spouse* is in the FTG, *disregard* any income that may have been allocated by the waiver spouse to the community spouse.
The waiver spouse is a FTG of one. CARES creates the separate FTG's and AG's.

28.10 HOME AND COMMUNITY-BASED WAIVERS LONG-TERM CARE NOTICES

CARES generates a Notice of Decision each time the *IM* worker confirms a case.

28.11 RESERVED

~~To make sure that Medicaid does not pay what the member still owes on the deductible, send a Medicaid Remaining Deductible Update (F-10109) to the fiscal agent indicating the amount of the bill that the member owes. The fiscal agent subtracts this amount from the bill and Medicaid pays the rest.~~

~~Fill out the Medicaid Remaining Deductible Update (F-10109) only if:~~

~~A Medicaid certified provider has provided the billed services.~~

~~The person, having met the deductible, is being certified. If he or she is not being certified, Medicaid will not pay any of the bill.~~

~~The date of the bill is the date the deductible was met. Since the member is not eligible until he or she has met the deductible, he or she still owes for all bills prior to that date.~~

~~Do not send more than one bill. In the series of bills which the member may submit to you, there will be only one bill which is larger than the amount needed to meet the deductible. Medicaid will consider the remainder of the bill for payment.~~

28.12 RESERVED

28.13 RESERVED

28.14 RESERVED

30.2 FINANCIAL TESTS

The asset limit for one person is $2,000. Count assets the same as for other *EBD* assistance groups.

The income limit for one person is $1,~~585~~627. This is gross income. There is no net income test.

TB-related assistance groups that fail the TB-related gross income test cannot become eligible for a Medicaid deductible.

If more than one person in the assistance group is TB-infected, test each person as a single individual with his or her own *FTG*. Do not deem assets or income from any other member of the assistance group.

Example 1: Mary and her spouse George are both applying for TB-related Medicaid. Test Mary and George as separate FTGs. Do not deem assets or income from Mary to George or from George to Mary. Test Mary's assets against the asset limit. Test her income against the income limit for one person. Test George's assets against the asset limit. Test his income against the income limit for one person.

Example 2: There are three children in the Kraan family. All of the children have TB. Consider each child to be a separate FTG. Test each child using only his or her own assets and income. Each child's assets do not exceed the asset limit. Each child's income limit does not exceed the income limit. Do not deem assets or income from the child's parents or from any of his or her siblings.

If only one person in the assistance group is TB-infected and that person is a:

- **TB-infected minor or 18-year-old:** Test him or her in the Financial Tests for Disabled Minors. Add the parents' deemed assets and income to the minor or 18-year-old's assets and income. Test him or her against the asset limit and the gross income limit.
- **TB-infected adult with assets or income who has a spouse with no assets or income:** Test the TB-infected adult's assets or income against the asset limit and the gross income limit.
- **TB-infected adult with assets or income who has a spouse with assets or income:** Use Worksheet 06 Supplemental Security Income-Related Determination, F-01305, (see Section 40.1 Worksheets Table of Contents) to determine the spouse's assets and net income. Add these totals to the TB-infected person's assets and gross income. Compare this total to the asset limit and the gross income limit.
- **TB-infected adult with no assets or income who has a spouse with assets or income:** Use Worksheet 06 Supplemental Security Income-Related Determination, F-01305, (see Section 40.1 Worksheets Table of Contents) to

determine the spouse's assets and net income. Compare these results to the asset limit and the gross income limit.

Note: When using Worksheet 06, *disregard* items 16-18. Replace item 19 with the TB-related income limit. Disregard item 20.

32.6 MEDICARE SAVINGS PROGRAMS ASSET LIMITS

Asset Limits for *QDWI*	
Group Size	**Asset Limit**
1	$4,000
2	$6,000

QMB, *SLMB*, and *SLMB+* have the same asset limit.

Asset Limits for QMB, SLMB, and SLMB+	
Group Size	**Asset Limit**
1	$7,~~560~~730
2	$11,~~340~~600

Divestment of assets has no effect on QMB, SLMB, SLMB+, or QDWI eligibility.

33.1 INTRODUCTION

SeniorCare is a prescription drug assistance program for Wisconsin residents who are ~~at least~~ 65 years ~~old~~of age or older and meet the program's ~~eligibility criteria. SeniorCare began September 1, 2002~~enrollment requirements.

~~SeniorCare is designed to help seniors with covered prescription drug costs. Eligible participants are issued SeniorCare identification cards and may receive SeniorCare benefits.~~

~~There~~ ~~is neither an asset test nor estate recovery for SeniorCare. Participation levels are determined by comparing the anticipated annual income of the *FTG* to a percentage of the *FPL* corresponding to the FTG size.~~

SeniorCare is administered by *DHS*, through *EM CAPO*. ~~County~~IM consortia and tribal agencies are not responsible for determining eligibility for SeniorCare, but may need to coordinate with workers in the EM CAPO for mixed cases. Mixed cases include people eligible for SeniorCare and:

1. FoodShare, **or**
2. A Medicare Savings Program , **or**
3. An unmet Medicaid deductible, **or**
4. Child care assistance, **or**
5. Are participating in a Department of Workforce Development (DWD) employment program, such as *W-2*.

Although SeniorCare is a subprogram of Medicaid, only the portions of the handbook that are referenced in Chapter 33 SeniorCare apply to SeniorCare policy.


SENIORCARE
Prescription Drugs for Wisconsin Seniors
RxBIN 610499
Issuer (80840)
ID 1234567890
Name IMA PARTICIPANT
Participants:
• Show this card each time you get your prescription drugs.
• For customer service, call 1-800-657-2038.
Pharmacists:
Submit claims electronically or send paper claims to:
Claims and Adjustments Unit
6406 Bridge Rd.
Madison, WI 53784-0002
Provider Services: 1-800-947-9627

33.2 APPLICATION

33.2.1 SeniorCare Application Introduction

An individual interested in participating in SeniorCare must complete a SeniorCare Application ~~Form~~form (F-10076). ~~An application may be obtained from a local Office on Aging, Senior Center, or Aging Resource Center.~~ Applications may ~~also~~ be printed from the Department of Health ~~Services~~Services' SeniorCare web site at: ~~http~~https://www.dhs.wisconsin.gov/~~seniorCare/index~~seniorcare/apply.htm~~. .~~. Local Aging and Disability Resource Centers may also have copies of the SeniorCare application. If the *applicant* is unsure where to obtain an application or wants to have one mailed to him/her, he or she should call 1-800- 657-2038 (TTY and translation services are available).

A $30 enrollment fee ~~is~~per person is required as a condition of eligibility. If the enrollment fee is not sent with the application, the eligibility begin date could be delayed (See Section 33.~~5~~3.2 ~~ID Cards~~Enrollment Fee).

SeniorCare applications should be mailed to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

Note: For benefit renewal requirements, see ~~33.5 SeniorCare Benefit Period~~Section 33.15 Annual Eligibility Renewal.

33.2.2 Application Processing

A valid application for SeniorCare is a SeniorCare Application ~~Form~~form (F-10076) with the applicant's:

1. Name, **and**
2. Address, **and**
3. Signature (~~See~~see 33.2.3 Signing the Application) in Section V. Applications that are not signed in Section V of F-10076) will be returned to the applicant.

However, non-financial (see Section 33.3 ~~SeniorCare~~ Nonfinancial Requirements) and income (33.6 ~~SeniorCare~~ Financial Requirements) information is needed to determine eligibility.

"General Delivery" may be used for a mailing address but ~~can not~~cannot be used as a residence address.

The presence of a signature on a SeniorCare application indicates intent to apply. When a signed application is received without an enrollment fee, the department will send an

enrollment fee request notice to the applicant(s). An application will not be approved until an enrollment fee is received.

When an application is received with an enrollment fee(s) where the applicant(s) has answered "No" to the question "Are you Requesting SeniorCare?", the department will assume that there is a request for at least one person. When an application is received without the enrollment fee where the applicant's answer to the question is "No", the department will follow up with the applicant(s) to determine his or her intent.

The date a valid application is received by the SeniorCare program is the application filing date. Eligibility for SeniorCare will be determined as soon as possible, but not later than 30 days from the date a valid application is received.

A delay in processing the application may occur if there is a delay in obtaining information or in receipt of the enrollment fee necessary for determining eligibility. If a delay occurs, the applicant will be notified in writing that there is a delay in processing the application. The notice will specify the reason for the delay and inform the applicant of his or her right to appeal the delay.

If the initial application is denied and the applicant wishes to reapply, he or she should check the "New Application" box on the application form. "Reapplication" refers to current ~~participants~~members who are requesting establishment of a new benefit period due to a change in circumstances.

33.2.4 Authorized Representative

An authorized representative may act on behalf of the SeniorCare ~~participant~~member at application and/or ~~reviews~~renewals, and is authorized to provide information and any documentation that is necessary to establish SeniorCare eligibility.

A SeniorCare applicant or member may ~~authorize someone to represent him or her by completing the~~ appoint an individual or an organization as an authorized representative ~~form F-10080. (**Note**: The early version of~~ by completing the SeniorCare Authorized Representative form (F-10080).

There ~~application included Section V for authorizing a~~ can be only one authorized representative~~.~~ at a time for a SeniorCare. There is no time limit on how long a person or organization can act as authorized representative. The appointment of the authorized representative is valid until the applicant or member notifies the agency of a change or removal in writing. SeniorCare authorized representatives can only act on the individual's behalf for SeniorCare.

Organizations acting as authorized representatives must provide the name and contact information of a person from the organization. Once the organization has been appointed as the authorized representative, anyone from the organization will be able to take action on behalf of the applicant or member (not just the person who signed the

form on behalf of the organization). If ~~the 07/02 version of F-10076 is submitted~~an organization is only changing the contact person for the organization, the member is not required to complete a new SeniorCare Authorization of Representative form if the organization is going to remain as the authorized representative.

The authorized representative should be familiar with ~~Section V completed, SeniorCare will accept the authorization of the representative.)~~the applicant or member's household situation and is expected to fulfill their responsibilities to the same extent as the individual being represented. An authorized representative is limited to doing any or all of the following on behalf of the applicant or member:

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

To change an authorized representative, the member must complete and submit the SeniorCare Authorization of Representative form to the SeniorCare program.

To remove an authorized representative, the member needs to let the SeniorCare program know of the removal in writing. The member does not need to gather additional signatures from the authorized representative or a witness to complete the removal of an authorized representative. Authorized representatives can also request in writing (for example, a signed statement) to be removed if they no longer want to act as the authorized representative. If an authorized representative is requesting to be removed, a signed statement is not needed by the member. An authorized representative designation is valid on a case until a written and signed request is received for removal.

