WISCONSIN DEPARTMENT OF HEALTH SERVICES
Division of Medicaid Services
1 W. Wilson St.
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To: Medicaid Eligibility Handbook Users

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

Re: **Medicaid Eligibility Handbook Release 22-03**

Release Date: 12/05/2022

Effective Date: 12/05/2022

EFFECTIVE DATE		The following policy additions or changes are **effective 12/05/2022** unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY UPDATES		
2.5.1.1	**Signatures from Representatives**	Added information about authorized representative signatures.
2.9.2	**Denial**	Added a note about requesting deductible periods.
7.3.3.5	**Ukrainian Parolees**	New section. (Effective 05/21/2022)
8.1.3	**Referral to CSA**	Added information about completing the Absent Parent page.
8.3.3	**Good Cause Claim**	Updated grammar and terms. (Effective 08/01/2022)
15.3.36	**Madison Forward Fund Guaranteed Income Payments**	New section.
15.3.37	**Assistance Based on Need (General Assistance)**	New section.
16.6.5	**Special Needs Trust**	Updated grammar and terms. Added citation information.
16.6.6	**Pooled Trusts**	Section rewritten.
16.7.4	**Annuities**	Section rewritten.
16.7.33	**Certain Payment Types Related to the COVID-19 Pandemic**	Removed information on payment types that count as assets. (Effective 06/03/2022)
17.2.5	**Verification**	Section removed.
17.2.6.1	**Transfers Made for a Purpose Other Than to Qualify for Medicaid**	Section rewritten.
17.2.6.2	**Trusts for Disabled Individuals**	Section rewritten.
17.2.6.14	**Irrevocable Annuities**	Section rewritten.
17.2.7.18	**Trusts for Disabled Individuals Established or Funded After the Beneficiary Turns 65**	Removed information about third party's involved in trusts.
17.2.7.19	**Third Party Adds Funds to a Pooled Trust**	Section removed and section that followed were moved up.

20.3.7	**Power of Attorney, Guardianship, or Conservator**	Section rewritten.
20.7.3	**Date of Death Matches**	Added information about date of death information received from Vital Records.
21.7.5	**Lost or Stolen Cards**	Updated grammar and terms.
22.2.2.2	**Overpayment Amount**	Clarified SWICA and FSH (Equifax) income information can be used as best available information. (Effective 08/10/2022)
24.3	**Deductible Period**	Clarified new application information during a deductible period.
24.7.1.1	**Countable Expenses**	Clarified information regarding transportation as a countable expense.
26.4.1.1	**Independence Accounts**	Added information about non-retirement/pension accounts as an Independence Account.
26.5.1	**Calculation**	Clarified MAPP tribal members are required to pay premiums.
27.1.4	**Minors in a Medical Institution**	New section.
29.1	**Katie Beckett**	Added criteria needed to qualify for Katie Beckett Medicaid.

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2.5 Valid Signature

2.5.1 Valid Signature Introduction

2.5.1.1 Signatures From Representatives

The following people can sign the application with their own name on behalf of the applicant:

1. **Guardian**
   When an application is submitted with a signature of someone claiming to be the applicant's guardian, obtain a copy of the document that designates the signer of the application as the guardian. From the documents provided, ensure that the individual claiming to be the applicant's guardian can file an application on their behalf.

   When someone has been designated as one of the following, only the guardian, not the applicant, may sign the application or appoint an authorized representative:
   - Guardian of the estate
   - Guardian of the person and the estate
   - Guardian in general

   If the applicant only has a legal guardian of the person, the guardian can sign the application since they are acting responsibly for an incompetent or incapacitated person. However, a legal guardian of the person cannot appoint an authorized representative. The applicant must be the one to appoint an authorized representative if they choose to have one.

   The applicant may appoint their guardian of the person to be their authorized representative. If the applicant has appointed their guardian of the person to be their authorized representative, the guardian may sign the application as the authorized representative.
2. **Conservator (Wis. Stat. 54.76(2))**
   A conservator is a person who is appointed by a court at an individual's request under Wis. Stat. 54.76(2) to manage the estate of the individual. When an application is submitted with a signature of someone claiming to be the applicant's conservator, a copy of the document that designates the signer of the application as the conservator is required.

   The conservator is not required to sign the application, though they are able to sign on behalf of the applicant. If an applicant has a conservator, the applicant can still sign the application on their own behalf.
3. **Authorized Representative**
   The applicant may authorize someone to represent them. An authorized representative can be an individual or an organization (see Section 22.5 Representatives). If the applicant needs to appoint an authorized representative when applying by telephone or in person, the applicant must complete the Appoint, Change, or Remove an Authorized Representative form (F-10126). When appointing an authorized representative, someone other than the authorized representative must witness the applicant's signature. If the applicant signs with a mark, two witness signatures are required.

   The authorized representative is not required to sign the application, though they are able to sign on behalf of the applicant. If an applicant has an authorized representative, the applicant can still sign the application on their own behalf.
4. **Durable Power of Attorney (Wis. Stat. ch. 244)**
   A durable power of attorney is a person to whom the applicant has given power of attorney

authority and agrees that the authority will continue even if the applicant later becomes disabled or otherwise incapacitated. Only a durable power of attorney for finances (may also be known as a durable power of attorney for finances and property) is considered to be the power of attorney for the purpose of providing a valid signature on the application. A power of attorney for health care is not considered the power of attorney for the purpose of providing a valid signature on the application.

When a submitted application is signed by someone claiming to be the applicant's durable power of attorney for finances, the agency must do both of the following:

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

Do not consider the application properly signed unless both of the above conditions are met. An individual's durable power of attorney for finances may appoint an authorized representative for purposes of making a health care application, if authorized on the ~~power~~Durable Power of ~~attorney~~Attorney for Finances form.

The ~~durable power~~Durable Power of ~~attorney~~ Attorney for Finances form will specify what authority is granted. The appointment of a durable power of attorney for finances does not prevent an individual from filing their own application, nor does it prevent the individual from granting authority to someone else to apply for public assistance on their behalf.

5. **Someone acting responsibly for an incompetent or incapacitated person**

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

6. **A superintendent of a state mental health institute or center for the developmentally disabled**
7. **A warden or warden's designee**
   A warden or warden's designee for an inmate of a state correctional institution who is a hospital inpatient for more than 24 hours.
8. **The superintendent of a county psychiatric institution**
   The superintendent of a country psychiatric institution may sign an application for a resident of the institution provided that the county social or human services director has delegated to them (in writing) the authority to sign and witness applications for residents of the institution. Retain a copy of this written authorization. The social or human services director may end the delegation when there is reason to believe that the delegated authority is not being carried out properly.

2.9 Denials and Terminations

2.9.2 Denial

If the person applied for health care and the IM agency denied the health care application 30 or fewer days ago, the person can re-request health care without submitting a new application or a new signature. The date of the new health care request is the new filing date.

Example 1	Keisha applied for health care on August 15. The IM agency processed the application on September 8 and denied health care for Keisha. Keisha calls the IM agency on September 20 to re-request health care. The new filing date for health care is September 20. The IM agency cannot require Keisha to submit a new application or a new signature since it is within 30 days of the denial date of her application.

If the person applied for health care and the IM agency initially denied the health care application (or ~~determined~~ the ~~person was~~ only ~~eligible for~~health care eligibility on the case is an unmet deductible) more than 30 days ago, the person must submit and sign a new application in order to re-request health care, regardless of the other non-health care programs the person is enrolled in.

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

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

Note	If someone who was determined eligible for an unmet deductible wishes to request a new deductible period, a new application is required regardless of when the previous deductible period was established and regardless of whether they or anyone else on the case is eligible for another health care program (see SECTION 24.3 DEDUCTIBLE PERIOD).

7.3 Immigrants

7.3.3 Immigrants Eligible for Medicaid

7.3.3.5 Ukrainian Parolees

Ukrainians and persons with no nationalities who were residing in Ukraine and subsequently paroled into the United States between February 24, 2022, and September 30, 2023, are to be treated as refugees when determining their eligibility for Medicaid.

In addition, Ukrainians and persons with no nationalities who were residing in Ukraine and subsequently paroled into the United States after September 30, 2023, are to be treated as refugees when determining their eligibility for Medicaid if they are one of the following:

- The spouse or child of a person described above paroled between February 24, 2022, and September 30, 2023,
- The parent or legal guardian of an unaccompanied child described above who was paroled between February 24, 2022, and September 30, 2023.

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

Class of Admission Code	Description	CARES Alien Registration Status Code
UHP, DT, PAR, or U4U	Humanitarian Parolee	Code 04

8.1 Medical Support

8.1.3 Referral to ~~CSA~~Child Support Agencies

The IM agency provides the CSA with information vital to opening medical support cases. The IM agency also supplies continuing information, which assists the CSA in providing medical support services. At confirmation, CARES automatically sends a referral to the CSA for all Medicaid applications and person adds that include minors, unless the referral field on the Absent Parent Page is answered "No." The information on the Absent Parent page must be filled out ~~completely and accurately~~accurately to the best of the worker's ability, given that detailed questions about absent parents (such as, name, Social Security number, date of birth, or contact information) cannot be asked during the application process for health care-only applications. The referral will still be sent to the CSA, even if the absent parent's name is unknown.

