WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
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To: Medicaid Eligibility Users

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

Re: **Medicaid Eligibility Handbook Release 19-02**

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EFFECTIVE DATE		The following policy additions or changes are **effective 09/10/2019** unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY UPDATES		
2.1	Applications Introduction	Updated hyperlinks.
2.8.2	Backdated Eligibility	Added cross reference to Section 15.6.8 Backdated Months. Effective 06/22/2019.
5.3.3	Release Form	Removed instruction for completing F-14014.
5.9.3	Presumptive Disability Determined by DDB	Updated cross reference to Process Help Section 9.4 Automated Medicaid Disability Determination.
7.3.2	Verification	Updated information on secondary or third level verification.
7.3.3.1	Qualifying Immigrants	Updated criteria for qualifying immigrants.
7.3.3.2	Lawfully Present Immigrant Children, Young Adults, and Pregnant Women	Updated criteria for lawfully present immigrant children, young adults, and pregnant women, and added a reference to Process Help Section 82.6 VIS SAVE Verification Responses Table.
7.3.8	Immigration Status Chart	Updated the Immigration Status Chart and added a reference to Process Help Section 82.6 VIS SAVE Verification Responses Table.
15.5.1	Income In-Kind	Clarified the requirement to verify the value of in-kind benefits.
15.6.5.1	IRS Tax Forms Worksheets	Clarified the use of worksheets to determine self-employment income. Effective 06/22/2019.
15.6.5.2	Worksheets	Included information under Section 15.6.5.1. Effective 06/22/2019.
15.6.5.3.1	Reporting Anticipated Earnings	Clarified the use of SEIRFs to determine self-employment income. Effective 06/22/2019.
15.6.6	Verification	Added information on using an existing SEIRF for a Program Add request. Effective 06/22/2019.
15.6.8	Backdated Months	New Section. Effective 06/22/2019.
15.7.3	Medical/Remedial Expenses	Clarified that Medicaid overpayments are not considered medical expenses.
16.5.4	Spaces	Clarified policy regarding burial spaces purchased through a Life Insurance-Funded Burial Contract (LIFBC).

The information concerning the Medicaid program provided in this handbook release is published in accordance with: Titles XI and XIX of the Social Security Act; Parts 430 through 481 of Title 42 of the Code of Federal Regulations; Chapters 46 and 49 of the Wisconsin Statutes; and Chapters HA 3, DHS 2, 10 and 101 through 109 of the Wisconsin Administrative Code.

17.2.5	Community Spouse	Added policy regarding divestment penalty periods.
17.5.2	Calculating the Penalty Period	Updated amounts and dates for annual indexing. Effective 07/01/2019.
18.6.2	Community Spouse Income Allocation	Updated amounts and dates for annual indexing. Effective 07/01/2019.
18.6.3	Family Member Income Allowance	Updated amounts and dates for annual indexing. Effective 07/01/2019.
22.1.7	Notify Members	Clarified that members in an MSP program do not receive notification as described this section.
22.2.2.2.1	Institutional Overpayments	Added information on members who fail to report a divestment that would result in penalty period, but otherwise qualify for LTC.
22.4.7	Bed Hold Payments and Notifications	Remove information on notifying members on the payment for LTC services received during the bed hold period.
26.5.3.3	Refunds	Clarification of refunds on premium payments.
27.10	Liability Effective Dates	Updated information on patient liability.
27.11	Institutions for Mental Disease	Updated names of institutions.
28.1	Adult Home and Community-Based Waivers Long-Term Care Introduction	Added basic information on community waivers.
28.6.2	Group A	Added information on financial eligibility for Group A members.
28.6.4	Cost Share Amount	Added information regarding timing of payment by members after enrollment.
28.6.4.2	Family Maintenance Allowance	Added cross-reference to Section 18.6 Spousal Impoverishment Income Allocation.
30	Tuberculosis	Removed text and added link to the BadgerCare Plus Handbook.
39.4.2	Elderly, Blind, or Disabled Deductions and Allowances	Updated amounts and dates for annual indexing. Effective 07/01/2019.
39.4.3	Institutional Cost of Care Values	Updated amounts and dates for annual indexing. Effective 07/01/2019.

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2.1 Applications Introduction

Anyone has the right to apply for Medicaid. However, individuals younger than 18 years old must have a parent or a legal guardian apply for Medicaid on their behalf unless they are living independently.

They may be assisted by any person he or she chooses in completing an application.

Encourage anyone who expresses interest in applying to file an application as soon as possible. When an application is requested:

1. Suggest the *applicant* use the ACCESS online application at the following site: access.wisconsin.gov/; or
2. Mail-in using the Wisconsin Medicaid for the Elderly, Blind or Disabled Application Packet (F-10101); or
3. Schedule a telephone or face-to-face interview.