33.2.5 Guardian and Power of Attorney

~~An applicant is not required to complete the *Authorized Representative* form F-10080 if a legal guardian or power of attorney (POA) is applying on the SeniorCare applicant's behalf.~~
If a SeniorCare applicant or member is represented by a legal guardian of the person and the estate, legal guardian of the estate, legal guardian in general, or conservator, the legal guardian or conservator must appoint the authorized representative. If the SeniorCare applicant or member only has a legal guardian of the person, the applicant or member must appoint the legal guardian of the person as an authorized representative if the member or member would like the legal guardian of the person to act on his or her behalf. If the applicant or member has a power of attorney, the applicant or member can still appoint an authorized representative.

Copies of guardianship or POA documentation ~~will be requested after the SeniorCare application has been submitted. Documentation~~ must be submitted to the SeniorCare Program before information about the applicant or ~~participant will~~member can be released to the guardian or POA~~. A~~, unless the POA ~~may also be~~is the authorized ~~for representation by completing the authorization of representation form (F-10080)~~ representative. The SeniorCare Authorization of ~~Information~~Representative form (F-10080) will be accepted in lieu of ~~submitting~~ the POA papers.

33.3 NONFINANCIAL REQUIREMENTS

33.3.1 SeniorCare Nonfinancial Requirements Introduction

To be non-financially eligible for SeniorCare, an *applicant* must:

1. Be at least 65 years of age.
2. Be a Wisconsin resident. A Wisconsin resident is an individual who meets at least one of the following criteria:
   - Has a permanent residence in Wisconsin
   - Is considered a Wisconsin resident for tax purposes
   - Is a registered voter in Wisconsin

   A SeniorCare ~~participant~~member may temporarily live outside the state of Wisconsin, as long as he or she maintains permanent residency in Wisconsin. Residency in a Wisconsin nursing home or an assisted living facility will meet this requirement. There is also not a specific period of time the applicant must be a Wisconsin resident before applying for SeniorCare.

3. Be a U.S. citizen or ~~a~~have qualifying ~~legal alien (~~immigrant status. (see Section 7.1 US Citizens and Nationals). An applicant who is a ~~resident alien~~not a U.S. citizen will need to have a qualifying immigrant status to be eligible for SeniorCare (see Section 7.3 Immigrants). The applicant will need to provide ~~a copy of both sides of~~ his or her ~~alien card and identify his or her country of origin. If~~immigration registration number. Verification of the applicant's immigration status will be made through the U.S. Citizenship and Immigration Services' Systematic Alien Verification for Entitlements (SAVE) program. In some cases, the individual may need to provide an official government document. For example, if the applicant's immigration status cannot be verified through SAVE or there are discrepancies between reported and verified data, supporting legal documentation must be provided by the applicant. ~~When legal documentation is not available and *SSA*~~

   If current SSDI, SSI, Medicare, Foster Care, or Adoption Assistance benefits have been verified, ~~this requirement has been met.~~the applicant is exempt from documenting their citizenship (see Section 7.2 Documenting Citizenship and Identity).

   ~~Verification of alien status can be made through the U.S. Bureau of Citizenship and Immigration Services' Systematic Alien Verification for Entitlement (SAVE) program.~~

4. ~~4.~~ Provide an SSN or be willing to apply for one~~ (20.3.2~~, unless they are exempt from the SSN requirement (see Section 10.1.1 Social Security Number~~).~~

4. ~~Applications~~ Requirements).

SeniorCare applicants only need to provide a number, which is verified through the data exchange with Social Security. If the SSN validation process returns a mismatch record, then the applicant must provide the Social Security card or another official government document with the SSN displayed. If an applicant does not yet have a SSN, he or she must be willing to apply for one.

If an applicant requires assistance in obtaining a SSN, the SeniorCare Program will assist him or her in applying for one. “Assisting the applicant” may include helping with filing the SS-5 SSN Application form, obtaining a birth certificate on behalf of the applicant, or assisting with obtaining another document needed to apply for the SSN.

SeniorCare applications without the SSN or with an incorrect SSN will not be returned. Applicants will be contacted and given an opportunity to provide a ~~SSN Eligibility~~valid SSN or apply for one. The SeniorCare program will ~~not be confirmed until~~honor the ~~SSN or proof of~~original application ~~for SSN has been supplied. If the SSN~~ date for individuals who initially provide an incorrect SSN or who need assistance in applying.

If the individual is not willing to provide or apply for an SSN or the proof of application is not received within 30 days of application for the SeniorCare application date, eligibility will be denied and any enrollment fee received will be refunded. The individual can reapply once they ~~have their~~are willing to provide or apply for an SSN. The ~~Eligibility~~eligibility begin date will be based on the new application receipt date.

The member should be informed if the SSN validation process indicates another individual is using the same SSN. The member should contact the Social Security Administration and request they conduct an investigation. The IM worker cannot provide the member with any information that would identify the individual who is using the member's SSN.

If the Social Security Administration finds that the SSN has been used fraudulently it may:

~~If a person requires assistance in obtaining a SSN, the SeniorCare Program will assist him or her in applying for one.~~

- Recommend further action be taken and/or
- Provide the member with the information on the fraudulent action so that the member may pursue action through the legal system.

Verify the SSN only once.

5. Not be a full-benefit Medicaid member (see Section 21.2 Full-Benefit Medicaid). This includes ~~participants~~members who are covered by BadgerCare Plus (see the BadgerCare Plus Handbook).
   Individuals are not considered Medicaid members for SeniorCare if they have an unmet Medicaid deductible (see Section 24.2 Medicaid Deductible Introduction) or receive one of the following:

   - Medicare Savings Program (see Section 32.1 Medicare ~~Beneficiaries Introduction~~Savings Programs).
   - TB-related Medicaid (see Chapter 30 Tuberculosis)

~~Emergency Services.~~

6. Not be an inmate of a public institution (6.9.3 Inmates of State Correctional Institutions).

7. Cooperate with providing information and/or verification necessary to determine eligibility (see Chapter 20~~.2 General Rules~~ Verification) and for quality assurance purposes.

   If a person requires assistance in obtaining the required verification, the SeniorCare program will assist him or her.

   If a person is not able to produce the required verification and the SeniorCare program is not able to produce the required verification, the SeniorCare program may not deny assistance.

   If a person is able to produce required verification but refuses or fails to do so, the application will be denied.

33.3.2 Enrollment Fee

In addition to the non-financial requirements listed above, each applicant must pay a $30 annual enrollment fee. The enrollment fee must be paid prior to eligibility confirmation. When a ~~participant~~member reapplies for a new benefit period, a new enrollment fee is required.

When a SeniorCare enrollment fee check is returned for non-sufficient funds, the applicant or member is mailed a ~~form~~ letter and provided ten calendar days to submit a replacement check. If a replacement check is not received, a ~~form~~ letter giving another 10 days to replace the fee is sent ~~to the participant.~~ . If the check is still not replaced, then ~~the~~ eligibility is denied or terminated. ~~A notice of decision is mailed to the participant. The termination date is 10 days after the notice of the decision (mail) date.~~

33.3.2.1 Refunds

No Application Received

If *EM CAPO* receives ~~a~~an enrollment fee without an application, a manual notice and application will be sent, if possible, to the individual from whom the enrollment fee was received. If ~~an Application~~a SeniorCare application is not received by EM CAPO within 45 days of the receipt of the enrollment fee, a refund will be processed at the request of the person who submitted the enrollment fee.

Application Denied

Anytime an application for SeniorCare is denied, a refund of the paid enrollment fee is automatically issued. A refund may be requested prior to eligibility being confirmed or within specified timelines outlined below.

Opt ~~out~~Out

In all opt-out cases, a refund will be issued only if the request to withdraw from the SeniorCare program is received by the later of:

- Ten days following issuance of the eligibility notice, or
- 30 days from the application filing date.

The date by which a request for refund must be received will be printed on the initial eligibility determination notice. Filing of a hearing request will not delay these deadlines for refunds.

Refunds are based on individual participation. A SeniorCare ~~participant~~member may receive an enrollment fee refund if he or she received an initial eligibility notification, but has not received any SeniorCare prescription drug benefits or services and requests to withdraw from the program (see Section 33.12.2 Withdrawal).

SeniorCare prescription drug benefits include use of the SeniorCare card to receive discounted drug prices in levels 1, 2a, and 2b. A refund may be issued if such charges are reversed by the pharmacy.

Use of the SeniorCare card at Level 3 where a spenddown has not been met constitutes receipt of SeniorCare prescription drug services. A refund of the enrollment fee may be issued if such claims are reversed by the pharmacy.

Example 1: ~~Henry was~~Julie is a SeniorCare ~~participant~~member at Level ~~1 whose~~2b. Julie's SeniorCare application filing date was October 26th, and her benefit period began ~~12/01/04. Henry passed away on 12/04/04. His daughter reported Henry's death~~November 1st. On November 15th, Julie calls the SeniorCare Customer Service hotline to withdraw from the SeniorCare program ~~on 12/10/04~~ and ~~requested~~request a refund of ~~his~~her $30 enrollment fee. ~~Henry's~~Julie used her SeniorCare card ~~had been used on 12/01/04 to purchase~~on November 10th, when she purchased a prescription~~.~~

however the pharmacy had reversed those charges on 12/05/04 since Henry's. Although Julie requested a refund within 30 days of her application filing date, she is not entitled to a refund, because she received her prescription had not been picked up. The $30 enrollment fee should be refunded in this case since Henry did not receive any SeniorCare prescription drug benefits or services.at a discounted cost by using her SeniorCare card.

Example 2: JulieMike is a Level 3 SeniorCare participant at Level 2b. Julie'smember. Mike's SeniorCare application filing date was 10/26/04October 28th and herhis benefit period began 11/01/04. November 1st. On 11/15/04 Julie calls SeniorCare Customer Service HotlineNovember 20th, Mike requests to withdraw from the SeniorCare program and request a refund of herthat his $30 enrollment fee. Julie be refunded to him. Mike used herhis SeniorCare card on 11/10/04November 18th, when shehe purchased a prescription. Although Julie requested a; however, he had not met his Level 3 spenddown, so he did not receive a discounted price for his prescription. Mike is entitled to a refund of his enrollment fee if the pharmacy reverses this prescription claim. He made the refund request within 30 days of herhis application filing date, she and he has not received any SeniorCare prescription drug benefits or services. If the claims are not reversed, Mike is not entitled to a refund, because she received her prescription at a discounted cost by using her SeniorCare card. .

Example 3: Mike is a Level 3 SeniorCare participant. Mike's SeniorCare application filing date was 10/28/04 and his benefit period began 11/01/04. On 11/20/04, Mike requests to withdraw from the SeniorCare program and that his $30 enrollment fee be refunded to him. Mike used his SeniorCare card on 11/18/04 when he purchased a prescription, however, he had not met his Level 3 spenddown, so he did not receive a discounted price for his prescription. Mike is entitled to a refund of his enrollment fee if the pharmacy reverses this prescription claim. He made the refund request within 30 days of his application filing date and he has not received any SeniorCare prescription drug benefits or services. If the claims are not reversed, Mike is not entitled to a refund.