Note:	A Referral to Child Support form (DCF-F-DWSP 3080) only needs to be completed when the Absent Parent page cannot be completed in CWW.

BadgerCare Plus Note: While IM agencies are to continue referring the following individuals who are receiving BadgerCare Plus, the CSA's will be determining on their own~~,~~ which cases will be provided Child Support Services. Not all BadgerCare Plus members will qualify for free Child Support services and be required to cooperate with CSA's.

The following individuals (including minors) for whom Medicaid is requested or being received, must be referred to the local CSA unless an exception is noted:

1. A pregnant ~~woman~~member who is unmarried or married and not living with her husband. ~~Pregnant women~~ However, pregnant members are not required to cooperate with the CSA during the pregnancy and for ~~two months~~an additional 60 days after the ~~end~~last day of the pregnancy~~.~~ and through the end of the month in which the 60th day occurs. The ~~woman's~~member's eligibility for Medicaid will continue during this period, regardless of ~~her~~the member's cooperation.
2. A child receiving SSI only if the parent or caretaker relative requests child support services for the child. Do not sanction this parent or caretaker relative if ~~he or she does~~ they do not cooperate with the CSA.
3. Non-marital co-parents when paternity has not been legally established. This includes a non-marital co-parent even when~~:~~ both parents are in the same home.
   ~~1. A Statement of Paternity has been completed,~~
   ~~2. Both parents are in the home.~~
   Exception: Do not refer parents to the CSA when both parents are in the home and the father is on the child's birth certificate or the father's paternity has been legally established~~. (Paternity is legally established~~ in another state by a court order or by a Voluntary Paternity ~~Acknowledgment~~Acknowledgement Form ~~signed on or after May 1, 1998 and~~ filed with ~~the Wisconsin Vital Records office.)~~a state agency.
   ~~Note If a father's name appears on a Wisconsin Birth Certificate for a child born after 5/11/1998, it means paternity has been established.~~
4. ~~Natural~~Biological or adoptive parent(s) not living in the household.
   Exception: Do not refer to the CSA when the only reason a parent or stepparent is not in the home is because ~~he or she is~~they are in the military.
5. Married ~~natural~~biological parents in the home, but:

a. Child was born prior to their marriage, and
b. Paternity was not established by court action, or the birth was not legitimized after their marriage.

Do not refer people residing in domestic abuse shelters to the CSA. Once a person moves out of a domestic abuse shelter, complete the Absent Parent page in CWW so that the referral is sent to the CSA.

8.3 Claiming Good Cause

8.3.3 Good Cause Claim

The Good Cause Claim form (DCF-F-DWSP2019~~The ,~~) must be provided to any Medicaid parent or caretaker who requests one. It describes the circumstances that support a claim and how to document a claim.

The parent or caretaker must sign and date the ~~claim in the presence of an IM worker or a notary public. The applicant/member's signature initiates~~Good Cause Claim form in order to initiate the claim. The original copy is filed in the case record, a copy is given to the parent or caretaker and a copy is attached to the referral document when a good cause claim is made at application.

A copy of good cause claims must be sent to the Child Support Agency (CSA) within two days ~~after~~ of signing a claim ~~is signed~~. When the CSA is informed of a good cause claim, they will immediately suspend all activities to establish paternity or secure medical support until notified of ~~your~~the final determination.

15.3 Exempt/Disregarded Income

15.3.36 Guaranteed Income Payments

Guaranteed income from a privately funded, non-profit organization up to $500 per month is excluded. This includes but is not limited to payments from the Madison Forward.

15.3.37 Assistance Based on Need (General Assistance)

Income is disregarded as Assistance Based on Need, also known as General Assistance, if it is:

- Provided under a program which uses income as a factor of eligibility, and
- Funded wholly by a state (including tribes), a political subdivision of a state, or combination of such jurisdictions.

16.6 Non-Burial Trusts

16.6.5 Special Needs ~~Trust~~Trusts

~~Disregard~~A special needs ~~trusts, also called supplemental needs trusts, whose sole beneficiary~~trust is a trust established for the sole benefit of a person under age 65 ~~and totally and permanently~~who is disabled ~~(under SSI program rules) if they~~.

Trusts that meet all ~~of~~ the following ~~conditions:~~requirements are disregarded.

1. ~~Established~~ The trust contains the assets of an individual who is under the age of 65 and disabled.

~~•~~ The trust was established for the sole benefit of the disabled ~~person.~~

~~○ Trusts established prior to December 13, 2016 may not be set up~~individual by ~~the member. They may only be established by the following:~~

~~▪ the member's~~their parent

~~▪ the member's~~, grandparent

~~▪ the member's~~, or legal guardian

~~▪ the~~, by the disabled individual, or by a court ~~on the member's behalf~~

~~○ Trusts established on or after December 13, 2016 may be set up by the member. They may also be established by the following:~~

~~▪ the member's parent~~

~~▪ the member's grandparent~~

~~▪ the member's legal guardian~~

~~▪ the court on the member's behalf~~

~~1.~~2. ~~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.~~Special needs trusts established prior to December 13, 2016, may not be established by the disabled individual. They may only be established by the disabled individual's parent, grandparent, or legal guardian, or by a court.

~~Contain a provision~~

Note	In the case of a legally competent, disabled adult, a parent or grandparent may establish a seed trust using a nominal amount of their own money (for example, $10) or an empty or dry trust. After the trust is established, the disabled adult's assets can be transferred into the trust.

~~2.~~3. The trust provides that, upon the death of the beneficiary, after subtracting taxes and a reasonable amount for administrative costs, Wisconsin Medicaid will receive all amounts remaining in the trust not in excess of the total amount ~~-~~ of ~~Medicaid~~medical assistance paid on behalf of the beneficiary.

~~Trusts~~A trust that ~~meet~~meets the above criteria ~~but are~~is treated as a special needs trust for Medicaid purposes even if the trust agreement does not specifically call it a special needs trust.

A trust that does not meet the above criteria is not treated as a special needs trust for Medicaid purposes, even if it is called a special ~~or supplemental~~ needs trust ~~are treated as special needs~~in the trust agreement. For trusts ~~for Medicaid purposes. Trusts that are called special or supplemental needs trusts but~~that 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 SECTION 16.6.3 REVOCABLE TRUSTS or SECTION 16.6.4 IRREVOCABLE TRUSTS ~~or~~ .

~~The funds deposited in, contributions~~Additions to~~, and distributions from the~~ the trust principal made directly to the special needs trust before the beneficiary reaches age 65 are disregarded. ~~The exception continues~~Distributions from the trust are also disregarded. These disregards continue after the ~~person~~beneficiary turns 65, provided ~~he or she continues~~they continue to be disabled. ~~However, a grantor cannot add~~

Additions to the trust after age 65

In general, additions to the trust after the beneficiary turns 65~~. Anything~~ are not disregarded. The value of any non-excluded assets added to the trust after the beneficiary ~~turns~~reaches age 65 is ~~a divestment. Money added~~considered available to the beneficiary.

However, if the beneficiary's right to receive support payments, U.S. Military Survivor Benefit Plan payments, or payments from an annuity has been irrevocably assigned to the trust before the trust beneficiary ~~turns~~turned 65 ~~is not a divestment~~, the payments are treated the same as payments made before the individual turned 65 and continue to qualify for the special needs trust exemption.

Interest, dividends, or other earnings of the trust after the beneficiary reaches age 65 remain excluded.

16.6.6 Pooled Trusts

~~Disregard pooled trusts for disabled persons managed by:~~

~~1. WISH Pooled Trust~~

A pooled trust contains the assets of many different individuals, each held in separate trust accounts and established through the actions of individuals for separate beneficiaries.

Pooled trusts that contain the assets of a disabled individual are disregarded for Medicaid purposes if they meet the following conditions:

1. The pooled trust is established and managed by a nonprofit association. Separate accounts are maintained for each beneficiary, but assets are pooled for investing and management purposes.
2. Accounts are established solely for the benefit of the disabled individual(s).
3. The account in the trust is established by the disabled individual's parent, grandparent, or legal guardian, by the disabled individual, or by a court.
4. The trust provides that, to the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, after subtracting taxes and a reasonable amount for administrative costs, Wisconsin Medicaid will receive all amounts remaining in the account not in excess of the total amount of medical assistance paid on behalf of the beneficiary.

The funds deposited in, contributions to, and distributions from the pooled trust are disregarded. The disregard continues after the person turns 65, provided they continue to be disabled.

Note	Assets that have been placed in a potential pooled trust account pending a disability determination are unavailable assets until the disability determination has been made. If the individual has been determined disabled by DDB, the pooled trust is an exempt asset as of the disability onset date. If the individual is not determined disabled, the assets are counted.