Provide any information, instruction, and/or materials needed to complete the application process. Provide a Notice of Assignment: Child Support, Family Support, Maintenance and Medical Support form (DWSP 2477) and Good Cause Notice (DWSP 2018) to each applicant with children applying for Medicaid or to anyone that requests either of these.

Refer requests for applications and other outreach materials from groups and persons involved in outreach efforts to www.dhs.wisconsin.gov/forms/index.htm.

Note: An application can be filed on behalf of a deceased person. If the application is filed within the same calendar month as the date of death or within the three months after the date of death, the application should be processed as if the applicant were alive. If the application is filed more than four months after the date of death, he or she is not eligible.

2.8 Begin Dates
2.8.2 Backdated Eligibility

Medicaid eligibility can be backdated up to three months prior to the month of application.

The backdated eligibility should not go back further than the first of the month, three months prior to the application month. The member may be certified for any backdate month in which he or she would have been eligible had he or she applied in that month.

A backdate request can be made at any time except when the member is already enrolled and backdating the member's eligibility would result in a deductible for the backdated period.

If a member has incurred a bill from a Medicaid-certified provider during a backdate period, instruct the member to contact the provider to inform them to bill Medicaid. The member may be eligible to receive a refund, up to the amount already paid to the provider.

Example 2: Mary who is 66 years old, applied for Medicaid on April 6, and was found eligible. At the time of application, Mary did not request a backdate.

In September Mary is billed for a doctor's appointment she had at the end of February. Mary can ask to have her eligibility backdated through February. She meets all non-financial and financial eligibility criteria in the months of February and March. Her worker certifies her for Medicaid for both months.

See Section 15.6.8 Backdated Months for information on counting self-employment income for backdated months.

For backdating rules for Medicare Beneficiaries, see Section 32.8 Medicare Savings Programs Backdating.

Assets

A person's asset eligibility in a backdate month is determined by whether or not he or she had excess assets on the last day of the month. If he or she had excess assets on the last day of

the month, he or she is ineligible for the entire month. If he or she was asset eligible on the last day of the month, he or she is eligible for the whole month.

5.3 Disability Application Process
5.3.3 Release Form

Ask the applicant to sign a Confidential Information Release Authorization - Release to Disability Determination Bureau form (F-14014). This is the only form DDB can accept. See Process Help Section 9.4 Automated Medicaid/BadgerCare Plus Disability Determination.

~~Leave the box blank that asks for the "Name and Address - Agency/Organization Authorized to Release Information." DDB has scanners that will automatically fill in the blank. Filling it in creates problems for them.~~

Applications for disability made by the applicant must include releases that are signed personally by the disabled applicant. Applications made on behalf of a disabled applicant must be accompanied by release forms signed by a legally appointed representative. A copy of the court order appointing a representative must be included with the application. An authorized representative's signature on the release is not acceptable unless he or she has a court order.

5.9 Presumptive Disability
5.9.3 Presumptive Disability Determined By DDB

If the applicant has an urgent need, but does not have one of the listed impairments, the IM worker must request DDB to make a presumptive disability determination. The IM worker must take the following actions once a medical professional has attested in writing, with the Medicaid Presumptive Disability form (F-10130), that there is an urgent need for medical services.

Note: If someone has an impairment, but not an urgent need, follow the normal disability application process (see Section 5.3 Disability Application Process).

1. Document the urgent need by placing the Medicaid Presumptive Disability form (F-10130) in the case file.

2. Complete, with assistance from the applicant as necessary, the following two forms:

   a. The MADA form (F-10112, formerly DES 3071).

   b. Release to Disability Determination Bureau form, F-14014.

3. ~~See Process Help Chapter 12 Automated Medicaid Disability Determination~~See Process Help Section 9.4 Automated Medicaid Disability Determination for submissions of the forms, if necessary. This process is now automated. However, if the automated process isn't working, send via fax (608-266-8297) each of the three forms listed above to DDB for both a presumptive and final disability determination.

DDB will make a presumptive disability finding on these cases and communicate their finding to the local IM agency within three business days of receiving the request for presumptive disability and the F-10112 form (not including the day the fax was received).

Federal Regulations generally require the evaluation of certain disabilities after a three month period of recovery from the original injury or medical event (major head injuries, stokes, heart attacks, etc.) It may not be possible to establish disability, either on a presumptive or final basis during that period. However, all applications should be submitted and a complete medical review will be made.

7.3 Immigrants
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.
- Cuban/Haitian entrants when SAVE or the Hub indicates the need.

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.