In all opt-out cases, a refund will be issued only if the request to withdraw from the SeniorCare program is received by the later of:

- Ten days following issuance of the eligibility notice, or
- 30 days from the application filing date.

The date by which a request for refund must be received will be printed on the initial eligibility determination notice. Filing of a hearing request will not delay these deadlines for refunds.

33.3.2.2 Refunds to Deceased ParticipantsMembers

A refund may also be requested by the family *member* of a deceased ~~participant~~member when all the following criteria are met:

1. He or she received an eligibility notification, and
2. Death occurs prior to the start of or within 30 days of the beginning of the SeniorCare benefit period, and
3. The request is made within 45 days of the date of death; and
4. He or she had not received any SeniorCare prescription drug benefits or services.

Example 3: Henry was a SeniorCare member at Level 1 whose benefit period began December 1st. Henry passed away on December 4th. His daughter reported Henry's death to the SeniorCare program on December 10th, and requested a refund of his $30 enrollment fee. Henry's SeniorCare card had been used on December 1st to purchase a prescription; however, the pharmacy had reversed those charges on December 5th, since Henry's prescription had not been picked up. The $30 enrollment fee should be refunded in this case since Henry did not receive any SeniorCare prescription drug benefits or services.

Note: If all of the above conditions are met, a refund will be issued even if the death is reported beyond the refund deadline date.

33.3.4 Other Insurance

~~Applicants~~Except for people enrolled in full-benefit Medicaid, applicants who have prescription drug coverage under other health insurance plans, including Medicare Parts ~~A~~B and ~~B~~D, may enroll in SeniorCare. SeniorCare is the payer of last resort except for state-funded-only programs, such as *WCDP*.

SeniorCare will coordinate benefit coverage with all other health insurance coverage. SeniorCare may also coordinate benefits with pharmacies that accept discount cards. Questions about individual health insurance coverage should be directed to the health insurance company. Questions regarding insurance carriers should be directed to:

Office of Commissioner of Insurance
Bureau of Market Regulation
P.O. Box 7873
Madison, WI 53707-7873
1-800-236-8517

33.3.5 Creditable Coverage

Wisconsin's SeniorCare prescription drug assistance program is considered to be creditable prescription drug coverage. This means SeniorCare meets or exceeds the standard Medicare Part D plan. If an individual chooses to enroll in SeniorCare instead of Medicare Part D, they will not have a penalty.

If an individual is enrolled in SeniorCare, they can keep SeniorCare and not pay extra if they decide to enroll in Medicare Part D later. However, if their SeniorCare coverage ends and he or she does not enroll in a Medicare Part D plan right away, they may have to pay more to enroll in Medicare Part D at a later date.

If an individual goes without creditable prescription drug coverage for 63 days or longer, their monthly premium for Medicare Part D will go up at least one percent for each month they did not have creditable coverage. For example, if they go nine months without coverage, their premium will always be at least nine percent higher that if they had enrolled in Medicare Part D right away.

If individuals enroll in a Medicare Part D plan, their coverage will typically begin about a month after they enroll. If they need help paying for their prescription drugs and they are enrolled in SeniorCare, they may choose to remain enrolled in SeniorCare until their Medicare Part D coverage begins.

If an individual does not enroll in a Medicare Part D plan when they are eligible, they may have to wait until the next enrollment period before they can enroll. The enrollment period is from October 15 through December 7 each year, and coverage begins January 1.

Individuals with limited resources may be able to get extra help paying premiums, deductibles, and copayments for Medicare Part D. They can apply or get more information about Extra Help, also called the Low Income Subsidy, by calling the Social Security Administration at 800-722-1213 or visiting www.socialsecurity.gov/extrahelp.

If applicants have questions about SeniorCare and Medicare Part D, or need help choosing which prescription drug plan is best for them, they should be referred to a benefits specialist at their local aging and disability resource center (ADRC) or the Wisconsin Medigap Part D and Prescription Drug Helpline at 1-855-677-2783 for questions about Medicare Part D and other prescription drug coverage options.

33.5 BENEFIT PERIOD

33.5.1 SeniorCare Benefit Period Introduction

The benefit period for SeniorCare is 12 consecutive months. The benefit period and eligibility remain intact unless the ~~participant~~ member:

1. Moves out of state,
2. Reapplies (33.11 ~~SeniorCare~~ Re-Application),
3. Requests to withdraw from the program (33.12 ~~SeniorCare~~ Early Termination), **or**
4. Dies.

Once eligibility has been established, any changes in income will not be considered until the next renewal, unless the individual reapplies for a new benefit period.

33.5.2 ID Cards

When an *applicant* is found eligible for SeniorCare, he or she is mailed a plastic SeniorCare ID card and information about how to use it. SeniorCare ~~participants~~members who renew their eligibility will continue to use their original card.

SeniorCare members must present their SeniorCare card to their pharmacy provider. The card does not show enrollment dates. The pharmacy provider will verify the member's enrollment at each visit.

If SeniorCare members have questions regarding their eligibility status or need a replacement SeniorCare card, they should call the SeniorCare Customer Service hotline at 1-800-657-2038.

33.5.3 Eligibility Begin Date

SeniorCare eligibility begins on the first day of the month following the month in which all eligibility requirements have been met. This includes receipt of a completed application and enrollment fee.

Exception: SeniorCare eligibility begins the day after ~~MA~~Medicaid eligibility ends if a SeniorCare application is submitted prior to the ~~MA~~Medicaid termination date and all eligibility requirements are met.

Example 1: Carol applies for SeniorCare on September 19th and meets all eligibility requirements. Her application is processed on October 10th, and eligibility is confirmed the same day. Carol's benefit period is from October 1st through September 30th.

Example 2: William applied for SeniorCare on September 19th but did not submit the enrollment fee with his application. His eligibility ~~"~~pends~~"~~ and a notice is issued. William submits the fee on October 1st and eligibility is confirmed the same day. William's benefit period is from November 1st through October 31st.

Example 3: Mary is notified that ~~MA~~Medicaid eligibility will end on November 30th because her assets exceed the program limit. She applied for SeniorCare on November 29th and will meet all SeniorCare eligibility requirements on December 1st (when she is no longer ~~an MA~~a full-benefit Medicaid member). Mary's benefit period is from December 1st through November 30th.

~~**Note:** If a gap in coverage of not more than one month occurs due to an agency error, eligibility for a new 12 month benefit period begins the first of the month the completed application is received and all eligibility requirements are met, including payment of the annual enrollment fee.~~

Note: If a gap in coverage of not more than one month occurs due to an agency error, eligibility for a new 12 month benefit period begins the first of the month the completed application is received and all eligibility requirements are met, including payment of the annual enrollment fee.

Example 4: Harold's ~~PPRA~~Renewal Application was mailed to him on December 13th to be completed for his new benefit period~~,~~ that ~~begins~~would begin February 1st. The ~~PPRA~~Renewal Application was mailed to the last known address in CARES which belonged to Harold's wife Mary who was in a nursing home. Mary passed away on May 2nd of this year and although the ~~local agency~~IM worker ended her Medicaid eligibility, the case address was not updated in CARES. Harold has not moved, so he was not required to report a change of address to the SeniorCare program. Due to the incorrect address, Harold did not receive the ~~PPRA~~Renewal Application form to complete until late in January. The completed ~~PPRA~~Renewal Application was received by the SeniorCare program on February 10th, along with a letter explaining why it was late. Harold's new SeniorCare benefit period is February 1st through January 31st, since the one month gap in coverage was due to an agency error.

33.6 FINANCIAL REQUIREMENTS

33.6.2 Income

Income for SeniorCare is based on what the FTG expects to receive in the next 12 month period, beginning with the month of application. The incomes for the applicant and his or her spouse are counted together if they live together. Applicants can use the previous year's information from tax returns or other sources as a guide when estimating what to report on their application. Applicants are asked to round income amounts to the nearest whole dollar when entering their good faith estimates on their SeniorCare application or renewal application.

Social Security income will always be verified. For all other income types, if reported amounts seem unreasonable or questionable, further verification may be obtained from the applicant or other available sources, such as a data exchange.

The income of a *spouse* who is in the SeniorCare *FTG* is included in the estimate of the annual, budgetable income even if he or she does not apply or is nonfinancially ineligible. However, the spouse's income is not counted if one of the exceptions noted in Section 33.4 Fiscal Test Group applies.

Annual income is determined prospectively from the month of application through the next 12 calendar months. Income exempted for Medicaid eligibility is also exempted for SeniorCare (see Section 15.3 Exempt and Disregarded Income), including *EITC* and income tax refunds (see Section 15.5.7 Income Tax Refunds).

Budgetable income consists of projected gross annual income, except for self-employment income, which uses net income (see Section 33.6.6 Self-Employment Earnings).

In the following income related sections, policy is defined according to the categories on the SeniorCare Application form, F-10076. All income listed in the following sections should be prospectively budgeted for a 12-month period beginning with the month of application.

33.6.3 Gross Social Security

When calculating anticipated gross annual Social Security income, add any deductions for Medicare Part B or D and court-ordered guardianship fees, alimony, and/or child support must be added to the net payment amount.

Exception: If a SeniorCare applicant is receiving Medicare premium assistance (see Section 32.1 Medicare Savings Programs), his or her monthly payment already includes the Medicare Part B premium.

The applicant should contact the *SSA* at 1-800-772-1213 if he or she does not know his or her Medicare premium amount.

When the applicant is a surviving spouse receiving benefits under his or her spouse's Social Security number, the amount should be considered the applicant's income and reported under the applicant's income column of the application.

Social Security income is verified through the Social Security Administration data exchange.

33.6.4 Gross Earnings

Budgetable gross earnings consist of all gross earned income, except for self-employment income, which uses net income (see Section 33.6.6 Self-Employment Earnings). Gross earnings include the following:

- AmeriCorps (see Section 15.5.9 AmeriCorps)
- Contractual income (see Section 15.5.2 Contractual Income)
- ~~Governor's Central City Initiative (see Section 15.5.7 Governor's Central City Initiative)~~
- Income in-kind (see Section 15.5.1 Income In-Kind)
- Income received by members of a religious order (see Section 15.4.16 Income Received by Members of a Religious Order and Section 15.5.12 Income Received by Members of a Religious Order)
- Jury duty payments (see Section 15.5.4 Jury Duty Payments)
- Salary
- Severance pay (see Section 15.5.11 Severance Pay)
- Wage advances (see Section 15.5.5 Wage Advances)
- Wages
- Wages and salaries received from a program funded under Title V—Older Americans Act of 1965 (see Section 15.5.13 Title V—Older Americans Act of 1965)
- Worker's compensation (see Section 15.5.6 Worker's Compensation)
- Respite care payment for services

33.6.5 Interest and Dividends

The SeniorCare applicant must report the estimated gross amount of all interest and dividends that he or she expects to receive in the next 12 months, beginning with the month of application. Sources of interest and dividends include, but are not limited to, the following:

- Bonds
- CDs

- Checking accounts
- Money market accounts
- Savings accounts
- Stocks
- Capital gains (see Section 33.6.5.1 Capital Gains)
- Trusts (see Section 33.6.5.2 Trusts)
- *IRA*s (see Section 15.4.4 Retirement Benefits)
- Annuities
- Land contracts (see Section 15.4.7 Land Contract)
- Loans (see Section 15.4.8 Loans~~/~~, Promissory Notes, and Mortgages)

Payments do not need to be directly received. If they are rolled back into the asset, they still must be reported.