Disregarded pooled trusts in Wisconsin include, but are not limited to:

- WisPACT Trust I
- ~~ARC of Greater Milwaukee, Inc.~~Life Navigators Community Trust II

~~The WISH Pooled Trust and the WisPACT Trust I must meet the following conditions:~~

1. ~~Are established and managed by a non-profit association. The pooled trust can contain funds that hold accounts funded by third parties for the benefit of the disabled person's own assets or income.~~
2. ~~Have separate accounts, within each fund, which are maintained for each beneficiary or the trust, but for purposes of investment and management of funds, the trust pools these accounts. There may be a separate fund with accounts that include or benefit persons who do not have a disability.~~
3. ~~Contain accounts with the funds of disabled individuals (based upon SSI and Medicaid rules) that are established solely for their benefit by a parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court. If the account includes a residential dwelling, the individual must reside in that dwelling, but a spouse, caregiver or housemate can also live there with the Medicaid applicant/member.~~
4. ~~For WISH Trusts, if the account includes a residential dwelling, the individual must reside in that dwelling, but a spouse, caregiver or housemate can also live there with the Medicaid applicant/member. This requirement does not apply to WisPACT trusts.~~
5. ~~Repay Medicaid to the extent that amounts remaining upon death are not retained by the trust.~~
    1. ~~This requirement can be satisfied when the individual trust account contains liquid assets and has a balance by returning that amount to the Medicaid program after subtracting a reasonable amount for administrative costs.~~
    2. ~~This requirement can also be satisfied when the pooled trust account includes real property, and the real property is retained by the pooled trust so long as the property continues to be used by another Medicaid member who is disabled (as established under SSI rules) or elderly (age 65 years or older). In addition, if the account contains liquid assets that had been used to help maintain the real property, the account funds may be retained to continue to maintain the housing that will be used by another Medicaid member.~~

~~Note:~~ ~~The assets that have been placed in a potential pooled trust pending a disability determination are unavailable assets until the disability determination has been made. If the individual has been determined disabled by DDB, the pooled trust is an exempt asset as of the disability onset date. If the individual is not determined disabled, the assets are counted.~~

16.7 Liquid Assets

16.7.4 Annuities

16.7.4.1 Annuity Introduction and Definitions

An annuity is a ~~written~~purchase contract ~~under which,~~ where the purchaser pays a lump sum or makes periodic payments to a bank or insurance company in return for ~~payment~~an expectation of ~~a premium or premiums, an individual will receive a series of payments at regular intervals for a specified time period.~~
future payments. The annuitant is the person entitled to the payments. ~~A purchaser can name himself or herself or another person~~These payments may continue for a fixed period or for as long as the annuitant~~. The purchaser may also name a~~ or another designated beneficiary ~~to receive~~ lives, creating an ongoing income stream. The annuity ~~payments after the annuitant's death~~may or may not include a remainder beneficiary clause under which, if the annuitant dies, the contracting entity converts whatever is remaining in the annuity into a lump sum or periodic payments that are paid to a designated beneficiary.

~~**16.7.4.1 Annuities Purchased After March 1, 2004**~~
~~(For annuities purchased before March 1, 2004, refer to).~~
~~Treat annuities purchased after March 1, 2004, as available assets in accordance with the following:~~

~~***16.7.4.1.1 Annuities That Can Be Surrendered***~~
It is most common for an annuity to have cash surrender value during the accumulation phase. The **accumulation phase** is the period when the investor makes deposits into the annuity to build up its cash value. Some annuities (such as immediate annuities) don't have an accumulation phase because they are annuitized at the time of purchase.

The **pay-out phase** (annuitization) begins at the time payments start going to the annuitant in accordance with the settlement option. The settlement option specifies the way the funds from the annuity will be paid out. It involves choosing the amount of each payment, how often payments will be made, and the length of time over which the payments will be made.

If the annuity's cash value is available for withdrawal (minus any penalty~~)~~), the annuity can be ~~"~~**surrendered**~~."~~. If the terms of the contract do not allow the annuity to be surrendered, it is considered **irrevocable**.

16.7.4.2 Treatment of Annuities as Assets or Income

When an annuity is in the payout phase, payments are only counted as unearned income if the annuity itself is considered an unavailable asset. Annuities that are considered available, countable assets include the following:

- Annuities that can be surrendered (see SECTION 16.7.4.3 CASH VALUE OF ANNUITIES THAT CAN BE SURRENDERED).
- Annuities purchased on or after March 1, 2004, that cannot be surrendered, but can be sold on the secondary market (see SECTION 16.7.4.4 AVAILABILITY OF ANNUITIES THAT CANNOT BE SURRENDERED (IRREVOCABLE ANNUITIES)).

16.7.4.3 Cash Value of Annuities That Can Be Surrendered

To determine the cash value of ~~annuities~~an annuity that can be surrendered (for example, an annuity in the accumulation phase), use the following formula:

1. Total deposits made to the annuity
2. Plus any earnings on the deposits not previously paid out
3. Minus any earlier withdrawals and any surrender costs charged for the withdrawal. Income tax withheld or tax penalties for early withdrawal should not be deducted from the cash surrender value.

16.7.4.4 Availability of Annuities That Cannot Be Surrendered (Irrevocable Annuities)

An irrevocable annuity may or may not be considered an available, countable asset, depending on when it was purchased and whether it can be sold on the secondary market.

If an irrevocable annuity was purchased **prior to March 1, 2004**, it is considered an unavailable asset on the date the settlement option is made final.

If an irrevocable annuity was purchased **on or after March 1, 2004**, it is only considered unavailable if the owner cannot sell the annuity on the secondary market.

Note	~~1. Total deposits made to the annuity.~~ ~~Plus~~ ~~2. Earnings on the deposits not previously paid out.~~ ~~Minus~~ ~~3. Withdrawals and surrender costs charged for withdrawal.~~ ~~Equals~~ ~~4. Annuity's value~~Even if the annuity contract states that it is "non-assignable" or "non-transferrable," it may still be possible to sell the rights to the income stream. In general, retirement and pension annuities cannot be sold on the secondary market.

~~16.7.4.1.2 Annuities That Cannot Be Surrendered (Effective~~To verify the availability of an irrevocable annuity purchased on or after March 1, ~~2009)~~

~~It has been established that a market exists for annuities that cannot be surrendered. Some companies have purchased such annuities. Check~~2004, the agency must check the annuity contract to see if ~~it~~the annuity (or the right to receive the income stream from the annuity) can be sold~~.~~:

- If it can be sold, it is ~~capable of being sold, consider it to be~~considered an available asset unless the applicant or member demonstrates that ~~he or she has~~they have made reasonable attempts to obtain a fair market price by offering the annuity for sale to companies active in the annuities market.
- If it appears that the annuity cannot be sold, verify this by having the annuity contract reviewed by a company active in the annuities market for an opinion of its value to the company. If the company documents an amount at which it values the annuity or the right to the payments, that amount ~~will be~~is considered an available asset. The annuity is considered an unavailable asset if the company provides documentation that it places no value on the annuity. Unavailable annuities must be evaluated for possible divestment (see SECTION 17.2.6.14 IRREVOCABLE ANNUITIES).

~~The annuity will be considered to be an unavailable asset if documentation is provided from the company stating that it places no value on the annuity. Payments from an annuity that is considered to be unavailable must be counted as income. Annuities that are considered to be unavailable must also be evaluated for possible divestment, in accordance with .~~

Example ~~2.~~1	Cynthia is 83 years old and applying for Medicaid. She ~~owns~~purchased an immediate annuity ~~purchased~~ for $110,000 after March 1, 2004. The annuity is paying out and cannot

	be surrendered. ~~It~~The contract states that it is irrevocable and non-~~transferable.~~assignable. It appears from the contract that it cannot be sold. The agency ~~has~~verifies this by having the annuity contract reviewed by a company in the annuities market. The company provides the agency with a written statement that it would value Cynthia's annuity contract at $82,000. Cynthia's annuity is therefore considered to be an available asset with a value of $82,000, which is the amount used to determine Cynthia's Medicaid eligibility. The payments from the annuity are not counted as income.

Example ~~3.~~2	Sam is 66 years old and applying for Medicaid. He ~~owns~~purchased an immediate annuity ~~purchased~~ for $110,000 after March 1, 2004. The annuity is paying out and cannot be surrendered. ~~It~~The contract states that it is irrevocable and non-~~transferrable~~transferable. It appears from the contract that it cannot be sold. The agency verifies this by having the annuity contract reviewed by a company in the annuities market. The company provides the agency with a written statement that it places no value on Sam's annuity contract. Sam's annuity is therefore considered to be an unavailable asset in determining his Medicaid eligibility. The payments from the annuity are counted as income. Because the annuity is unavailable and was purchased during the look back period, it must be evaluated for possible divestment.

~~**16.7.4.2 Annuities Purchased Before March 1, 2004**~~
~~Annuities that can be surrendered (in the accumulation phase)~~
~~The accumulation phase of an~~

16.7.4.5 Annuity Disclosure Requirement for Long-Term Care

People applying for or receiving Medicaid long-term care services are required at application and renewal to disclose information about any annuities that meet **both** of the following criteria:

- The institutionalized person or their community spouse has an interest in the annuity~~ is the period when the purchaser puts money into~~ .
- The annuity was purchased or substantively changed on or after January 1, 2009.