7.3.3 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.*

*If these immigrants lawfully entered the U.S. on or after August 22, 1996, they must also bemeet one of the following criteria:

- Be lawfully residing in Wisconsin and an honorably discharged veteran of the U.S. Armed Forces (see Section 7.3.10 Military Service)
- Be lawfully residing in Wisconsin and on active duty (other than active duty for training) in the U.S. Armed Forces (see Section 7.3.10 Military Service)
- Be lawfully residing in Wisconsin and the spouse , unmarried dependent child, or surviving spouse of either an honorably discharged veteran or a person on active duty in the U.S. Armed Forces
- ~~Be an Amerasian~~
- Be a certain Amerasian immigrant defined under §584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988, with Class of Admission codes: AM1, AM2, AM3, AM6, AM7 or AM8.
- 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).

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 criteria:

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

Women who have an immigration status requiring a five-year waiting period before being eligible for BadgerCare Plus will have the waiting period lifted when their pregnancy is 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 eligiblemany of the immigrant and non-immigrant statuses. For those who are not in a qualifying Immigrant category, but are lawfully present, use the Registration Status Code of 20. Please see Process Help, Section 82.6 VIS SAVE Verification Responses Table for a list of SAVE Responses and the appropriate Registration Status Code in CWW to apply.

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 following to join a K-3 alien.	TPS, 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.)	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~~	~~8 U.S.C. 1101(a)(15)(S)(ii)~~

reward from the State Department.	
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 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

Immigrants who doare not appear in the lists abovea qualifying immigrant nor lawfully present (for example, someone with a status of *DACA*) and who apply for Medicaid and meet all eligibility requirements, except for citizenship and immigration status, are entitled to receive Medicaid Emergency Services only (see Chapter 34 Emergency Services).

Pregnant immigrants who doare not appear in the list abovea qualifying immigrant nor lawfully present and who apply for the BadgerCare Plus Prenatal Program and meet the eligibility requirements except for citizenship and immigration status, are entitled to receive 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. 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.

7.3.8 Immigration Status Chart

Please see Process Help, Section 82.6 VIS SAVE Verification Responses Table for a list of SAVE Responses and the appropriate Registration Status Code in CWW to apply.

CARES TCTZRegistration Status Code	Immigration Status	Arrived Before August 22, 1996	Veteran* Arrived Before August 22, 1996	Arrived On or After August 22, 1996	Veteran* Arrived On or After August	Children Under 19 and Pregnant Women;

					22, 1996	**Arrived on or after August 22, 1996**

15.5 Earned Income
15.5.1 Income In-Kind

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

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

Do not count meals and lodging for armed services members.

To determine the value of in-kind benefits, use the prevailing wage (but not less than the minimum wage) in the community for the type of work the person does to earn the benefits. In order to determine the value of the in-kind benefits, the verification must include the amount of time the person does the work activity each month.

Example 1: Sue weeds her neighbor's garden about an hour a week in exchange for a hot meal. The in-kind value of this exchange is the prevailing wage, not less than minimum wage, for the weekly hour of weeding that Sue does for her neighbor. The value is not based on the value of the hot meal. Sue is not a landscape architect or a master gardener, so the prevailing wage would be minimum wage. The required verification for this in-kind income is documentation, such as a signed statement, from her neighbor that Sue weeds an hour a week for her neighbor in exchange for a hot meal.

Example 2: Roy walks his neighbor's dog a few times a month in exchange for transportation to and from his doctors' appointments. Roy tells the worker that he thinks this is worth $20 a month for the 8 hours a month he walks the dog, which would equal $2.50 an hour. The worker would ask for verification that includes how often and for how long each time Roy walks the dog ~~at least once a month~~ in exchange for transportation to and from appointments. Since Roy is not a bonded dog walker or a professional dog trainer, the worker would enter minimum wage as a reasonable prevailing wage for this exchange.

15.6 Self-Employment Income
15.6.5 Calculating Income Maintenance Income

IM income (see Section 15.6.1.1 Income) is anything you receive in cash or in-kind that you can use to meet your needs for food, clothing, and shelter by either:

1. Using IRS tax forms completed for the previous year, or
2. Anticipating earnings (see Section 15.6.5.3 Anticipated Earnings)

15.6.5.1 IRS Tax Forms and Worksheets

IM workers should not complete any IRS tax forms on an applicant's or member's behalf. It is the responsibility of the applicant or member to complete IRS tax forms.

Workers should only consult IRS tax forms only if **all** of the following conditions are met:

- The business was in operation at least one full month during the previous tax year.
- The business has been in operation six or more months at the time of the application.
- The person does not claim a significant change in circumstances since the previous year.

If all three conditions are not met, use anticipated earnings (see Section 15.6.5.3 Anticipated Earnings).