Irrevocable interest that a SeniorCare applicant receives for an irrevocable burial trust is not budgetable income.

Note: Unlike Medicaid, income that is received irregularly and infrequently and is under $20 per month should be reported as budgetable income for SeniorCare applicants.

33.6.6 Self-Employment Earnings

SeniorCare will budget net self-employment income, which is calculated by deducting ~~estimated~~allowable business expenses, losses, and depreciation from gross self-employment income~~.~~ (see Section 15.6 Self-Employment Income).

If the net self-employment earnings are anticipated to be a loss, the amount should be reported as zero.

Negative amounts should not be reported. Any reported losses will be budgeted as zero and will not be used to offset other income ~~(see Section 15.6.5.2 Worksheets).~~.

33.6.6.1 Rental Income

If rental income is reported to the IRS as self-employment income and is subject to the federal self-employment tax for rental income (usually real estate agents or individuals in a business where extensive services are provided to the renters), depreciation should also be deducted from the gross rental income. Refer to Section 15.6.4 Self-Employed Income Sources for more information about rental income for self-employed members.

Refer to Section 33.6.8.3 Rental Income if rental income is not reported as self-employment income.

~~**Note:** See Section 15.5.3 Rental Income for more information about calculating net rental income for SeniorCare participants.~~

33.6.7 Gross ~~Pension~~Retirement Income

Examples of retirement income that should be ~~included in the gross pension amount~~ counted for SeniorCare include:

- Veterans retirement benefits
- ~~•~~ Railroad Retirement ~~benefits~~
- ~~Retirement~~Board benefits ~~(see Section 33.6.7.1~~
- The taxable portion of IRAs, annuities, work-related retirement plans, and pensions

- ~~•~~ Retirement ~~Benefits)~~
- ~~Veterans~~ benefits~~. (see Section 15.3.26 VA Allowances)~~

~~33.6.7.1 Retirement Benefits~~

~~Retirement benefits are~~ include work-related plans for providing income when employment ends (e.g., pension, disability, or retirement plans administered by an employer or union). Other examples are funds held in an IRA and plans for self-employed individuals, sometimes referred to as Keogh plans.

~~Retirement~~The funds in retirement accounts, including IRAs, Keogh plans, etc., are assets and are therefore not counted for SeniorCare.

~~Periodic~~ However, periodic payments ~~received~~, withdrawals, and distributions the individual expects to receive from ~~a~~their retirement account or annuity in the next 12 months are counted as income. ~~A periodic payment~~The only exception is ~~any partial payment~~when the individual has never previously made withdrawals from ~~a retirement~~the account~~. Withdrawal of~~ and he or she withdraws the full amount ~~from any retirement account that has never had a withdrawal made from it~~at one time. This is not considered a periodic payment and is not countable income.

Note: Rolling over an IRA (transferring the funds from one IRA to another) is the conversion of an asset from one form to another. Any potential income from an IRA rollover is countable income for SeniorCare.

Example 2: Mike owns a $2,000 IRA and plans to withdraw all of it this year. Mike has not withdrawn any money from this IRA in the past.

If Mike withdraws the full $2,000 at one time, the $2,000 continues to be considered an

asset. This is a conversion from one form of an asset to another.

If Mike were planning to make a one-time withdrawal of $1,000 from the $2,000 IRA in the next 12 months, the $1,000 would be considered income. He should report this income on his SeniorCare application. and it should be budgeted.

If Mike were planning to withdraw $100 monthly from his IRA in the next 12 months, the $100 he plans to receive monthly from the IRA is counted as income. He should report this income on his SeniorCare application and it should be budgeted.

33.8 COUNTABLE COSTS

33.8.1 SeniorCare Countable Costs Introduction

In order for the prescription drug purchase to count towards meeting a spenddown or deductible, it must be:

1. Prescribed for the eligible SeniorCare ~~participant~~member,
2. Purchased during the benefit period, and
3. Covered by the SeniorCare program (see Section 33.6 ~~SeniorCare~~ Financial Requirements).

All covered prescription drug costs the ~~participant~~member incurs will be tracked, and the SeniorCare Program will coordinate coverage with other insurance companies~~.~~ if the member has other coverage. If the prescription is covered by other insurance, only the portion not paid by other insurance is applied toward the spenddown or deductible.

When a ~~participant's~~member's out-of-pocket expense requirements are met for a deductible or spenddown, participating pharmacies will be informed.

33.9 ADDITION OF A SPOUSE

33.9.1 SeniorCare Addition of a Spouse Introduction

The following exceptions apply when one *spouse* (hereafter referred to as Spouse 2) is determined eligible after the participating spouse's (hereafter referred to as Spouse 1) benefit period has begun.

In all of these situations, Spouse 1's eligibility and benefit period does not change, unless he or she chooses to reapply (see Section 33.11 ~~SeniorCare~~ Re-Application).

If Spouse 2 becomes eligible after Spouse 1's benefit period has begun, Spouse 2's benefit period ends on the same date that Spouse 1's benefit period ends.

The participation level for Spouse 2 depends on whether:

1. Spouse 2 was married and living with Spouse 1 at the time of Spouse 1's application (see Section 33.9.2 Adding a Spouse No Change in FTG).

    a. If ~~spouse~~Spouse 1's eligibility was determined at level 2a or 2b, then refer to 33.9.2 Adding a Spouse No Change in FTG.
    b. If ~~spouse~~Spouse 1's eligibility was determined at level 3 then refer to ~~(~~Section 33.9.2.2 Adding a Spouse, No FTG Change, At level 3~~)~~. Refer to the applicable policy depending on whether or not the spenddown has been met as follows:

        - Met spenddown (see Section 33.9.2.2.1 Unmet Spenddown)
        - Unmet spend (see Section 33.9.2.2.2 Met Spenddown)

Or

2. Spouse 2 was not included in the *FTG* (e.g~~.~~., single or not living with Spouse 1) at the time of Spouse 1's application. (see Section 33.9.3 FTG Changes), but they are now residing together.

1.

a. If spouse 1's eligibility was determined at level at level 2a or 2b, refer to Section 33.9.3.1 FTG Changes at Level 2a and 2b)

    b. If spouse 1's eligibility was determined at level 3, refer to Section 33.9.3.2 FTG Changes At Level 3

See 33.9.4 Addition of a Spouse Summary Table

33.9.2.1 Adding A Spouse, No FTG Change, At Levels 2a and 2b

Spouse 2's deductible is prorated if the couple's gross annual income is between 160% and 240% of the *FPL*, and Spouse 2 becomes SeniorCare eligible after Spouse 1's benefit period has begun. To prorate the deductible, multiply the required deductible amount ($500~~/$~~ or $850) by the number of months in Spouse 2's benefit period and divide by 12.

Example 2: Mary and Jim apply for SeniorCare in January. They have an annual income ~~of $28,800, which is~~ between 160% and 200% of the FPL for a FTG of two (see Section 39.11~~).~~ SeniorCare Income Limits and Participation Levels). Their income places them in Level 2a ~~(~~$with a $500 deductible~~).~~.

Jim is determined eligible for SeniorCare, but Mary's eligibility for SeniorCare is denied because she is 64. Mary is refunded her enrollment fee. Jim's 12-month benefit period begins February 1st. Jim has a $500 deductible.

In June, Mary will turn 65. At *adverse action* in the month of May, *CARES* will process this case through batch. At that time, the application status is updated if the *applicant* who is turning 65 is:

1. In an open SeniorCare case, **and**
2. The individual has requested SeniorCare.

A letter is sent to Mary notifying her that if she still wishes to participate in SeniorCare, she must submit her $30 annual enrollment fee. If Mary's enrollment fee is received before July 1st, she will be determined eligible beginning July 1st.

Because Mary paid her enrollment fee on July 5th, Mary's benefit period begins August 1st, and ends January 31st, when Jim's benefit period ends. Mary's deductible is prorated. Since there are six months in her benefit period, $500 is multiplied by six and the total is divided by 12.

$500 x 6=$3,000/12=$250

Mary's deductible is $250. Once Mary meets the $250 deductible by purchasing covered prescription drugs, she is eligible to purchase covered prescription drugs at the co-payment amounts through the remainder of her benefit period.

Jim's eligibility and benefit period are not affected. If the couple's income were between 200% and 240% of the FPL, the example would be the same except that the $500 deductible would be $850.

33.9.4 Addition of a Spouse Summary Table

The following table assumes that Spouse 1 and Spouse 2 do not apply for SeniorCare at the same time.

	SPOUSE 1's Eligibility	SPOUSE 2's Eligibility
Benefit Period: **Begin Date**	First of month following receipt of a valid application and enrollment fee.	First of month following receipt of a valid application and enrollment fee. Will be later than Spouse 1's begin date.
Benefit Period: End Date	End of twelfth month of eligibility unless terminated early.	Same end date as Spouse 1 regardless of when Spouse 2 applies.
Participation Level: Married at time of Spouse 1's application	FTG of two. Participation Level determined based on annual ~~self-reported~~ income of both spouses.	FTG of two. Participation Level determined based on annual ~~self-reported~~ income from Spouse 1's application. Eligibility results will be the same as Spouse 1.
Participation Level: Single or not living together at time of Spouse 1's application.	Gross annual income test based on a FTG of one. When adding a new spouse, Spouse 1 does not need to reapply until the end of the twelve-month benefit period unless he or she chooses to do so.	Gross annual income test based on a FTG of two. Participation Level determined based on annual ~~self-reported~~ income of both spouses. Participation Level may be different than Spouse 1's. Spouse 2 must estimate income at the time he or she applies. Spouse 1's income remains the same.
Deductible:	Has a $500/$850 deductible based on Participation Level.	Required deductible is prorated based on number of months of eligibility and amount of deductible.
Spenddown: Unmet Original FTG of 2	Covered prescription drugs of Spouse 1 used to meet spenddown until Spouse 2 is added. Once spenddown is met, Spouse 1 has a deductible of $850.	Projected income from Spouse 1's application will be used to determine Spouse 2's eligibility. Covered prescription drugs of both spouses are used to meet the spenddown. Once spenddown is met, Spouse 2 has a prorated deductible.
Spenddown: Met Original FTG of 2	No change in spenddown for Spouse 1.	No new spenddown when Spouse 2 is added. Spouse

		2 has a prorated deductible.
Spenddown: Unmet Original FTG of 1	No change in spenddown for Spouse 1.	Spouse 2 has a prorated spenddown and deductible.
Spenddown: Met Original FTG of 1	No change in spenddown for Spouse 1.	Spouse 2 has a prorated spenddown and deductible.