The following actions are considered substantive changes:

- Additions of principal
- Elective withdrawals
- Requests to change the distribution of the annuity~~. During~~
- Elections to annuitize the ~~accumulation phase,~~contract
- A change in ownership
- Any other non-routine action not listed below

The following actions **do not** subject an annuity that was purchased prior to January 1, 2009, to the disclosure requirement:

- Routine transactions such as notification of an address change, notification of death or divorce of a remainder beneficiary, and other similar circumstances
- Changes that occur based on terms of the annuities that existed prior to January 1, 2009, and which do not require a decision, election, or action to take effect
- Changes beyond the control of the individual, such as a change in law, a change in the policy of the issuer, or a change in the terms based on other factors, such as the issuer's economic status

A separate annuity disclosure form (Annuity Information - Disclosure, F-10192) must be completed for each annuity owned by the institutionalized person or their community spouse. This form must also be sent to SSI recipients who are applying for a community-based long-term care program (including Family Care, Family Care Partnership, and PACE). A copy of the completed form and any documents verifying the status of the annuity must be stored in the case file.

If the long-term care applicant or member, their spouse, or representative **refuses to disclose the required information** related to the annuity, the applicant or member is **ineligible for Medicaid long-term care** services for failure to cooperate in providing requested information.

16.7.4.6 Remainder Beneficiary Designation Requirement for Long-Term Care

After receiving the completed annuity disclosure form, the IM agency must send the Issuer of Annuity - Notice of Obligation (F-10190) to the annuity issuer instructing them to make the Wisconsin Department of Health Services Estate Recovery Program a remainder beneficiary. The issuer must be allowed up to 30 days to confirm the designation has been made.

The Wisconsin Department of Health Services Estate Recovery Program must be the primary remainder beneficiary unless a community spouse, disabled child, or minor child is ~~an~~ listed as the primary remainder beneficiary. If a community spouse, disabled child, or minor child is the primary beneficiary, the Wisconsin Department of Health Services Estate Recovery Program must be the secondary remainder beneficiary.

When the issuer responds and indicates that the state has been designated the remainder beneficiary or that there is no death benefit available ~~asset because the annuitant can cash it in for its cash value~~ under this annuity, the annuity must be treated as meeting the designation requirement, and the agency should proceed with the long-term care eligibility determination.

~~Cash value (also known as surrender value) equals:~~

1. ~~Total deposits made to the annuity.~~

~~+~~

2. ~~Earnings on the deposits not previously paid out.~~

~~–~~

3. ~~Withdrawals and surrender costs charged for withdrawal.~~

~~In determining the cash value, do not deduct income tax withheld or tax penalties for early withdrawal.~~

~~Annuities in the pay-out phase (cannot be surrendered)~~

~~The pay-out (annuitization) phase begins at the time payments start going to the annuitant in accordance with the settlement option. The settlement option specifies the way the funds from the annuity will be paid out. It involves choosing the amount of each payment, how often payments will be made, and the length of time over which the payments will be made.~~

~~An annuity becomes an unavailable asset on the date the settlement option is made final. This means even if the payment starts months later, it is unavailable on the date the settlement option is made final.~~

If the issuer does not respond within 30 days of the date when the Notice of Obligation form was sent, the IM agency must contact the issuer by phone and request that they respond within 10 days. If the issuer does not respond within 40 days after the Notice of Obligation form was sent, the agency should contact the CARES Problem Resolution Center for further guidance.

If the form from the annuity issuer indicates that the remainder beneficiary designation change is in process and provides a date by when the designation will be completed, the IM agency should treat this

annuity as meeting the designation requirement and proceed with the long-term care eligibility determination. If the issuer fails to confirm that the designation change has been completed by the date indicated on the form, the IM agency must contact the issuer and request that they confirm within 10 days that the changes have been completed. If the issuer has not responded 10 days after the request was made, contact the CARES Problem Resolution Center for further guidance.

Once the state has been designated as the remainder beneficiary, the annuity issuer must notify the local agency about any changes made to that annuity to ensure the annuitant does not change the terms of the annuity beneficiary designation at a later date. The issuer acknowledges this obligation by completing and returning the Notice of Obligation form.

Copies of the completed forms must be saved in the case file.

The IM agency should not make a final decision on the Medicaid long-term care application until one of the following occurs:

- The applicant provides the required disclosure or beneficiary designation forms by the verification due date.
- Verification has been received that the Wisconsin Department of Health Services has been legally named as the appropriate remainder beneficiary of the annuity or that no death benefit is available under the annuity.
- Verification has been received that the beneficiary designation change is in process.
- The issuer indicates that the applicant, member, or spouse failed to cooperate with the issuer's process to name the State as a remainder beneficiary.
- The IM agency receives direction from the CARES Problem Resolution Center to certify the applicant or member for Medicaid long-term care coverage.

A **divestment penalty period** must be imposed for applicants and members who **refuse to cooperate** in this annuity beneficiary designation process. The divested amount is the full purchase price of the annuity.

16.7.33 Certain Payment Types Related to the COVID-19 Pandemic

There is no uniform policy for how to count payment types related to the COVID-19 pandemic; some payment types are counted as assets and some payment types are not counted as assets. The criteria used to evaluate whether a payment type is counted as an asset include:

- The text of the federal law that authorized the payment type~~;~~
- Guidance received from federal agencies~~; and~~
- Whether the payment can be considered "disaster assistance~~".~~"

~~The payment types that count as assets (according to the specific policies noted below) include but are not limited to:~~

- ~~Federal recovery rebates (sometimes referred to as Coronavirus stimulus payments or economic impact payments) issued by the IRS in response to the federal COVID-19 public health emergency should be disregarded as assets for 12 months following the month of receipt. After the 12-month disregard period has passed, count any remaining amount as an available non-exempt asset.~~
- ~~Retroactive Pandemic Unemployment Assistance payments are counted as an asset the month they are received.~~
- ~~Retroactive Pandemic Emergency Unemployment Compensation payments are counted as an asset the month they are received.~~

- ~~Retroactive Federal Pandemic Unemployment Compensation (FPUC) payments are counted as an asset the month they are received. This policy is effective November 23, 2020.~~

The payment types that do not count as assets **include but are not limited to**:

- We're All In Small Business Grants.
- Child Care Counts supplementary payments, which are payments awarded to child care providers.
- Wisconsin Emergency Rental Assistance (WERA) payments.
- COVID-19 Funeral Assistance.
- Emergency Assistance for Rural Housing/Rural Rental Assistance.
- Homeowner Assistance Fund payments.
- Housing Assistance and Supporting Services Programs for Native Americans payments.
- Higher Education Emergency Relief Fund (HEERF) payments.
- Retroactive Pandemic Unemployment Assistance (PUA), Pandemic Emergency Unemployment Compensation (PEUC), Federal Pandemic Unemployment Compensation (FPUC), Mixed Earner Unemployment Compensation (MEUC), Extended Benefits (EB), and Lost Wages Assistance (LWA) payments.
- Federal recovery rebates (sometimes referred to as Coronavirus stimulus payments or economic impact payments) issued by the IRS in response to the federal COVID-19 public health emergency.

17.2 Evaluation of Transfers for Divestment

17.2.5 ~~Verification~~Reserved

~~Verification of a divestment can be provided by the applicant, member, spouse, or someone acting on their behalf. Statements from physicians, insurance agents, insurance documents, and/or bank records that confirm the person's statements should be considered. Self-attestation is not sufficient verification. Verification to show that the divestment was allowed must include both:~~

- ~~Proof of the specific purpose and reason for the transfer.~~
- ~~Information establishing that the resource was transferred for a purpose other than to qualify for Medicaid.~~

17.2.6 Allowed Divestments

17.2.6.1 ~~Sufficient Resources~~Transfers Made for ~~Five Years of Long-Term Care~~a Purpose Other Than to Qualify for Medicaid

A divestment that occurred in the look back period or any time after does not affect eligibility if the person who divested can show that the divestment was not made with the intent to qualify for Medicaid.

The person must present evidence that shows the specific purpose and reason for making the transfer ~~by an applicant or member who has~~and establish that the resource was transferred for a purpose other than to qualify for Medicaid. Verbal assurances that they were 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 institutionalized person or community spouse transferred resources without an intent to qualify for Medicaid. This list is not intended to be all-inclusive; in other situations, the person's intent must be evaluated on a case-by-case basis to determine whether a divestment occurred.

1. Sufficient resources to cover five years of long-term care

A transfer by an institutionalized person or their spouse who, immediately after the transfer, still had sufficient financial resources ~~or Long Term Care~~(including long-term care insurance ~~for at least a~~) to cover five ~~year period at the time~~ years of ~~the transfer~~ long-term care is an allowed divestment and doesn't result in a penalty period.

For the average monthly nursing home cost of care in effect at the time of ~~a divestment~~the transfer, see Section 39.4.3 ~~Institutional Cost of Care Values.~~ LTC Post-Eligibility Allowances (view history pages for prior year amounts).This cost per month multiplied by 60 months provides the amount to compare to the income, assets, and insurance held by the individual ~~at the time of~~immediately after the ~~divestment~~transfer.