~~*15.6.5.2 Worksheets*~~

If you decide to use IRS tax forms, use them together with the charts in Process Help, Section 16.2 Self-Employment Income, or the self-employment income worksheets, which identify ~~net~~which income and ~~depreciation~~expenses need to be entered onto the Self-Employment page by line on the IRS tax forms.

For each operation, select the worksheet you need (if applicable) and, using the provided tax forms and/or schedule, complete the worksheet~~. These are:~~ (if applicable) and enter the income and expenses onto the Self-Employment page.

1. *Sole Proprietor* - Farm and Other Business

   There is no worksheet for Sole Proprietor. See Process Help, 16.2.2.3.2 Entering Information for a Sole Proprietorship to identify which lines need to be entered in CWW for each of the following IRS tax forms:

   - IRS Form 4797 - Capital & Ordinary Gains ~~(F-01983)~~

- IRS Schedule C or C-EZ (Form 1040~~)—~~) - Profit or Loss From Business ~~(F-01984)~~
- ~~IRS Schedule D (Form 1040)—Personal Capital Gains or Losses (F-01985)~~
- IRS Schedule E (Form 1040) - Rental and Royalty Income ~~(F-01986)~~
- IRS Schedule F (Form 1040) - Farm Income ~~(F-01987)~~

2. Partnership (F-16036)

   - IRS Form 1065 - Partnership Income
   - IRS Schedule K-1 (Form 1065) - Partner's Share of Income

~~3. Corporation (F-16034)~~

~~IRS Form 1120 - Corporation Income~~

3. Subchapter S Corporation (F-16035)

   - IRS Form - 1120S - Small Business Corporation Income
   - IRS Schedule K-1 (Form 1120S - Shareholder's Share of Income

~~If not already calculated on the worksheet, divide IM income by the number of months that the business was in operation during the previous tax year. Sole proprietor worksheets already account for this.~~

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

When a household has more than one self-employment operation, the losses of one may be used to offset the profits of another. Apply this offset only to those self-employment operations that produced earned income. Do not apply a loss from unearned income to a gain in earned income. Losses from self-employment cannot be used to offset other earned or unearned income.

15.6.5.2 Depreciation

Depreciation is an allowable deduction for EBD Medicaid cases.

If past circumstances do not represent circumstances, workers should calculate self-employment income based on anticipated earnings. Anticipated earnings should also be used in the following situations:

- The applicant's or member's business underwent a significant change in circumstances. A significant change in circumstances is any change that can be

expected to affect income over time. It is the applicant's or member's responsibility to report significant changes. The following are examples of significant changes:

  - The owner sold or closed down the business.
  - The owner sold a part of his or her business (e.g., one of two retail stores).
  - The owner is ill or injured and will be unable to operate the business for a period of time.
  - A plumber gets the contract on a new apartment complex. The job will take nine months and his or her income will increase.
  - A farmer suffers unusual crop loss due to the weather or other circumstances.
  - There is a substantial cost increase for a particular material such that there will be less profit per unit sold.
  - Sales are consistently below previous levels for an unknown reason. The relevant period may vary depending on the type of business (consider normal sales fluctuations).
- The applicant's or member's business was not in operation for at least one full month during the previous tax year.
- The applicant's or member's business was not in operation for six or more months when the person applied for or renewed benefits or reported changes.

IM workers should determine whether it is necessary to use anticipated earnings on a case-by-case basis and document the reasons for the determination in case comments.

The date of an income change is the date a worker and applicant or member agree that a significant change in circumstances occurred. IM workers must also judge whether the person's report was timely to decide if the case was overpaid or underpaid. Changes are then effective according to the normal prospective budgeting cycle.IM workers should not recover payments made before the agreed upon date.

15.6.5.3.1 Reporting Anticipated Earnings

The Self-Employment Income Report form (F-00107) (also called a SEIRF) simplifies reporting income and expenses when earnings must be anticipated. It can be used to report income for any type of business with any form of organization. However, some people, especially farm operators, may find it easier to complete the applicable IRS Form 1040 schedule when income and expense items are more complex.

For anticipated earnings to be determined, the applicant or member must complete a SEIRF for the months of operation since the significant change in circumstances occurred, not to exceed 12 months. (**Note:** The beginning of a business is a significant change in circumstances.) ~~He~~When requesting verification, the SEIRF forms will be prepopulated with the individual's and business' information, and will identify each individual month for which income and expenses are needed. However, he or she may complete a separate SEIRF for each month or combine the months on one SEIRF.

When a new self-employment business is reported or when a significant change in circumstance occurs, recalculate self-employment income as follows:

- When **six or more months** of actual self-employment information is available (but tax information is not available), calculate monthly average self-employment income using all the months' (at least six months, but no more than 12 months) income.