Note: If Spouse ~~1 terminates~~1's eligibility is terminated prior to ~~spouse~~Spouse 2's request~~. A~~, a new application is required for a new 12-month benefit period.

33.10 CHANGES

33.10.1 SeniorCare Changes Introduction

The following changes must be reported to the SeniorCare program within 10 days:

1. Address (including a change in mailing address or permanent residency outside of Wisconsin).
~~1. Address.~~
~~2.~~1. Household Composition (including~~examples include~~ marriage, divorce, separation, or someone moving to a nursing home or other medical facility).~~)~~
~~3.~~2. Death.

Changes may be reported by phone to the SeniorCare Customer Service hotline~~Hotline~~ at 1-800-657-2038.

Changes may also be reported by writing to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

Members~~Participants~~ are asked to include an *SSN* or case number on any written correspondence.

If an individual~~a participant~~ reports any changes before the case has been confirmed in CARES, the new information will be used in his or her SeniorCare eligibility determination.

Changes reported after the case has been confirmed in CARES will be applied to the member's~~participant's~~ SeniorCare benefits as follows:

1. Address change:
   a. Reports of address changes within Wisconsin will result in SeniorCare notices being sent to the new address. SeniorCare benefit levels will not change for the current benefit period.
   b. Address changes that result in termination of Wisconsin residency result in discontinuation of SeniorCare benefits. The member will be provided~~ Provide the participant~~ with at least 10 day~~s~~ notice before the effective date of an adverse action .

Note: Reporting an out-of-state address does not necessarily signify that an *applicant* is not a Wisconsin resident (see Section 33.3 SeniorCare Nonfinancial~~NonFinancial~~ Requirements).

2. Death

A member's~~participant's~~ death ends SeniorCare eligibility on the date of death. A 10-day notice for adverse action is not required when an adverse action is the result of a participant's death. The "early termination date" for the member~~participant~~ should be equal to the member's~~participant's~~ date of death.

If a member's~~participant's~~ *spouse* dies, the member~~participant~~ will remain eligible at the same benefit level through the current SeniorCare benefit period. The member~~participant~~ may wish to re-apply to establish a new benefit level if the spouse's death will result in a reduction in income.

3. Change in household composition

If a member~~participant~~ experiences a change in household composition, the SeniorCare benefit level will not change through the remainder of the SeniorCare benefit period. The member~~participant~~ may wish to re-apply to establish a new benefit level if the change in household composition will result in a better level of participation.

4. Inmate of a *Public Institution* (See Section ~~public institution (~~6.9.3 Inmates~~ of State Correctional Institutions~~).

An inmate of a public institution is ineligible for SeniorCare on the date incarceration begins. The member will be provided~~ Provide the participant with~~ adequate notice before the effective date of the adverse action. The "early termination date" is equal to the notice mailing date.

If a member's~~participant's~~ spouse is an inmate of a public institution the member~~participant~~ benefit level will remain eligible as the same benefit level through the current SeniorCare benefit period. The member~~participant~~ may wish to re-apply to establish a new benefit level if the spouse's incarceration will result in a better level of participation.

5. Change in Circumstance

If an~~An~~ applicant needs~~who wishes~~ to ~~change or~~ correct their~~information on his or her submitted~~ application, or has a change in circumstances during the application processing period, they may need~~do so prior~~ to report this information before their eligibility is determined in order to have the change impact their SeniorCare eligibility and participation level~~being confirmed in CARES~~.

Depending on the nature of a client-reported error or agency -discovered error, a member's~~participant's~~ eligibility will be re-determined (see Section~~See~~ 33.10.2 Correction of Errors). The member will be provided~~ Provide the participant~~ with at least 10 day~~s~~ notice before the effective date of an adverse action. If the case has already been confirmed in CARES, and the individual reports a change in

circumstances since they applied (for example, a job loss), eligibility will not be redetermined. The~~the~~ applicant may opt out and reapply if he or she so desires.

Example 1: Sally and Fred are husband and wife and applied for SeniorCare in July. Both Sally and Fred were found eligible at Level 2a with a deductible ~~(Level 2a)~~ for August. In September, Fred loses his job. He reports the change to the SeniorCare program. This change will not affect Sally or Fred's SeniorCare benefits, because Fred reported the change after his case had been confirmed in CARES. ~~In order to have eligibility redetermined Fred and Sally will need to file a re-application (33.11 SeniorCare Re-Application) and submit enrollment fees for each. Without the income from Fred's job, Sally and Fred would be able to purchase prescription drugs at the co-payment level, if a reapplication is filed.~~

If Fred had reported the change prior to his case being confirmed in CARES, the change would have been applied to Sally and Fred's eligibility determination, and they would have paid the co-payment amounts for prescription drugs. If Fred and Sally wish, they may request to file a reapplication (see Section 33.11 ~~SeniorCare~~ Re-Application) and submit enrollment fees to have their eligibility redetermined and change their benefit level. Without the income from Fred's job, Sally and Fred would be able to purchase prescription drugs at the co-payment level, if a reapplication is filed.

33.10.2 Correction of Errors

All errors made on the SeniorCare Application (F -10076~~0076~~) must be reported by the member~~participant~~ or his or her *Authorized Representative* , POA, or Guardian to the SeniorCare Customer Services hotline~~Hotline~~ at 1-800-657-2038 (TTY and translation services are available) or in writing to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

An error may include, but is not limited to:

1. Doubling of income (for example, totaling income on the application incorrectly).
2. Incorrect entries (for example, income~~Income~~ amounts are off by a factor of 100 due to the ~~.(~~lack of decimal point).~~)~~
3. Application processing errors.

An applicant who wishes to report a change in circumstances from what was~~/correct information~~ on his or her submitted application may do so, but to impact eligibility, this change should be reported prior to eligibility being confirmed in CARES (see Section 33.10.1 #5 Change in Circumstance). ~~.~~

If a memberparticipant has been found eligible for either an incorrect SeniorCare benefit level or spenddown amount due to an error, action will be taken to correct the mistake. he The effective date of the correction is based on whether the error is determined to be due to agency errorAgency Error or *Applicant*/Member /Participant error, as follows.:

33.10.2.1 Agency Error

Agency errors for SeniorCare will be determined on a case by case basis. If the error resulted in an overpayment, past benefits are not recoverable. If the error resulted in an underpayment, corrected benefits will be restored back to initial eligibility date of the current benefit period.

33.10.2.2 Applicant or Member Error

If an applicant or memberthe error resulted in an overpayment, benefit recovery will be pursued, and the correction is processed with an effective date based on adverse action notice. The member will be providedProvide the participant with at least 10 days notice before the effective date of an adverse action.

If the error resulted in an underpayment and he or she reported the error within 45 days of the mail date of the notice of decision, restore corrected benefits should be restored back to the initial eligibility date of the benefit period. If the error is not reported within 45 days of the notice of decision mail date, the effective date of the correction is the first of the month in which the error is reported.

Example 2: In August, Charlie lost this job at the Burger Palace. In September, Charlie applied for SeniorCare. In his application, Charlie erroneously reported income of $1150 per month from the Burger Palace job. Charlie's notice of decision had a mail date of October 1, and stated that Charlie had a $1500 spenddown.

Depending on when Charlie reports this error, his benefits may be corrected back to the eligibility begin date or the first month in which the error was reported (see Section .(33.10.2 Correction of Errors).

If he reported the error by November 15, within the first 45 days after the notice of decision mail date, his benefits would be corrected back to the original effective date.

If he reported the error November 16 or later (more than 45 days after the notice of decision mail date), the benefit level change would be made effective the first of the month in which the error was reported.

Example 3: Eric applied for SeniorCare in July and was determined eligible at level 1 effective August 1. Prior to applying for SeniorCare, Eric got a part-time job that had begun in June. When Eric applied for SeniorCare, he neglected to report his anticipated part-time earnings on the SeniorCare application.

Eric receives his notice of decision, dated August 8. The notice informs him that he is eligible at level 1. Eric reviews the income used in his eligibility determination that is printed in the notice and realizes that he forgot to report the earnings from his part-time job. He calls the SeniorCare Customer Service hotline on August 21 to report his error.

Eric indicates that he is working 10 hours per week and earns $10 per hour. He plans to keep the job as long as possible. He estimates that his earnings will be $5,200 for his 12-month benefit period. The only other income that Eric receives is Social Security. His earnings in addition to the annual Social Security income move him from level 1 to level 2b.

Since the income correction will result in a negative impact on his eligibility, the effective date of the corrective benefit is October 1, providing Eric with a 10-day notice of the negative action in his case.

Prior to reporting this mistake, Eric had purchased several prescriptions at the copayment levels with his SeniorCare card. Since the correction resulted in Eric's eligibility at level 2b, he must now meet an $850 deductible between October 1 and July 31 (the end of his 12-month benefit period). SeniorCare will have overpaid Eric's benefits and could seek recovery of the overpaid amount.

33.12 EARLY TERMINATION

~~33.12.1 Early Termination~~
~~33.12.2 Withdrawal~~

33.12.1 SeniorCare Early Termination

SeniorCare eligibility is terminated prior to the end of the established benefit period if:

1. A member~~participant~~ no longer meets non-financial eligibility requirements, or
2. S/he requests to withdraw from the program, or
3. S/he requests to establish a new benefit period and eligibility for the new benefit period is confirmed (see Section 33.11 ~~SeniorCare~~ Re-Application).

When SeniorCare eligibility has been terminated prior to the end of the established benefit period and the SeniorCare Program is notified that all eligibility requirements are again satisfied, within one calendar month of SeniorCare eligibility termination, the benefit period is restored.

Exception: SeniorCare members~~participants~~ who lose SeniorCare eligibility solely due to receipt of Medicaid~~MA~~ benefits do not have their benefit period terminated; however, they are not eligible for SeniorCare benefits or services for the calendar months that they receive Medicaid~~MA~~ benefits.

If Medicaid~~MA~~ eligibility ends prior to the end of the SeniorCare benefit period, and the member~~participant~~ is still SeniorCare eligible, SeniorCare eligibility automatically resumes.

Example 1: Amy applies for SeniorCare on October 4th and is determined eligible effective November 1st. In December she applies for Medicaid~~MA~~ and is determined eligible, effective December 1st. Amy is not eligible for SeniorCare benefits or services while she is receiving Medicaid~~MA~~.