Example ~~11~~1:	Lucius had a money market account ~~that could pay for more than five years of Long Term Care services. At that time,~~. Lucius gave his nephew a graduation present ~~to his granddaughter~~ worth $25,000. After the gift, Lucius' money market account still had enough funds to pay for more than five years of long-term care services. Two years later, Lucius ~~suffers~~suffered a traumatic brain injury and ~~is~~was institutionalized. Because the cost of specialized nursing home care is significantly greater than a regular nursing home,

	Lucius depletes his money market account and must apply for ~~institutional~~Institutional Medicaid after only two years. Because Lucius still had enough money to pay for five years of care at a regular nursing home ~~at the time~~after he gave the gift to his ~~granddaughter~~nephew, the gift is an allowed divestment and doesn't result in a penalty period.

Example ~~12~~2:	Pierce had an investment portfolio with assets that could pay for more than five years of ~~Long Term Care~~long-term care services. ~~At that time,~~ Pierce paid for his granddaughter to take a trip to Europe. Immediately after the transfer, his investment portfolio still contained enough funds to pay for more than five years of long-term care services. Later, his investments plummeted in value due to the stock market~~,~~. Before the stock market recovered, he entered a nursing home and ~~he~~ quickly spent his remaining assets on his care. Pierce then applied for Medicaid to continue receiving his necessary ~~Long Term Care~~ long-term care services. Because Pierce still had enough assets to pay for his long-term care for five years ~~when~~immediately after he made the gift to his granddaughter, the gift is an allowed divestment and doesn't result in a penalty period even though the gift was in Pierce's ~~look back~~look back period.

~~**17.2.6.2 Life Expectancy of Less Than Five Years**~~

2. Sufficient resources to cover long-term care for remaining life expectancy

A transfer by an institutionalized person or their spouse is an allowed divestment ~~is allowed~~ and doesn't result in a penalty period if both of the following conditions are met:

- The institutionalized person's life expectancy was less than five years at the time of the transfer~~.~~ (see SECTION 39.8 LIFE EXPECTANCY TABLE).
- ~~The~~ Immediately after the transfer, the institutionalized ~~person's~~ person still had sufficient resources~~,~~ (including long-term care insurance~~, or both were sufficient~~) to pay for their long-term care services for their remaining life expectancy~~.~~

~~-~~For the average monthly nursing home cost of care in effect at the time of the ~~divestment~~transfer, see SECTION 39.4.6 ~~Institutional Cost of Care Values.3~~ INSTITUTIONAL COST OF CARE VALUES (view history pages for prior year amounts). This cost per month multiplied by 60 months provides the amount to compare to the income, assets, and insurance held by the individual ~~at~~immediately after the ~~time of the divestment~~transfer.

~~17.2.6.~~3. Unexpected ~~Need~~need

An unexpected need is evaluated by considering the institutionalized person's health and age at the time of the divestment. If the institutionalized person did not anticipate the need for ~~Long Term Care~~long-term care services in the next five years and divested, it is an allowed divestment and doesn't result in a penalty period.

Example ~~13:~~3	Gerard had no health issues, was gainfully employed, and was 50 years old when he gave $50,000 to his daughter. Two years later, Gerard experienced a heart attack that caused him to need ~~Long Term Care~~long-term care services for the rest of his life. When he gave the $50,000 to his daughter, Gerard was not expected to have set aside resources for five years of long-term care. This gift is an allowed divestment and doesn't result in a penalty period.

~~17.2.6.~~4. Pattern of ~~Gifting~~gifting

If the institutionalized person or their spouse had a pattern of gifting money, such as to family members~~ ~~or charities, prior to the ~~look back~~look back period, similar divestments during the ~~look back~~look back period are allowed and don't result in a penalty period if both of the following conditions are met:

- There is no gap in the years or occasions the gifts occurred.
- The total value of yearly gifts given as part of a pattern don't exceed 15~~ percent~~% of the ~~individual's~~individual or couple's annual gross income ~~(~~in the ~~same~~ year ~~as~~ the ~~gift) and~~gifts were given.
- ~~There is no gap in the years or occasions the gifts occurred (see).~~

This allowed divestment is not limited to gifts made on traditional gift-giving occasions such as birthdays, graduations, and weddings. It can include a pattern of giving to assist family members with educational or vocational goals.

Example ~~14:~~4	Jacques is applying for long-term care. He has five grandchildren~~ and gave each $2,000 when they graduated from high school.~~. Two of Jacques's grandchildren graduated during his look back period~~. Jacques can show a pattern of gifting the $2,000 for~~, and he gave them each $1,000 as graduation ~~to the other grandchildren~~ gifts. The amounts of those graduation gifts did not exceed 15% of his income in the years they were given. Jacques can also show that, prior to the look back period~~. The $4,000~~, he ~~gifted~~gave similar gifts to two of his other grandchildren when they graduated from high school. He has therefore shown that the gifts given to his grandchildren during the look back period ~~is~~ were part of a "pattern of gifting." The gifts are an allowed divestment and ~~doesn't~~don't result in a penalty period.

~~17.2.6.~~5 ~~Spending~~. Resources spent on ~~Support~~support of ~~Dependent Relatives~~dependent relatives

The institutionalized ~~person's current~~person or their spouse's support of dependent relatives who were living with them ~~or their spouse~~ at the time of the transfer is an allowed divestment and doesn't result in a penalty period when either of the following conditions are met:

- The ~~applicant, member,~~institutionalized person or their spouse claims the relative as a dependent for IRS tax purposes~~, or~~.
- The ~~member or~~institutionalized person or their spouse provides more than 50~~ percent~~% of the cost of care and support for the dependent relative.

17.2.6.2 Trusts for Disabled Individuals

A trust for a disabled individual (sometimes called a third-party trust) is an irrevocable trust established solely for the benefit of:

- The grantor's disabled child (of any age)
- Any other disabled person who is under 65 years of age

The beneficiary must meet the definition of disability in SECTION 5.2.1 DEFINITION OF DISABILITY.
If the beneficiary is the grantor's disabled child, the grantor may transfer funds to the trust without penalty at any time, provided that the beneficiary continues to be disabled.

If the beneficiary is not the grantor's disabled child, the grantor may transfer funds to the trust without penalty until the beneficiary turns age 65, provided that the beneficiary continues to be disabled. Anything added to the trust after the beneficiary turns age 65 is a divestment (see SECTION 17.2.7.18 TRUSTS FOR DISABLED INDIVIDUALS ESTABLISHED OR FUNDED AFTER THE BENEFICIARY TURNS 65).

Note	Unlike special needs and pooled trusts, trusts for disabled individuals are not required to have any type of Medicaid "payback provision" that becomes effective upon the death of the beneficiary.

Third-party trusts for disabled individuals in Wisconsin include, but are not limited to:

- WisPACT Trust II
- Life Navigators Community Trust I

A trust for disabled individuals can also be a freestanding irrevocable trust with a private trustee, as long as it meets the conditions above.

17.2.6.~~6~~ 3 Divestment by the Community Spouse After Five Years

17.2.6.~~7~~ 4 Divorce or Separation Action

17.2.6.~~8~~ 5 Involuntary Loss of Property

17.2.6.~~9~~ 6 Intent To Sell for Fair Market Value (FMV)

17.2.6.~~10~~ 7 Undue Hardship Request Is Granted

17.2.6.~~11~~ 8 Transfer of Homestead Property

17.2.6.~~12~~ 9 Transfer of Assets to Spouse or Blind or Disabled Children

17.2.6.~~13~~ 10 Certain Payments to Relatives for Services Provided

17.2.6.~~14~~ 11 Payments to Relatives While the Institutionalized Person Did Not Receive Room and Board

17.2.6.~~15~~ 12 Trusts Established by a Will

17.2.6.~~16~~ 13 Regulated Gambling Losses

17.2.6.~~17~~ 14 Irrevocable Annuities

An irrevocable annuity purchased, created, or substantively changed during the look back period or after eligibility is established may be an allowed divestment.

~~A~~"Substantively changed ~~annuity~~" means ~~any~~ action was taken ~~by an individual~~ that changes the course of payments made under an annuity or the treatment of the income or principal of an annuity. See SECTION 16.7.4.3 ANNUITY DISCLOSURE REQUIREMENT FOR LONG-TERM CARE~~This includes all of the following:~~ for information about what types of transactions constitute a substantive change.

- ~~An addition of principal.~~
- ~~An elective withdrawal.~~
- ~~A request to change the distribution of the annuity.~~
- ~~An election to annuitize the contract.~~
- ~~A change in ownership.~~

~~An irrevocable annuity purchased, created, or changed during the look back period or after eligibility is established is~~

To be an allowed divestment ~~if both and below are true.~~

~~The~~, the annuity ~~names~~must name the ~~"~~Wisconsin Department of Health Services Estate Recovery Program~~"~~ as ~~the~~a remainder beneficiary (see Section 16.7.4.6~~4~~ Remainder Beneficiary Designation Requirement for Long-Term Care) and meet at least one of the following ~~is true:~~ criteria:

~~1. The Estate Recovery Program is the primary remainder beneficiary if there is no spouse, disabled child, or minor child.~~

~~2. The Estate Recovery Program is the secondary remainder beneficiary if there is a spouse, disabled child, or minor child.~~

~~1. At least one of the following is true:~~

1. ~~A~~ The annuity was created through a **retirement account conversion**
   ~~The annuity was~~. This includes annuities created from funds in a Roth IRA, 408 IRA, or other employer-sponsored retirement plan.
2. ~~An~~ The annuity is an **individual retirement annuity** if it is:
   a. ~~The annuity is considered~~Considered an individual retirement annuity according to Sec. 408(b) of the Internal Revenue Code of 1986 (IRC)~~Sec. 408(b) of the Internal Revenue Code of 1986 (IRC),~~, or
   b. ~~The annuity is a deemed~~Deemed IRA under a qualified employer plan according to Sec. 408(q) of the IRC~~Sec. 408(q) of the IRC.~~.