Example 2: James applies for Medicaid on November 1, 2017. He reports that he was self-employed starting in April 2017. The agency asks James to complete SEIRFs for April, May, June, July, August, September, and October so that his prospective self-employment income can be determined for his Medicaid certification period (November 2017–October 2018).

- When **two or more full months but less than six months** of actual self-employment information is available, calculate a monthly self-employment net income average using all of the actual income information. Because at least three months of income is needed, if the business has only been in operation two months, calculate the monthly self-employment net income average using the actual income information for two months, and an estimate of net income for the next month.

Example 3: Bonnie applies for Child Care and Medicaid on April 5, 2016. She reports that she was self-employed starting in January 2016. The agency asks Bonnie to complete a SEIRF for January, February, and March so that her prospective self-employment income can be determined for her Child Care and Medicaid certification period (April 2016–March 2017).

- When **at least one full month but less than two full months** of actual self-employment income information is available, calculate a monthly net income average using the actual net income received in any partial month of operation, the one full month of operation, and an estimate of net income for the next month.

Example 4: Ricardo applies for FoodShare and Medicaid on February 5. He was self-employed starting December 15. The agency asks Ricardo to complete a SEIRF for December, January, and February so that his prospective self-employment income can be calculated. The completed SEIRF includes Ricardo's actual income and expenses for December and January, and his expected income and expenses for February. The worker divides the total by three to determine an anticipated monthly average income amount. This amount would be used until Ricardo reports a significant change in self-employment or until Ricardo renews his benefits.

- When there is **less than one full month** of actual income information available, calculate a monthly net self-employment income average using the actual net income received in the partial month (since the significant change in circumstance occurred) and estimated income and expenses for the next two months.

Example 5: Jenny is a Medicaid member who has been self-employed as a hairdresser since 2012. Jenny's Medicaid certification period is December 2015 to November 2016. The worker used Jenny's 2014 tax return to establish a monthly income amount.

In March 2016, Jenny reports that she has been unable to work since breaking her arm on February 17. She is not sure when she will be able to return to work, but it will not be until at least May.

Jenny completes a SEIRF for February 17–February 28 (actual income since the significant change in circumstance occurred), and for March and April using a best estimate of income. The worker uses these three months (February, March, and April) to determine a prospective self-employment income estimate for the remainder of the certification period (through November 2016).

Use the average until the member's next renewal or if a significant change in circumstances is reported between renewals.

Use the anticipated earnings amount until the person completes an IRS tax form or reports a significant change in circumstances.

15.6.6 Verification

Self-employment income information is not available through data exchanges and therefore must be verified (see Section 20.3.8 Income).

Completed and signed IRS tax forms (see Section 15.6.2.2 By IRS Tax Forms) are sufficient verification of farm and self-employment income. A completed and signed SEIRF (or SEIRFs) is also sufficient verification.

If a Program Add request is made on a case with self-employment income, use the existing SEIRF information, instead of re-verifying it, if all of the following are true:

- A recent determination was made.
- SEIRFs were used.
- No significant change has been reported by the individual.
- The business has not filed taxes in the meantime.

Note: It is not necessary to collect copies of supportive verification, such as receipts from sales and purchases. However, verification can be requested when the information given is in question (see Section 20.4.1 Questionable Items Introduction). If requesting verification, workers must document the reason for the request in case comments.

15.6.8 Backdated Months

Self-employment income is averaged over the number of months the business has been in operation in a tax year or anticipated based on an average of SEIRFs. It is not based on exact income for a single month, as that does not take into consideration seasonal work and fluctuating income for the business. If an individual had applied in a backdated month, eligibility would not be determined on the basis of one month of self-employment income; instead, eligibility would be based on an average of at least three months of income.

When a self-employed applicant or member requests backdated benefits for health care, workers must do the following:

1. Average self-employment income for the application month forward (to determine ongoing eligibility).
2. Determine eligibility for the backdated months as if the applicant or member had applied in the earliest backdated month requested:
    - If income is reported via federal taxes, the tax filing year has not changed, and no significant change in circumstances has occurred, the same averaged income and expenses from the tax forms can be used for ongoing and backdated eligibility.
    - In all other scenarios, workers must consider SEIRFs and the average to be counted if that earliest month was the application month. If estimates would have been used, but the month has passed, actual information should be provided on the SEIRFs.
3. Consider any significant changes that occurred during the backdated months that would require a new average to be calculated for the second and/or third month. If there has not been a significant change or a change in the tax filing year during the backdated months, the average calculated for the earliest month can be used throughout the backdated months.

Example 6: Maggie applied for Medicaid in June and requested backdated eligibility to March. She has been self-employed as a seamstress since February of the same year. She does not file taxes.

For the application month of June, SEIRFs would be used for all available months – February, March, April, and May to budget average income for the month of June and ongoing.