In January, Amy inherits $5,000 and is notified that her Medicaid~~MA~~ eligibility ends January 31st, because her assets exceed the limit. Amy still meets SeniorCare eligibility requirements, so SeniorCare eligibility will resume from February 1st through October 31st.

See Section 33.15 ~~SeniorCare~~ Annual Eligibility Review for termination as it applies to the need for an annual review.

33.13 NOTICE OF DECISION

A written notice is sent to the *applicant* indicating SeniorCare certification, benefit reduction, denial, or termination.

The initial notice of decision will provide information regarding total income used for determining the participation~~participant~~ level. It will also provide the member~~participant~~ with information regarding spenddown, deductible and co-payment amounts.

For reductions, denials, or terminations, the notice contains reasons for the action, with any supporting regulations. It also specifies the circumstances under which SeniorCare benefits will be continued if a hearing is requested.

SeniorCare members~~participants~~ will be notified of an *adverse action* at least 10 days prior to the effective date of the adverse action, except under certain circumstances.

Timely notice requirements do not apply when:

1. A prescription drug billing must be reversed due to an incorrect billing, and that reversal results in a benefit or service change.
2. A member~~participant~~ chooses to withdraw from the program.
3. A member~~participant~~ requests to establish a new benefit period and eligibility for the previous benefit period is terminated (see Section 33.11 ~~SeniorCare~~ Re-Application).
4. A person is an inmate ~~of a Public Institution~~ .

1. A member passes away.

~~5. Death of a participant.~~

33.14 APPEALS

33.14.3 Hearing

The hearing will be held at a location determined by the DHA.

Hearings will be:

1. Held at a time reasonably convenient to the petitioner, department or agency staff and the administrative law judge.
2. Reasonably accessible to the petitioner.
3. Held on department or agency premises, subject to the judgement of the administrative law judge.
4. Accessible to those in need of accommodations for a disability or translation. ~~(~~For information about an accommodation for a disability or translation for a hearing, call 1-608-266-3096.

33.15 ANNUAL ELIGIBILITY RENEWAL~~REVIEW~~

An annual eligibility review is required for each participant by the end of the current 12 month benefit period to prevent a gap in coverage.

Members are mailed a preprinted Renewal Application and instructions approximately six weeks prior to the end of their current benefit period. The Renewal Application is preprinted with the information currently on file for the member. Members are required to review the information for accuracy, make any necessary changes, answer any questions, and return the signed form with their enrollment fee.

Eligibility for a new benefit period begins on the first day of the month immediately following the end of the previous benefit period when:

1. A valid pre-printed Renewal Application~~CARES renewal application~~ or new application form (F-10076) is received by the end of the current benefit period, and
2. All eligibility requirements are met, including payment of the $30 annual enrollment fee per person.

Note: For the definition of "valid," see Section 3~~3~~3.2.2 Application Processing.

33.16 BENEFITS

33.16.1 SeniorCare Benefits Introduction

For all of the participation levels, SeniorCare allows the following:

1. The generic form of any covered prescription drug, unless the medical practitioner writes on the prescription that the brand name form of the covered prescription drug is medically necessary.
2. Insulins are the only general category of over-the-counter drugs that are covered.
3. For levels 1 and 2a all prescription drugs covered by Medicaid. Some limitations apply to prescription drug coverage for levels 2b and 3 if a rebate agreement has not been signed by the drug manufacturer.
4. Chemotherapy drugs that are FDA approved and the manufacturer has signed a rebate agreement.

Most prescriptions are limited to a 34-day supply of medication. There are a few classes of medications that are allowed to be filled as a three-month supply. Members should work with their pharmacist and prescriber to determine whether it is clinically appropriate to dispense a three-month supply.
~~Reimbursement for most drugs is limited to a 33-day supply. Some maintenance drugs may be provided in a 100-day supply.~~

The co-payment amount is not affected by the number~~#~~ of days in the supply.

Note: Some drugs require prior approval from the SeniorCare program, called prior authorization.

Note: The member~~-~~
~~**Note**: The participant~~ should contact his or her provider to verify that SeniorCare covers a specific drug.

SeniorCare does not cover the following:

1. Prescription drugs administered in a physician's office~~.~~
2. Prescription drugs that are experimental or are for~~have a~~ cosmetic~~;~~, not a medical, purpose~~.~~
3. Over-the-counter drugs ~~(except for insulin)~~ such as vitamins and~~or~~ aspirin, ~~prilosec OTC,~~ even with a prescription~~.~~
4. Prescription drugs for which ~~prior~~ authorization has been denied.
1. Prescription drugs from manufacturers who have not signed the appropriate rebate agreement
~~5. Colostomy supplies and other durable medical supplies (DMS) even though they may need a prescription.~~

- Prescription drugs for members~~participants~~ in levels 1 and 2a are limited to drugs from manufacturers who have signed a federal rebate agreement.

- Prescription drugs for members in levels~~Levels~~ 2b and 3 are limited to drugs from manufacturers who have signed~~for which~~ a SeniorCare rebate agreement with the state of Wisconsin.

6. Drugs that have~~has~~ not been dispensed from a pharmacy.

Note: Immunizations and vaccines (for example, flu shots, pneumonia vaccines, etc.) are not covered under the SeniorCare program.

If a member chooses to purchase a prescription that is not covered under SeniorCare, they are responsible for the cost at the pharmacy's retail price and it will not count towards their spenddown and/or deductible.

~~6.~~5. SeniorCare provides medication therapy management (MTM) services. The MTM services are provided ~~signed~~ by the pharmacist to answer the member's questions about the drugs they get. The goal of MTM services is to help the member understand more about the drugs they take, make sure they are taking their drugs properly, and make sure they are only taking drugs they need~~manufacturer~~.

37.1 CHILDREN'S LONG-TERM SUPPORT (CLTS) WAIVER PROGRAM INTRODUCTION

37.1.1 Program Purpose

CLTS is a Medicaid Home and Community-Based Waiver Program that enables children and youth with disabilities to live at home and participate in family and community life rather than reside in an institution or nursing home. The waiver program allows Medicaid to pay for supports and services that normally are not covered by Medicaid.

The CLTS Waiver Program serves eligible children and youth in the following three target groups:

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

37.1.2 Eligibility Requirements

To be eligible for the CLTS Waiver Program, an individual must meet all of the following:

- Be under 22 years old
- Meet an institutional level of care, as determined by the CLTS Functional Screen
- Meet nonfinancial and financial eligibility criteria for a full-benefit category of Medicaid (see Section 21.2 Full-Benefit Medicaid)
- Reside in a setting allowed by CLTS Waiver policy

A disability determination is not required for the CLTS Waiver Program.

37.2 AGENCY ROLES AND RESPONSIBILITIES

County waiver agencies (CWAs) complete the level of care assessment and determine eligibility for the CLTS Waiver Program. Being enrolled in any form of full-benefit Medicaid (see Section 21.2 Full-Benefit Medicaid) is a prerequisite for participation in the CLTS Waiver Program. If the child is eligible for a type of non-CARES Medicaid such as Foster Care Medicaid, Adoption Assistance Medicaid, SSI Medicaid, or Katie Beckett Medicaid, the child is not referred to IM.

CLTS Waiver Program applicants and participants who are not open for a type of non-CARES
Medicaid must complete a health care application, and they must first be tested for eligibility using HCBW rules (see Section 37.3 HCBW CARES Processing for the Children's
Long-Term Support Waiver Program). If an applicant or participant is ineligible for HCBW, he or she must then be tested for BadgerCare Plus.

When a CLTS waiver applicant or participant is determined to be ineligible for a CARES form of Medicaid, the IM agency sends notice of Medicaid ineligibility to the member. Additionally, IM must notify the CLTS case manager if an applicant or member is not eligible for a CARES Medicaid source.

When an applicant or participant is determined to be ineligible for the CLTS Waiver Program, the CWA sends notice regarding the waiver program to the family. The CWA must also inform the IM agency if an HCBW member is no longer functionally eligible (that is, they no longer meet an institutional level of care).

37.3 HCBW MEDICAID CARES PROCESSING FOR THE CLTS WAIVER PROGRAM

When a child who is functionally eligible for the CLTS program is referred to IM, he or she must first be tested for eligibility using HCBW rules. To be eligible for HCBW Medicaid, the child must be both Medicaid-eligible and functionally eligible. To determine eligibility for HCBW, only the child's income is counted. Effective 10/01/09, assets are no longer counted for disabled or institutionalized children. Since assets are disregarded, there can be no divestment in a HCBW Medicaid case for a child.

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

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.

37.3.1 HCBW CARES Processing for Minor Children

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 initial 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

37.3.2 HCBW CARES Processing for Young Adults 18–21

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.

The renewal process is the same for all HCBW members (see Section 37.3.1 HCBW CARES Processing for Minor Children).

37.4 COST SHARING

37.4.1 Group A

Group A members are Medicaid eligible via *SSI* (including *SSI-E* Supplement and *1619a* and *1619b*) or a full-benefit Medicaid subprogram (see Section 21.2 Full-Benefit Medicaid) other than HCBW Medicaid.

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

Individuals eligible as Group A have no CARES cost share obligation, although BadgerCare Plus participants may be required to pay a premium and other cost sharing based on income.

37.4.2 Group B and B Plus

Group B members are defined as those not in Group A, but who have gross income at or below the nursing home institutions categorically needy income limit (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables).

Group B Plus members are defined as those not in Group A, who have gross income above the nursing home institutions categorically needy income limit, but whose income does not exceed the cost of the appropriate institutional care by more than the medically needy income limit (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables).

Group B and B Plus members do have a cost share, including CLTS participants who are enrolled in HCBW Medicaid.

37.4.3 Calculating a Cost Share for HCBW Members

Cost sharing is the monthly amount a HCBW member may have to contribute to the cost of their waiver services. Only the income of the member is counted when calculating the cost share.

CWA staff submits the Medicaid Waiver Eligibility and Cost Sharing Worksheet, F-20919 to IM at application or review when an individual needs a CARES source of Medicaid. The cost share amount for HCBW Medicaid is calculated in CARES following the process outlined in Section 28.6.4 Cost Share Amount.

Note: Not all deductions apply to CLTS participants who are under age 18. Do not apply the special housing amount or the family maintenance allowance to minors. If the CLTS participant is married, spousal impoverishment policies do apply.

37.5 CLTS PARENTAL PAYMENT

Following the procedures of the Uniform Fee System (Wis. Admin. Code ch. DHS 1), CWA staff determines if the parent(s) must contribute toward the CLTS supports and services their child receives. The Parental Payment Fee is calculated separately from an HCBW cost share by the CLTS case manager.