~~1. Purchased~~

3. The annuity ~~is~~was **purchased from a life insurance company or other commercial company** that sells annuities as part of its normal course of business~~.~~, and meets **all** of the following criteria.

~~1. The purchased annuity must meet all of the following:~~

a. **Non-assignable**
   The owner cannot transfer or sign over title, rights, or interested to a third party.

~~a.~~b. **Currently ~~Issuing Equal~~issuing equal monthly payments**
   The annuity is currently issuing substantially equal monthly payments to the institutionalized person or spouse with no balloon, deferred, or graduated payments. Payment amounts may vary due to changes in interest rates.

~~b.~~c. **Full ~~Payback (Period Certain~~payback (period certain)**
   The annuity is a period-certain annuity that returns the full principal and interest within the annuitant's life expectancy as listed in the Period Life Table.

~~c.~~d. **Actuarially Sound**
   The number of months that annuity payments will be issued should be less than the number of months of the individual's life expectancy (multiply figure from the Period Life Table by 12).

Note:	Annuities that provide for indefinite "lifetime payments" may not return the full principal and interest within the member's life expectancy and are not actuarially sound.

For irrevocable annuities that do not meet the above criteria, the divested amount is the full purchase price of the annuity.

Example 20:	Rashon applies for HBCW. He had invested in a Roth IRA while he was working. He converted the IRA to an irrevocable annuity when he retired ~~6~~six months ago and named the Wisconsin Department of Health Services Estate Recovery Program as the beneficiary. Since the annuity meets the conditions in 17.2.6.14 Irrevocable Annuities, the purchase of the annuity is an allowed divestment.

Example 21:	Bowen applied for institutional Medicaid on July 28. On July 18, his community spouse Yun

	used $126,500~~.00~~ of the couple's resources to purchase an irrevocable ~~9~~nine-year period certain immediate annuity from the XYZ Life Insurance Company. Yun is the annuitant. Yun was 74 years old on the date the annuity was purchased and had a life expectancy of 9.75 years (117 months). The annuity will issue regular monthly checks of $1,488.75 for a set period of ~~9~~ nine years or 108 total months. The insurance company will pay out a total of $160,785~~.00~~ over the period of the annuity contract. The contract date of the annuity was July 18 and the first monthly payment was issued on August 18. The annuity names the Wisconsin Department of Health Services Estate Recovery Program as the beneficiary, was purchased from a life insurance company, will issue regular monthly payments, is currently issuing payments and will provide for full return of principal and interest during the community spouse's life expectancy. Therefore, since the annuity meets the conditions in 17.2.6.14 Irrevocable Annuities, the purchase of the annuity is an allowed divestment.

17.2.6.~~18~~ 15 Promissory Notes, Loans, Land Contracts, and Mortgages

17.2.7 Divestments That Are Not Allowed and Result in a Penalty Period

17.2.7.18 Third Party Establishes a Pooled Trust

~~A~~When a third party establishes or adds funds to a trust for the benefit of a disabled person (see SECTION 17.2.6.2 TRUSTS FOR DISABLED INDIVIDUALS~~establishing a pooled trust~~), it is an unallowable divestment and results in a penalty period for the third party ~~if it meets all~~unless either of the following ~~criteria~~conditions are met:

- ~~The beneficiary of the trust is disabled and age 65 or older.~~
- The beneficiary of the trust ~~is not~~was disabled and under the age of 65 at the time of the transfer.
- The beneficiary is third party's disabled child.
- ~~The third party applies for Long Term Care Medicaid or is already eligible for it.~~
- ~~The trust was established during the third party's look back period or after they became eligible for Long Term Care Medicaid.~~

The divested amount is the total amount of funds transferred to establish the ~~pooled~~ trust.

~~17.2.7.19 Third Party Adds Funds to a Pooled Trust~~

~~Any funds added during the look back period or after eligibility is established by a third party to a trust for a disabled individual after the beneficiary turns age 65 is an unallowable divestment and results in a penalty period for the third party when all of the following are met:~~

- ~~The beneficiary of the trust is disabled and age 65 or older.~~
- ~~The beneficiary of the trust is not the third party's disabled child.~~
- ~~The third party applies for Long Term Care Medicaid or is already eligible for it.~~
- ~~The funds were added to the trust during the third party's look back period or after they became eligible for Long Term Care Medicaid.~~

~~The divested amount is the total amount of funds added to the pooled trust.~~

~~17.2.7.20~~ 17.2.7.19 Irrevocably Assigned Life Insurance Funded Burial Contracts With a Remaining Cash Surrender Value

Irrevocable life insurance funded burial contracts (LIFBC) must be evaluated as assets per 16.5.3.1 Irrevocable Assignment of Life Insurance-funded Burial Contracts in order to evaluate for divestment. If the calculations of cash surrender value CSV have any amount left over, that amount is the divested amount. It is an unallowable divestment and results in a penalty period.

Example 38:	Les has irrevocably assigned the ownership of his life insurance policy to a funeral home to fund a burial contract. The face value of the LIFBC is $3,000. The Statement of Funeral Goods and Services shows $3,000 for the pre-arrangement of the funeral, of which $1,300 is designated for a casket and $1,700 for funeral expenses (services and cash advances for such things as flowers and the obituary). The $1,700 funeral expense portion reduces the $1,500 burial fund exclusion (see 16.5.5 Burial Funds), and so $1,500 of this LIFBC is his exempt burial fund. The $1,300 casket doesn't reduce the burial fund exclusion (see 16.5.5 Burial Funds) and is not a countable asset because it is a purchase of a burial space. Because the LIFBC was assigned irrevocably, it must be determined if Les is receiving other goods or services at FMV for the remaining $200 designated for funeral expenses. If he is not receiving goods or services at fair market value, consider the remaining $200 a divestment.

17.2.7.~~21~~ 20 Irrevocably Assigned Life Insurance Funded Burial Contracts With a Face Value That Exceeds the Statement of Funeral Goods and Services

17.2.7.~~22~~ 21 Unregulated Gambling Losses

17.2.7.~~23~~ 22 Voluntary Foreclosure or Repossession

17.2.7.~~24~~ 23 Homestead Property

17.2.7.~~25~~ 24 Jointly Held Assets and Value of the Asset Is Transferred

17.2.7.~~26~~ 25 Adding Someone as an Additional Owner of an Asset

20.3 Mandatory Verification Items

20.3.7 Power of Attorney ~~and~~, Guardianship, or Conservator

~~Verify~~ If the applicant or member states they have a power of attorney ~~and any guardianship type as specified by the court. Ask for any~~, documentation ~~regarding~~of the power of attorney appointment is required. Only a durable power of attorney ~~or court-ordered guardianship. For applications and other relevant applicant information, refer~~for finances is considered to ~~Power of Attorney as "Power of Attorney for Finances."~~

~~The IM agency must determine the guardianship type specified by~~be the ~~court. Only~~ power of attorney for health care programs. “Durable” means that the ~~person designated as "guardian of~~ power of attorney continues even if the ~~estate," "guardian of the person and estate," or "guardian in general" may attest to the accuracy of the information on the application form and sign it. Do not require a "conservator" or "guardian of the person" to sign the application form~~applicant or member becomes incapacitated.

If the applicant or member states they have a legal guardian, documentation of the court-ordered guardianship is required.

If the applicant or member states they have a conservator, documentation of the court-ordered conservatorship is required.

If verification is not provided, do not grant the claimed power of attorney ~~or~~, guardian, or conservator access to case notices or follow any direction provided by that person unless ~~he or she is~~they are an authorized representative. Do not deny or terminate eligibility for failure to provide the requested verification.

20.7 When to Verify

20.7.3 Date of Death Matches

~~When a~~Wisconsin Medicaid uses data exchanges with the Wisconsin Vital Records Office and the Social Security Administration (SSA) to identify when an applicant or member has died and to verify the date of death.

When date of death (DOD) information received from Vital Records exactly matches an applicant or member's SSN and other demographic information, it is considered verified, and a notice of decision is sent to the household. No refutation period is required.

When DOD information received from Vital Records matches an applicant or member's SSN but does not exactly match other demographic information, another source, such as a family member or another data exchange, must be used before the DOD can be considered verified.