If she had applied in March, her income would have been averaged based on actual income for the months of February, March, and April, so SEIRFs for February, March, and April would be used for determining her eligibility for Medicaid for the backdated months of March, April, and May.

Example 7: Glenn applied for Medicaid in September and requested backdated eligibility to June. He has been self-employed as a farmer, but reported having a true significant change in circumstances in May.

-

For the application month of September, SEIRFs would be used for all months since the significant change – May, June, July, and August to budget average income for the month of September and ongoing.

-

If he had applied in June, his income would have been average based on actual income for the months of May, June, and July, so SEIRFs for May, June, and July would be used for determining his eligibility for Medicaid for the backdated months of June, July, and August.

-

Example 8: Hershel applied for Medicaid and FoodShare for himself in April and requested backdated eligibility to January. He owns a bakery and filed taxes. However, he reports that his previous year's taxes no longer reflect his earnings due to a true significant change that occurred in March.

-

For the application month of April, SEIRFs would be used for all months since the significant change occurred in March, so Hershel's actual income for March and estimated income for April and May would be used to budget average income for the month of April and ongoing.

-

If he had applied in January, taxes would be used as verification of his income, so his taxes can be used for determining his eligibility for Medicaid for the backdated months of January and February.

-

However, because of the significant change in March, an average of March, April, and May SEIRFs would be used for determining his eligibility for Medicaid for the backdated month of March.

15.7 Income Deductions
15.7.3 Medical/Remedial Expenses

Medical/remedial expenses are used in all the following:

- *HCBW* programs
- Patient liability calculations for residents of a medical institution
- Cost share and *MAPP* premium calculations

Medical expenses are anticipated, incurred expenses for services or goods that have been prescribed or provided by a professional medical practitioner (licensed in Wisconsin or another state). The expense is for diagnosis, cure, treatment, or prevention of disease or for treatment affecting any part of the body. These are expenses that are the responsibility of the member, and cannot be reimbursable by any other source, such as Medicaid, private insurance, or employer.

The following are examples of medical expenses:

- Deductibles and copayments for Medicaid, Medicare, and private health insurances
- Health insurance premiums.
- Bills for medical services that are not covered by Wisconsin Medicaid
- For purposes of meeting a Medicaid deductible, medical services received before the person became eligible for Medicaid (Past medical bills cannot be used for MAPP premium calculations.)

Medicaid overpayments are not medical expenses and cannot be used as an income deduction to lower a patient liability, cost share, or to meet a deductible.

Remedial expenses are costs incurred for services or goods that are provided for the purpose of relieving, remedying, or reducing a medical or health condition. These are expenses that are the responsibility of the member and cannot be reimbursable by any other source, such as Medicaid, private insurance, or employer.

Some examples of remedial expenses are:

- Case management
- Day care
- Housing modifications for accessibility
- Respite care
- Supportive home care
- Transportation
- Services recognized under Wis. Stat. § 46.27
- Community Options Program expenses that are included in the person's service plan

Remedial expenses do not include housing or room and board services.

16.5 Burial Assets
16.5.4 Spaces

Burial space exemptions apply only to EBD fiscal group members. Burial space exemptions include all the following, if they have been paid for: or are included in a contract to purchase with a LIFBC that meets the criteria in Section 16.5.3 Life Insurance-Funded Burial Contracts:

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

Exempt multiple spaces of any value under the following conditions:

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

If the burial space expenses are being paid for through an LIFBC for a relative with a qualifying relationship (other than the EBD person and that person's spouse), allow only those expenses listed above in Section 16.5.3 as exemptions. Any other goods or services purchased through the LIFBC would be a divestment.

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

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

17.2 Divestment Definitions
17.2.5 Community Spouse

See *community spouse* in Glossary. A divestment penalty period will be imposed on the Institutionalized Spouse if the Community Spouse divests assets within the first five years after the Institutionalized Spouse has been determined eligible for LTC services (Institutional Medicaid or any of the HCBW programs).

17.5 Penalty Period

17.5.2 Calculating the Penalty Period

For divestments on or after January 1, 2009, the divestment penalties are calculated by days using the average daily nursing home private pay rate. The rate effective July 1, ~~2018~~2019 is $~~286.15~~287.29. This rate may be updated annually (see Section 39.4.3 Institutional Cost of Care Values).

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

Example 1: Jeff applied for Family Care. One month earlier, Jeff had transferred $18,500 in cash to his son. At the time of application, Jeff is otherwise eligible for Family Care. Since $18,500 divided by $~~286.15~~287.29 equals 64.~~65~~39 days, CWW will calculate a divestment penalty period of 64 days for Jeff.

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~~818.34 plus excess shelter allowance (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances) up to a maximum of $3,160.50.