38.1 RESERVED

38.2 RESERVED

38.3 RESERVED

38.4 RESERVED

38.5 RESERVED

39.4 ELDERLY, BLIND, OR DISABLED ASSETS AND INCOME TABLES

39.4.1 Elderly, Blind, or Disabled Assets and Income Table

The values in the following table were effective January 1, 2019.~~2018.~~

Group Size				
Category		**1**		**2**
SSI-Related Categorically Needy Limits	Assets	$2,000.00	Assets	$3,000.00
	Income	$597~~583~~.78 (+ actual shelter up to $257~~250~~.00)	Income	$903.38~~882.05~~ (+ actual shelter up to $385.67~~375.00~~)
SSI-Related Medically Needy Limits	Assets	$2,000.00	Assets	$3,000.00
	Income	$591.67	Income	$591.67
***SSI* Payment Level**				
Federal SSI Payment Level	Income	$771~~750~~.00	Income	$1,157~~125~~.00
SSP	Income	$83.78	Income	$132.05
Total	Income	$854~~833~~.78	Income	$1,289~~257~~.05
SSI Payment Level + E Supplement	Income	$950.77 (Home Maintenance Maximum Allowance)~~$929.77~~		$1,634~~602~~.41
SSI E Supplement	Income	$95.99		$345.36
Community Waivers Special Income Limit	Income	$2,313~~250~~.00		
Institutions Categorically Needy Income Limit	Income	$2,313~~250~~.00		
Substantial Gainful Activity Limit (non-blind individuals)	Income	$1,220~~180~~.00		
Substantial	Income	$2,040~~1,970~~.00		

Gainful Activity Limit (blind individuals)				

39.4.2 Elderly, Blind, or Disabled Deductions and Allowances

The cost-of-living adjustments in the following table were effective January 1, 2019~~2018~~.

Description		Amount
Personal Needs Allowance (effective 7/1/01)		$45.00
EBD Maximum Personal Maintenance Allowance		$2,313~~250~~.00
EBD Deeming Amount to an Ineligible Minor		$386~~375~~.00
Community Waivers Basic Needs Allowance		$951~~930~~.00
Parental Living Allowance for Disabled Minors	**1 Parent** **2 Parent**	$771~~750~~.00 $1,157~~125~~.00
MAPP Standard Living Allowance Standard Living Allowance = SSI + State Supplement + $20		$874~~853~~.00

The spousal impoverishment values in the following table were effective July 1, 2018.

Description	Amount
Community Spouse Lower Income Allocation Limit	$2,743.34
Community Spouse Excess Shelter Cost Limit	$823.00
Family Member Income Allowance	$685.83

39.4.4 Maximum Cost Share Amount for Family Care, Family Care Partnership, or *PACE*

The values in the following table were effective January 1, 2019.

Description	Amount
Maximum Cost Share Amount for an individual in Group B+ for Family Care, Family Care Partnership, or PACE	$2,777.00

39.5 FEDERAL POVERTY LEVEL TABLE

Comment [MF1]: Please make sure that 39.6 gets updated, too. It is in the "cover sheet" above but not inserted in the content below this.

Group Size	Annual FPL	100% FPL	120% FPL	135% FPL	150% FPL	160% FPL	200% FPL	240% FPL	250% FPL	30% of 200% FPL
1	$12,490	$1,040.83	$1,249.00	$1,405.12	$1,561.25	$1,665.33	$2,081.66	$2,497.99	$2,602.08	-
2	16,910	$1,409.17	$1,691.00	$1,902.38	$2,113.76	$2,254.67	**$2,818.34**	$3,382.01	$3,522.93	**$845.50**
3	21,330	$1,777.50	$2,133.00	$2,399.63	$2,666.25	$2,844.00	$3,555.00	$4,266.00	$4,443.75	-
4	25,750	$2,145.83	$2,575.00	$2,896.87	$3,218.75	$3,433.33	$4,291.66	$5,149.99	$5,364.58	-
5	30,170	$2,514.17	$3,017.00	$3,394.13	$3,771.26	$4,022.67	$5,028.34	$6,034.01	$6,285.43	-
6	34,590	$2,882.50	$3,459.00	$3,891.38	$4,323.75	$4,612.00	$5,765.00	$6,918.00	$7,206.25	-
7	39,010	$3,250.83	$3,901.00	$4,388.62	$4,876.25	$5,201.33	$6,501.66	$7,801.99	$8,127.08	-
8	43,430	$3,619.17	$4,343.00	$4,885.88	$5,428.76	$5,790.67	$7,238.34	$8,686.01	$9,047.93	-
9	47,850	$3,987.50	$4,785.00	$5,383.13	$5,981.25	$6,380.00	$7,975.00	$9,570.00	$9,968.75	-
10	52,270	$4,355.83	$5,227.00	$5,880.37	$6,533.75	$6,969.33	$8,711.66	$10,453.99	$10,889.58	-
11	56,690	$4,724.17	$5,669.00	$6,377.63	$7,086.26	$7,558.67	$9,448.34	$11,338.01	$11,810.43	-
12	61,110	$5,092.50	$6,111.00	$6,874.88	$7,638.75	$8,148.00	$10,185.00	$12,222.00	$12,731.25	-
13	65,530	$5,460.83	$6,553.00	$7,372.12	$8,191.25	$8,737.33	$10,921.66	$13,105.99	$13,652.08	-
14	69,950	$5,829.17	$6,995.00	$7,869.38	$8,743.76	$9,326.67	$11,658.34	$13,990.01	$14,572.93	-
15	74,370	$6,197.50	$7,437.00	$8,366.63	$9,296.25	$9,916.00	$12,395.00	$14,874.00	$15,493.75	-
16	78,790	$6,565.83	$7,879.00	$8,863.87	$9,848.75	$10,505.33	$13,131.66	$15,757.99	$16,414.58	-
17	83,210	$6,934.17	$8,321.00	$9,361.13	$10,401.26	$11,094.67	$13,868.34	$16,642.01	$17,335.43	-
18	87,630	$7,302.50	$8,763.00	$9,858.38	$10,953.75	$11,684.00	$14,605.00	$17,526.00	$18,256.25	-
19	92,050	$7,670.83	$9,205.00	$10,355.62	$11,506.25	$12,273.33	$15,341.66	$18,409.99	$19,177.08	-
20	96,470	$8,039.17	$9,647.00	$10,852.88	$12,058.76	$12,862.67	$16,078.34	$19,294.01	$20,097.93	-
21	100,890	$8,407.50	$10,089.00	$11,350.13	$12,611.25	$13,452.00	$16,815.00	$20,178.00	$21,018.75	-
22	105,310	$8,775.83	$10,531.00	$11,847.37	$13,163.75	$14,041.33	$17,551.66	$21,061.99	$21,939.58	-
23	109,730	$9,144.17	$10,973.00	$12,344.63	$13,716.26	$14,630.67	$18,288.34	$21,946.01	$22,860.43	-
24	114,150	$9,512.50	$11,415.00	$12,841.88	$14,268.75	$15,220.00	$19,025.00	$22,830.00	$23,781.25	-
each additional person	$4,420	$368.33	$442.00	$497.25	$552.50	$589.33	$736.66	$883.99	$920.83	-
		QMB	SLMB	SLMB+ (QI-1)	MAPP Premium Limit	SeniorCare Tier One Limit	QDWI and Lower **SI Inc Alloc** SeniorCare Tier 2a Limit	SeniorCare Tier 2b Limit	MAPP	Excess Shelter Allowance
					Annual Figures for SeniorCare		$19,984.00 $27,056.00	$24,980.00 $33,820.00	$29,976.00 $40,584.00	

Group Size	Annual FPL	100% FPL	120% FPL	135% FPL	150% FPL	160% FPL	200% FPL	240% FPL	250% FPL	30% of 200% FPL
1	$12,140	$1,011.67	$1,214.00	$1,365.75	$1,517.51	$1,618.67	$2,023.34	$2,428.01	$2,529.18	-
2	16,460	$1,371.67	$1,646.00	$1,851.75	$2,057.51	$2,194.67	**$2,743.34**	$3,292.01	$3,429.18	**$823.00**
3	20,780	$1,731.67	$2,078.00	$2,337.75	$2,597.51	$2,770.67	$3,463.34	$4,156.01	$4,329.18	-
4	25,100	$2,091.67	$2,510.00	$2,823.75	$3,137.51	$3,346.67	$4,183.34	$5,020.01	$5,229.18	-
5	29,420	$2,451.67	$2,942.00	$3,309.75	$3,677.51	$3,922.67	$4,903.34	$5,884.01	$6,129.18	-
6	33,740	$2,811.67	$3,374.00	$3,795.75	$4,217.51	$4,498.67	$5,623.34	$6,748.01	$7,029.18	-
7	38,060	$3,171.67	$3,806.00	$4,281.75	$4,757.51	$5,074.67	$6,343.34	$7,612.01	$7,929.18	-
8	42,380	$3,531.67	$4,238.00	$4,767.75	$5,297.51	$5,650.67	$7,063.34	$8,476.01	$8,829.18	-
9	46,700	$3,891.67	$4,670.00	$5,253.75	$5,837.51	$6,226.67	$7,783.34	$9,340.01	$9,729.18	-
10	51,020	$4,251.67	$5,102.00	$5,739.75	$6,377.51	$6,802.67	$8,503.34	$10,204.01	$10,629.18	-
11	55,340	$4,611.67	$5,534.00	$6,225.75	$6,917.51	$7,378.67	$9,223.34	$11,068.01	$11,529.18	-
12	59,660	$4,971.67	$5,966.00	$6,711.75	$7,457.51	$7,954.67	$9,943.34	$11,932.01	$12,429.18	-
13	63,980	$5,331.67	$6,398.00	$7,197.75	$7,997.51	$8,530.67	$10,663.34	$12,796.01	$13,329.18	-
14	68,300	$5,691.67	$6,830.00	$7,683.75	$8,537.51	$9,106.67	$11,383.34	$13,660.01	$14,229.18	-
15	72,620	$6,051.67	$7,262.00	$8,169.75	$9,077.51	$9,682.67	$12,103.34	$14,524.01	$15,129.18	-
16	76,940	$6,411.67	$7,694.00	$8,655.75	$9,617.51	$10,258.67	$12,823.34	$15,388.01	$16,029.18	-
17	81,260	$6,771.67	$8,126.00	$9,141.75	$10,157.51	$10,834.67	$13,543.34	$16,252.01	$16,929.18	-
18	85,580	$7,131.67	$8,558.00	$9,627.75	$10,697.51	$11,410.67	$14,263.34	$17,116.01	$17,829.18	-
19	89,900	$7,491.67	$8,990.00	$10,113.75	$11,237.51	$11,986.67	$14,983.34	$17,980.01	$18,729.18	-
20	94,220	$7,851.67	$9,422.00	$10,599.75	$11,777.51	$12,562.67	$15,703.34	$18,844.01	$19,629.18	-
21	98,540	$8,211.67	$9,854.00	$11,085.75	$12,317.51	$13,138.67	$16,423.34	$19,708.01	$20,529.18	-
22	102,860	$8,571.67	$10,286.00	$11,571.75	$12,857.51	$13,714.67	$17,143.34	$20,572.01	$21,429.18	-
23	107,180	$8,931.67	$10,718.00	$12,057.75	$13,397.51	$14,290.67	$17,863.34	$21,436.01	$22,329.18	-
24	111,500	$9,291.67	$11,150.00	$12,543.75	$13,937.51	$14,866.67	$18,583.34	$22,300.01	$23,229.18	-
each additional person	$4,320	$360.00	$432.00	$486.00	$540.00	$576.00	$720.00	$864.00	$900.00	-
		QMB	SLMB	SLMB+ (QI-1)	MAPP Premium Limit	SeniorCare Tier One Limit	QDWI and lower **SI Inc Alloc** SeniorCare Tier 2a Limit	SeniorCare Tier 2b Limit	MAPP	Excess Shelter Allowance
					Annual Figures for SeniorCare		$19,424.00 $26,336.00	$24,280.00 $32,920.00	$29,136.00 $39,504.00	

39.6 COST-OF-LIVING ADJUSTMENT

To calculate the *COLA disregard* amount, do the following:

1. Find the *AG*'s current gross *OASDI* Benefits income. The gross OASDI income is the sum of the following:

    - OASDI check.
    - Any amount that has been withheld for a Medicare premium.
    - Any amount withheld to repay an earlier overpayment.