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

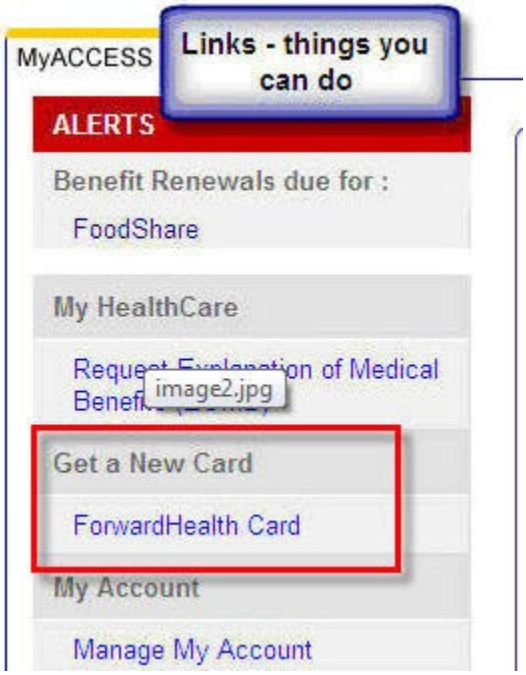
This 10-day period is known as the "refutation period." A letter is automatically sent to the primary person requesting a response if the individual is not deceased. The response due date must be extended to a longer period to allow for mailing delays due to weekends or holidays (will follow the VCL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

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

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

21.7 ForwardHealth Cards

21.7.5 Lost/ or Stolen Cards



If a member needs a replacement card, ~~he or she~~ they or an authorized representative, can request a replacement card by:

1. Going to ACCESS.
    1. Create ~~a~~ an ACCESS Account, then
    2. Go to your ACCESS Account Home Page and select a new ForwardHealth card (see ACCESS User Guide, Section 4.10 Get a New Card~~,~~), or
2. Contacting Member Services at 1-800-362-3002.

Workers may also log into the Partner Portal and select "Replacement ID Card Request" under the Quick Links on the right side of the page.

If the member has multiple benefit ID cards, there will be a choice of which ID card to request. A new ForwardHealth card will be created the evening of the request and will be sent out the following business day.

Replacement cards are issued automatically when the card has been returned as undeliverable and the member's address changes.

~~You cannot request replacement cards using F-10110 (formerly DES 3070) or CARES.~~

22.2 Overpayments

22.2.2 Overpayment Calculation

22.2.2.2 Overpayment Amount

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

Earned income information available through the State Wage Information Collection Agency (SWICA) or through Equifax from the Federal Data Services Hub (FDSH) can be used as best available information when determining if an overpayment has occurred. When using these data sources as best available information, Equifax information from the FDSH must be looked at first. If this information is reasonably compatible with what the member reported (see section 20.3.8.1 Reasonable Compatibility for Income for Health Care and 22.2.1.2.4 Eligibility and Premium Determinations Based on Reasonable Compatibility), there is no overpayment. If there is no Equifax information from the FDSH or it is incomplete, SWICA information can be used. If this information is reasonably compatible with what the member reported, there is no overpayment.

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

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

If a case was ineligible due to excess income, the overpayment amount is the lesser of the following:

- Fee-for-service claims and any HMO capitation payments Medicaid paid. Any contributions made by the member (such as premiums) for each month in which an overpayment occurred are deducted from the overpayment amount.
- The amount the member would have paid toward a deductible (if eligible for a deductible)

If a case or person was ineligible for reasons other than excess income or wasn't eligible for a deductible, the overpayment amount is the amount of fee-for-service claims paid by the state and any HMO and MCO capitation rates the state paid. Any contributions made by the member (for example, premiums or cost share) for each month in which an overpayment occurred are deducted from the overpayment amount.

~~For~~See the following sections for more information about overpayment amounts for ~~long-term care (), MAPP (), and deductible () cases, see the appropriate sections.~~different subprograms:

- Section 22.2.2.2.1 Long Term Care Overpayments
- Section 22.2.2.2.2 Deductible-Related Overpayments
- Section 22.2.2.2.3 Medicaid Purchase Plan Overpayments
- Section 22.2.2.2.4 Qualified Medicare Beneficiary Overpayments

24.3 Deductible Period

The Medicaid deductible period is a period of six consecutive months. It is the length of time the group has for meeting the Medicaid deductible. See SECTION 5.9.5 ELIGIBILITY for an exception to the six-month deductible period for backdate periods after a formal disability determination has been made for a member certified under a presumptive disability.

The applicant can choose to begin the Medicaid deductible period as early as three months prior to the month of application and as late as the month after the month of application.

Example 1:	John applies for Medicaid in July. He can choose to begin his six-month Medicaid deductible period in April, May, June, July, or August.

However, the first month of a deductible period may not be a month in which the person is ineligible for excess assets or is non-financially ineligible. The applicant may choose a six-month deductible period that includes one or more months (except for the first month) in which they are ineligible for excess assets or for a non-financial reason. Excess income is still calculated and included in the deductible amount for any months that the applicant may be ineligible due to assets or a non-financial reason. If the applicant meets the deductible, they may only be certified for Medicaid during the months when they were non-financially and asset eligible.

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 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, but no longer had the $5,000 on June 30. Her deductible period will run from April through September. However, if she meets the deductible in April, she would only be eligible through the end of April and from June 1 to September 30. If she meets the deductible in May, she would only be eligible from June 1 to September 30. Due to excess assets in May, she may not be eligible for any day in that month.

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 30 through May 18. She meets the deductible with a countable expense from April 10, so she should be certified from April 10 through April 29, and May 19 through September 30.

Example 5:	Janet applies for Medicaid in July and requests a Medicaid deductible period from April through September. She gave birth on June 30. Janet paid the full deductible amount, so is certified from April 1 through June 30.

For backdate months, when a person had excess assets in any of the three months prior to the month of application, his or her eligibility in the backdate month is determined by whether or not they had excess assets on the last day of the month.

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 received a $10,000 gift. On May 29, he spent the $10,000 on a new roof. His assets were below the asset limit by the last day of the month, and he is otherwise eligible except for excess income for both backdated months, so his deductible period can begin in May.

A new deductible period can be established at any time before the current deductible has been met. The person must sign and submit a new application in order for the new deductible period to be established. A new application is required regardless of when the previous deductible period was established or if anyone in the household is eligible for another health care program such as a Medicare Savings Program.

Example 7~~:~~	Jeff applies for Medicaid in January. His monthly excess income is $100. His Medicaid deductible is $600 and his deductible period is January 1 through June 30. In April, Jeff's monthly excess income decreases to $10 a month. Jeff reports the decreased income in April and now has a choice between two different deductible recalculations. He can either have the agency recalculate the original $600 deductible which would then become a $330 deductible (three months of $100 excess income and three months of $10 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 through September with a $60 deductible obligation ($10 x 6 = $60). 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 Section 24.6.1 Income or Deduction Changes).

Members who have been certified for Medicaid after meeting a deductible will have to complete a renewal to establish a new deductible period. No renewal notice is sent regarding the new deductible period if the applicant did not meet the deductible for the current period.

24.7 Meeting the Deductible

24.7.1 Countable Costs

24.7.1.1 Countable Expenses

The following are expenses that can be counted against the deductible if they meet the conditions listed in 24.7.1 Countable Costs:

1. Medical expenses. Medical expenses are costs for services or goods that have been prescribed or provided by a professional medical practitioner (licensed in Wisconsin or another state) regardless of whether the services or goods are covered by Medicaid. Medical expenses for services or prescriptions acquired outside of the United States may be counted toward a deductible if a licensed medical practitioner or pharmacy provided the service or drug.

   Some examples of medical expenses are deductibles and co-payments for Medicaid, for Medicare, for private health insurance; and bills for medical services which are not covered by the Wisconsin Medicaid program.

Note:	ForwardHealth interChange (iC) data may be used to calculate Medicaid co-payments from the previous deductible period.

2. Remedial expenses. Remedial expenses are costs for services or goods that are provided for the purpose of relieving, remedying, or reducing a medical or health condition. Some examples of remedial expenses ~~are~~include:
   a. Case management
   b. Day care~~.~~
   c. Housing modifications for accessibility~~.~~
   d. Respite care~~.~~
   e. Supportive home care~~.~~

      Supportive Home Care is necessary assistance to help people meet their daily living needs, ensure adequate functioning in their home, and safely access their community. Services may include:
      i. Assistance with activities of daily living
      ii. Attendant care
      iii. Supervision
      iv. Reporting changes in the participant's condition~~,~~
      v. Assistance with medication and medical procedures which are normally self-administered~~, or~~
      vi. The extension of therapy services, ambulation and exercise~~.~~
      vii. Tasks associated with routine household upkeep, including general housekeeping chores, lawn mowing, snow removal, changing storm or screen windows and other household services that are essential to the participant's safety, well-being and care at home~~.~~

   ~~1. Transportation.~~
   f. Transportation to obtain medical care. This includes but is not limited to taxi, rideshare services, bus fares, or a person's own vehicle at a cost of $0.24/mile. A transportation log is sufficient verification. The log should provide the time and date of the appointment, name and address of the provider, time departed, time returned, and miles driven.

~~f.~~g. Community Based Residential Facility (CBRF), Adult Family/Foster Home (AFH), Residential Care Apartment Complex (RCAC), and all other community substitute care setting program costs not including room and board expenses.

~~g.~~h. Remedial expenses do not include housing or room and board expenses.