      "Excess shelter allowance" means shelter expenses above $~~823.00~~845.50. Subtract $~~823.00~~845.50 from the community spouse's shelter costs. If there is a remainder, add the remainder to $2,~~743~~818.34 (see Section 39.4.2 Elderly, Blind, or Disabled Deductions and Allowances).

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

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

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

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

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

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

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

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

18.6.3 Family Member Income Allowance

The institutionalized person can allocate up to $~~685.83~~704.58 per month to each dependent family member who lives with the community spouse.

The allocated amount is the difference between $~~685.83~~704.58 and the actual monthly income of the dependent family member.

22.1 Estate Recovery

22.1.7 Notify Members

Provide a copy of the Wisconsin Medicaid Estate Recovery Program Handbook (P-13032) to every Medicaid member 54 1/2 years old or older or institutionalized at application and review., except members who are only applying for or a member of one of the Medicare Savings Programs. Have each member or his or her representative read the notice of liability on the application form ("Estate Recovery"). He or she acknowledges understanding of this notice when signing the application.

22.2 Corrective Action
22.2.2.2.1 Institutional Overpayments

The overpayment amount for an institutional case is the amount Medicaid paid.

If a member failed to report a divestment that would have resulted in a penalty period and the member is still otherwise eligible for long-term care, do not recover benefits Medicaid paid during the time in which the penalty period would have been served. Instead, impose the penalty period for ongoing eligibility as outlined in Section 17.5.4 Penalty Period Begin Date for Members.

Note: Patient liability should not be subtracted from the claims paid by Medicaid when determining the overpayment amount.

22.4 Undue Hardship
22.4.7 Bed Hold Payments and Notifications (Divestment Only)

When an undue hardship waiver request is received by an IM agency from an institutionalized individual, the agency will send the institution the Undue Hardship Bed Hold Notice (F-10189) to inform the institution that the request was received. The notice will inform the institution that a bed hold payment will be made on the client's behalf for the period of time while the IM agency is making a decision about the hardship waiver request. The period covered begins on the date a written hardship waiver request is received at the IM agency until the date the agency issues its decision on the waiver request, up to a maximum of 30 calendar days.

Use the Undue Hardship Waiver Decision (F-10188) to notify the institution of the agency's decision about the undue hardship waiver and the availability of the bed hold payment (when applicable).

If the request for an undue hardship waiver is approved, the divestment penalty period will be waived and the need for a bed hold payment is therefore unnecessary.

If the undue hardship waiver request is denied, indicate on the Undue Hardship Waiver Decision (F-10188) the dates for which the state will make the bed hold payments. Attach a copy of the Undue Hardship Waiver Decision (F-10188) to the manual Notice of Denial of Benefits/Negative Change in Benefits (F-16001) that you send the applicant or member.

~~In addition to the requirements in Section 22.4.6, the Notice of Denial of Benefits/Negative Change in Benefits (F-16001) must inform the applicant or member that Medicaid/ForwardHealth will pay for long-term care services received during the bed hold period. Certify the bed hold period by completing an electronic Medicaid certification (see Process Help Handbook Section 81.3 Electronic F-10110 [formerly the 3070 and HCF-10110]).~~

Only one bed hold payment will be made for each divestment penalty period. Bed hold payments can only be made on behalf of individuals residing in medical institutions (i.e., nursing homes, etc.) who are requesting an undue hardship waiver. Bed hold payments will not be made for individuals not residing in a medical institution.

26.5 MAPP Premiums
26.5.3.3 Refunds

The fiscal agent issues refunds if the ~~member~~premium was paid and is for a month in which one of the following situations occurs:

~~1. Lost MAPP eligibility and already paid the premium. Refunds will only be given if *adverse action* notice requirements were met.~~

1. ~~Overpaid. The~~ The individual was ineligible for MAPP.
2. A change is reported that results in no premium or a lower premium amount. If the change is reported within 10 days of when the change occurred, the lower or $0 premium amount is effective during the month in which the change occurred. If the change is not reported within 10 days of when the change occurred, the lower premium amount is effective during the month in which it was reported. The fiscal agent will refund any excess premium that was paid. See Section 26.7 MAPP Changes for information on change reporting.

   Note: When determining if a change was reported within 10 days of when the change occurred, the worker should use the reported date of change from the member. If the worker has information that makes the reported date of change questionable, the worker can request verification of the date of change.

3. The individual overpaid and the excess cannot be applied to the next month's premium.

~~2. Retroactive adjustment. The premium was recalculated and reduced for prior month(s).~~

4. ~~Requested~~The member requested to close MAPP and already paid the premium.

The member's estate can receive a refund if he or she dies between adverse action and the beginning of the benefit month.