    Do not include in the gross income any Medicare Plan B premiums that the state has purchased for the AG.

2. On the COLA Disregard Amount Table below, find the last month in which the person was eligible for and received a check for both OASDI and *SSI*.
3. Find the decimal figure that applies to this month.
4. Multiply the person's current gross OASDI income by the applicable decimal figure. The result is the COLA disregard amount.

COLA Disregard Amount Table	
Jan - Dec 2017	0.019608
Jan - Dec 2016	0.022540
Jan - Dec 2015	0.022540
Jan - Dec 2014	0.038879
Jan - Dec 2013	0.053083
Jan - Dec 2012	0.068912
Jan - Dec 2011	0.101266
Jan - Dec 2010	0.101266
Jan - Dec 2009	0.101266
Jan - Dec 2008	0.150535
Jan - Dec 2007	0.169633
Jan - Dec 2006	0.196160
Jan - Dec 2005	0.227819
Jan - Dec 2004	0.248120
Jan - Dec 2003	0.263585
Jan - Dec 2002	0.273752
Jan - Dec 2001	0.292156
Jan - Dec 2000	0.316093
Jan - Dec 1999	0.332122
Jan - Dec 1998	0.340693
Jan - Dec 1997	0.354254
Jan - Dec 1996	0.372453
Jan - Dec 1995	0.388355
Jan - Dec 1994	0.405015
Jan - Dec 1993	0.420093
Jan - Dec 1992	0.436983
Jan - Dec 1991	0.457071
Jan - Dec 1990	0.484888
Jan - Dec 1989	0.508011
Jan - Dec 1988	0.526934
Jan - Dec 1987	0.546002
Jan - Dec 1986	0.551828
Jan - Dec 1985	0.565303
Jan - Dec 1984	0.580003

COLA Disregard Amount	
January to December 2018	0.027237
January to December 2017	0.046311
January to December 2016	0.049164
January to December 2015	0.049164
January to December 2014	0.065058
January to December 2013	0.078875
January to December 2012	0.094272
January to December 2011	0.125745
January to December 2010	0.125745
January to December 2009	0.125745
January to December 2008	0.173672
January to December 2007	0.192250
January to December 2006	0.218055
January to December 2005	0.248852
January to December 2004	0.268599
January to December 2003	0.283643
January to December 2002	0.293533
January to December 2001	0.311436
January to December 2000	0.334721
January to December 1999	0.350313
January to December 1998	0.358651

January to December 1997	0.371842
January to December 1996	0.389545
January to December 1995	0.405015
January to December 1994	0.421221
January to December 1993	0.435888
January to December 1992	0.452318
January to December 1991	0.471859
January to December 1990	0.498918
January to December 1989	0.521412
January to December 1988	0.539819
January to December 1987	0.558367
January to December 1986	0.564035
January to December 1985	0.577143
January to December 1984	0.591443

39.11 SENIORCARE INCOME LIMITS AND PARTICIPATION LEVELS

39.11.1 SeniorCare Income Limits Introduction

For applicants determined eligible, SeniorCare pays for a portion of covered prescription drugs. ~~(See 33.6 SeniorCare Financial Requirements),~~ depending on the person's participation level.

Effective with benefit periods starting September 1, 2003 there are four participation levels. The level of benefits an *applicant* receives depends on his or her annual income and, for some, on the amount they spend on covered prescription drugs during their 12-month benefit period.

The participation levels are:

- **Level 1:** Co-Payment (Annual income is at or below 160% of the *FPL*.)
- **Level 2a:** Deductible $500 (Annual income is greater than 160% of the FPL and less than or equal to 200% of the FPL.)
- **Level 2b**: Deductible $850 (Annual income is greater than 200% of the FPL and less than or equal to 240% of the FPL.)
- **Level 3:** Spenddown (Annual income is above 240% of the FPL.)

Note: The FPL may be adjusted~~is set~~ annually. See ~~by the Department of Health Services see~~ 39.5 Federal Poverty Level ~~FPL~~ Table for current FPLs. If the FPL changes during the eligibility determination process or before a redetermination can be completed, the new levels will be used.

If the FPL changes during the eligibility determination process or before a redetermination can be completed, the new levels will be used.

SeniorCare Levels of Participation	
Income Limits*	**Annual Out-of-Pocket Expense Requirements and Benefits**
Level 1 **Income at or below 160% of FPL** At or below $19,984~~424~~ per individual or $27,056~~26,336~~ per couple annually.*	▪ No deductible or spenddown. ▪ $5 co-pay for each covered generic prescription drug. ▪ $15 co-pay for each covered brand name prescription drug.
Level 2a	▪ $500 deductible per person. ▪ Pay the SeniorCare rate for drugs until the

Income above 160% and at or below 200% FPL $19,984~~425~~ to $24,980~~280~~ per individual and $27,057~~26,337~~ to $33,820~~32,920~~ per couple annually.*	$500 deductible is met. ▪ After $500 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.
Level 2b **Income above 200% and at or below 240% of FPL** $24,981~~281~~ to $29,976~~136~~ per individual and $33,821~~32,921~~ to $30,584~~39,504~~ per couple annually.	▪ $850 deductible per person. ▪ Pay the SeniorCare rate for most covered drugs until the $850 deductible is met. ▪ After $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.
Level 3 **Annual income is above 240% of the FPL** $29,977~~137~~ or higher per individual and $40,585~~39,505~~ or higher per couple annually.*	▪ Pay retail price for drugs equal to the difference between the member's~~your income~~ and $29,976~~136~~ per individual or $40,584~~39,504~~ per couple. This is called "spenddown." ▪ Covered drug costs for spenddown will be tracked automatically. During the spenddown, there is no discount on drug costs. ▪ After spenddown is met, meet an $850 deductible per person. ▪ Pay SeniorCare rate for most covered drugs until the $850 deductible is met. ▪ After the $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.

* These income amounts are based on the 2019~~2018~~ federal poverty guidelines, which typically increase by a small amount each year.

39.11.5.1 Level 3: Fiscal Test Group of One

A SeniorCare participant considered as a FTG of one with gross annual income above 240% FPL pays retail prices for covered prescription drugs until those payments equal the spenddown amount.

After the spenddown has been met by purchasing drugs at regular prices the participant has an annual deductible of $850. During the deductible period the participant will get a discount off the retail price for most covered prescription drugs during the deductible period.

After this deductible is met, he or she is required to pay a $5 copayment for each covered generic prescription drug, and a $15 copayment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name copayment.

Example 1: Dorothy's annual income is $30,976~~136~~. This is $1,000 more than 240% of the FPL for a FTG of one. Her spenddown amount for the 12-month benefit period is $1,000. Dorothy pays the retail price for her covered prescription drugs until those payments equal the spenddown amount.

If Dorothy meets the spenddown during her benefit period, she can begin purchasing covered prescription drugs at the discounted rate. These costs are applied toward the $850 deductible.

After this deductible is met, Dorothy purchases covered prescription drugs at the copayment amounts for the remainder of her benefit period

39.11.5.2 Level 3: Fiscal Test Group of Two

Married persons considered as a FTG of two with annual income greater than 240% FPL and in which both spouses are determined non-financially eligible at the same time pay retail price for covered prescription drugs until the spenddown requirement is met. In this case, the spenddown amount is shared, and covered prescription drugs purchased for either person in the married couple will count toward meeting the spenddown requirement, when both are eligible.

After the spenddown has been met, each spouse must meet a separate $850 deductible requirement. Participants will get a discount off the retail price for most covered prescription drugs during the deductible period. Only the covered prescription drugs purchased for an individual spouse may count toward that spouse's deductible.

After a spouse has met his or her deductible, he or she is required to pay a $5 copayment for each covered generic prescription drug, and a $15 copayment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name co-pay.

Example 2: Bob and Alice's annual income is $42,584~~41,504~~, which is $2,000

more than 240% of the FPL for a FTG of two. Both spouses are eligible and, for the 12-month benefit period, their joint spenddown amount is $2,000.

Bob and Alice pay for their covered prescription drugs at retail price until the $2,000 spenddown is met. Covered prescription drugs purchased for either Bob or Alice will count toward the spenddown requirement.

After Bob and Alice meet the spenddown, each person has a $850 deductible. Only covered prescription drugs purchased for Bob count toward his deductible, and only covered prescription drugs purchased for Alice count toward her deductible.

Bob meets his deductible in two months. He then purchases covered prescription drugs at the copayment amounts for the remainder of his benefit period. Alice meets her deductible in three months. She then purchases covered prescription drugs at the copayment amounts for the remainder of her benefit period.

If only one spouse in a married couple is determined eligible, only his or her costs count toward the spenddown. He or she pays retail price for covered prescription drugs until the spenddown requirement is met.

Example 3: Tracy and Dave's annual income is $43,584~~41,504~~, which is $2,000 more than 240% of the FPL for a FTG of two. Because Tracy is 63 years old, only Dave is eligible for SeniorCare. For the 12-month benefit period Dave's spenddown amount is $2,000.

Tracy and Dave pay for their covered prescription drugs at retail price. Only covered prescription drugs purchased for Dave count toward the spenddown requirement.

After Dave has met the $2,000 spenddown, he has a $850 deductible. Only covered prescription drugs purchased for Dave count toward his deductible. After Dave meets his deductible, he purchases covered prescription drugs at the copayment amounts for the remainder of her benefit period.