27.10 Liability Effective Dates

~~Nursing homes, state centers, and state mental hospitals receive a CARES weekly paper report, #CCN150RA, that lists the patient liability amounts for their Medicaid residents. The report includes case number, primary person name, patient liability status (approval, closure, increase, decrease, unchanged), the date the action was confirmed, prior patient liability amount, current patient liability amount, effective begin date, and effective end date.~~

Income changes which are reported timely and result in an increased patient liability or cost share have the following effective dates:

- **Before** adverse action: Effective the first of the following month.
- **After** adverse action: Effective the first of the month after the following month.

Do not complete F-10110 (formerly DES 3070) for retroactive patient liability or cost share increases since the member must receive timely notice. This includes scenarios in which a member is switching from a patient liability to a cost share or from a cost share to a patient liability.

Decreases in patient liability or cost share are always effective the first of the month in which the decrease in income occurs or the decrease is reported, whichever is later. ~~If the date of change that you enter into CARES will cause an incorrect effective date on the fiscal agent's file, run with dates in CARES. Do not complete a F-10110 (formerly DES 3070) unless you are unable to confirm the decrease after running with dates in CARES.~~

Note: If an Administrative Law Judge or court orders a decreased liability or cost share, the agency must follow the court order and apply changes retroactively as stated in the court order.

27.11 Institutions for Mental Disease

Brown

Bellin Psychiatric 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, Inc., Brown Deer

Rogers Memorial Hospital Inc., 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, Inc., 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 Adult Home And Community-Based Waviers 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:

- Family Care
- Family Care Partnership
- *PACE*

Medicaid Eligibility
Community waivers enable elderly, blind, or disabled people to live in community settings rather than in state institutions or nursing homes. They allow Medicaid to pay for services and supports permitting a person to remain in a community setting that normally are not covered by Medicaid. These programs include Family Care, Family Care Partnership, PACE, and IRIS.

IM workers are responsible for determining Medicaid eligibility as well as cost share amounts, if applicable. ADRC staff and IRIS consultants are responsible for determining the person's eligibility for enrollment in the specific community waiver program.

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 of 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

28.6 Home and Community-Based Waivers Long-Term Care Eligibility Groups and Cost Sharing

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.

Group A members are financially eligible with no cost share. They are only subject to the asset limit and any premiums associated with the full-benefit Medicaid source, if applicable. For example, if the member's Medicaid source is MAPP, s/he would be subject to the MAPP asset limit and premium calculated. If the member's Medicaid source is BadgerCare Plus, the member would not have an asset limit, but may still have a premium calculated.

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.

28.6.4 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. Members who owe a cost share must pay one in the month that they enroll in a community waiver program, even if they only receive services for part of a month. If the member changes from one MCO to another MCO in the same month after paying a cost share to the original MCO, he or she does not owe a cost share to the new MCO that month.

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.

Cost Share or Patient Liability Effective Dates

Income changes which are reported timely and result in an increased patient liability or cost share have the following effective dates:

- **Before** adverse action: Effective the first of the following month.
- **After** adverse action: Effective the first of the month after the following month.

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. For spousal cases, the institutionalized person can allocate income to the community spouse and children in the home, see Section 18.6 Spousal Impoverishment Income Allocation.

28.6.4.3 Special ~~Excempt~~Exempt Income

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

30.1 Tuberculosis Medicaid

For information on Tuberculosis Medicaid, please see BadgerCare Plus Handbook, Chapter 43.

39.4 Elderly, Blind, Or Disabled Assets and Income Tables

39.4.2 Elderly, Blind, or Disabled Deductions and Allowances

The cost-of-living adjustments in the following table were effective January 1, 2019.

Description		Amount
Personal Needs Allowance (effective 7/1/01)		$45.00
EBD Maximum Personal Maintenance Allowance		$2,313.00
EBD Deeming Amount to an Ineligible Minor		$386.00
Community Waivers Basic Needs Allowance		$951.00
Parental Living Allowance for Disabled Minors	**1 Parent** **2 Parent**	$771.00 $1,157.00
MAPP Standard Living Allowance Standard Living Allowance = SSI + State Supplement + $20		$874.00

The spousal impoverishment values in the following table were effective July 1, ~~2018~~2019.

Description	Amount
Community Spouse Lower Income Allocation Limit	$2,~~743~~818.34
Community Spouse Excess Shelter Cost Limit	$~~823.00~~845.50
Family Member Income Allowance	$~~685.83~~704.58

39.4.3 Institutional Cost of Care Values

The values in the following table were effective July 1, ~~2018~~2019.

Description	Amount
Daily Average Private Pay Nursing Home Rate	$~~286.15~~287.29
Monthly Average Private Pay Nursing Home Rate	$8,~~703.73~~738.40
Monthly Rate for State Centers for Persons with Developmental Disabilities	$~~25,329.48~~27,930.10