~~h.~~i. CBRF, AFH, RCAC, and all other community substitute care setting program costs, not including room and board expenses, can be counted as a remedial expense only as they are incurred. CBRF, AFH, RCAC and all other community substitute care setting program costs will be considered incurred as of the date that the member is billed for these expenses by the CBRF, AFH, RCAC or other community substitute care setting. The billing procedure used by the CBRF, AFH, RCAC or other community substitute care setting (one month in advance, bimonthly, etc.) for Medicaid residents should be the same as that which is used for its non-Medicaid residents.

~~i.~~j. In determining how much of a CBRF, AFH, RCAC or other community substitute care setting expense can be applied to meet a medical deductible, use the facility's breakdown of the room and board versus program costs, with the program costs to be applied to the deductible.

3. Ambulance service and other medical transportation (21.4.2 Transportation).
4. Medical insurance premiums paid by a member of the fiscal test group or FFU. These insurance premiums include disease specific and per diem hospital and nursing home insurance payments. This includes all Medicare premiums paid by the member. Do not allow accidental insurance policy premiums as a countable cost.

Note:	Unlike other expenses listed in this section that may not be applied toward a deductible until they are incurred, count medical insurance premiums from the first day of the deductible period, if the premium will be coming due anytime during the current deductible period. This includes all Medicare premiums owed by the member during the deductible period.

5. Medical bills paid by a party who is not legally liable to pay them can be counted against a deductible.

   Examples of parties that pay medical bills when not legally liable include, but are not limited to: Churches, fraternal organizations, Children's Special Health Needs Unit of the Division of Public Health, Veterans Administration and the AIDS Drug Assistance Program (ADAP).
6. Medical services received at a Hill-Burton facility. The Hill-Burton Act was enacted by Congress to provide federal assistance for the construction and modernization of health care facilities. Medical facilities which receive Hill-Burton assistance must provide without charge a reasonable volume of services to persons unable to pay for those services.
7. In-kind payments. These are services or goods supplied to the provider in lieu of cash. Self declaration of the bill being satisfied is adequate verification.
8. Medical or remedial expenses that are paid or will be paid by a state, county, city or township administered program that meets the conditions detailed in 24.7.1. # 3.

   Examples include:
   a. General Assistance
   b. Community Options Program
   c. AIDS Drug Assistance Program (ADAP)

Example 12:	Fred receives a medical service which will be paid by ADAP. When Fred comes in to apply for Medicaid and has to meet a deductible this medical

	bill that has not been paid can be used immediately because it will be paid by the state administered ADAP program.

Example 13:	Sally received a medical service in January which was paid by the state administered, state funded Community Options Program in the same month. In February Sally applies for Medicaid requesting a backdate to January. Sally has excess income and must meet a deductible. Since the medical bill was paid by COP within three months of Sally's Medicaid application it can be used to meet Sally's Medicaid deductible.

9. Medical or remedial expenses that have been paid or will be paid by Indian Health Services that meet the conditions detailed in 24.7.1 # 3

Example 14:	On January 1, Michael received a medical service which will be paid by Indian Health Services. When Michael applies for Medicaid on January 10 he has to meet a deductible. The bill for the January 1 medical services may be used immediately because it will be paid by the Indian Health Services program.

Example 15:	Charlie received a medical service in January which was paid by Indian Health Services in the same month. In February Charlie applies for Medicaid requesting a backdate to January. Charlie has excess income and must meet a deductible. Since the bill was paid by Indian Health Services within three months of Charlie's Medicaid application it can be used to meet Charlie's Medicaid deductible.

10. SeniorCare Enrollment Fees

26.4 MAPP Financial Requirements

26.4.1 Assets

26.4.1.1 Independence Accounts

Someone who has been determined eligible for MAPP can establish an Independence Account after MAPP eligibility has been confirmed. These accounts are an exempt asset. There is no limit to the number of accounts, and no restriction on what the money can be used for. The accounts are for the member to deposit earned and unearned income into. They cannot be used for the member to deposit other assets, such as an inheritance.

Only funds deposited in a registered Independence Account while the member is eligible for MAPP may be exempted from the asset limit. Any deposits made prior to MAPP enrollment or during periods of MAPP ineligibility are not exempt assets.

Note that there are different rules for retirement/pension accounts and non-retirement/pension accounts regarding how they may be registered as Independence Accounts and when funds may be deposited:

- **Existing retirement/pension accounts** may be registered as Independence Accounts after the applicant has been approved for MAPP. The amount that was already accumulated in the retirement/pension account before it was designated as an Independence Account is called the "Pre-Independence Account Balance." The Pre-Independence Account Balance is considered a countable asset when MAPP eligibility is determined. Funds may be deposited in a retirement/pension account designated as an Independence Account during periods of MAPP ineligibility. However, any funds deposited during a period of MAPP ineligibility must be added to the account's Pre-Independence Account Balance and considered a countable asset.
- **Non-retirement/pension accounts** may only be opened and registered as Independence Accounts after the applicant has been approved for MAPP. The amount the MAPP member opens the account with is part of the Independence account balance and is not counted. Non-retirement/pension accounts registered as Independence Accounts may only have funds deposited during months when the member is eligible for MAPP**. If any funds are deposited in a non-retirement/pension account during a period of MAPP ineligibility, the Independence Account's entire balance will be considered a countable asset.**
    - For non-retirement/pension accounts registered as Independence Accounts on or after August 1, 2020, there should be no Pre-Independence Account Balance at any time because the only deposits that are allowed into these accounts are those made while the account owner is a MAPP member.
    - For non-retirement/pension accounts that were registered as Independence Accounts prior to August 1, 2020, any existing amount entered in the Pre-Independence Account Balance field will continue to count for all Medicaid programs, and the Independence Account Balance will be exempt for all Medicaid programs that have an asset test. However, no new funds may be deposited in non-retirement/pension accounts during months when the member is ineligible for MAPP. If new funds are deposited during months when the member is ineligible, the entire asset will be counted.

Example 1:	Sheila is approved for MAPP. She has an established retirement account through her employer that currently has a $5,000 balance. The $5,000 was considered a countable asset during her eligibility determination. Sheila registers the retirement account as an

	Independence Account with the IM agency. The money deposited into this retirement account while Sheila is a MAPP member will be considered an exempt asset as a part of an Independence Account. The $5,000 Pre-Independence Account Balance will continue to be a countable asset.

Example 2:	Mac is approved for MAPP in October. He fills out the Independence Account form to register his already established savings account as an Independence account. The IM worker will be unable to approve this account as an Independence Account because it was opened and established with funds deposited prior to Mac's MAPP eligibility.

Example 3:	Tom is approved for MAPP. After he receives his Notice of Decision, he opens a savings account and registers it as an Independence Account. Tom is eligible for MAPP from July to October, eligible for Medically Needy SSI-related Medicaid from November to December, and eligible for MAPP again in January. Although his Independence Account will be considered exempt when his eligibility for both MAPP and Medically Needy SSI-related Medicaid is determined, he may not deposit any money into the account during November and December because he is not eligible for MAPP during that time. If he does deposit money during those months, the Independence Account's entire balance will be considered a non-exempt asset.

Example 4:	Tom is approved for MAPP. After he receives his Notice of Decision, he registers his existing IRA as an Independence Account. This IRA has a balance of $1,000 prior to registration as an Independence Account, so that $1,000 is a countable asset. Tom is eligible for MAPP from July to October, eligible for Medically Needy SSI-related Medicaid from November and December, and eligible for MAPP again in January. Although the amount deposited into his Independence Account in July, August, September, October, and January will be considered exempt when determining his eligibility for both MAPP and Medically Needy SSI-related Medicaid, any money deposited into the IRA during November and December would be added to the $1,000 Pre-Independence Account Balance and counted as an asset because Tom was not eligible for MAPP during those two months.

To qualify as an Independence Account, an account must be:

1. Registered with the IM Agency.
    a. Completing the F-10121 Medicaid Purchase Plan (MAPP) Independence Account Registration form registers the Independence Account with the IM agency.
    b. Scan the completed F-10121 to ECF and provide a copy to the member.
2. A separate financial account owned solely by the MAPP member.
3. Established after MAPP eligibility is confirmed, with the following exceptions:
    a. Pension and retirement accounts (see Section 26.4.1.3 Pension or Retirement Accounts)
    b. Non-retirement accounts that were registered as Independence Accounts before August 1, 2020 during a member's previous period of MAPP eligibility

Cash, escrow accounts for a home sale, money owed, prepaid debit cards, and tax refunds may not be designated as Independence Accounts.

A member's deposits of earned or unearned income into an Independence Account may total no more than 50% of the member's gross earnings over the 12-month certification period. If the member's

deposits exceed 50% of their actual gross earnings over the same twelve-month period, a penalty is assessed (see Section 26.5.1.1 Independence Account Penalty).

Amounts withdrawn from a MAPP Independence Account during the 12-month certification period do not affect the limit on the gross amount that may be deposited during the same period without penalty.

Example 5:	The agency is processing Fred's MAPP renewal. During the previous 12-month certification period, Fred earned $5,000 from his job and received $12,000 in unearned income. During that same period, he deposited $3,000 into his Independence Account. At one point he withdrew $500 from his Independence Account to pay for car repairs. The penalty is based solely on total deposits in excess of 50% of gross earnings over the twelve-month period. Withdrawals are irrelevant when determining the penalty. In this example, 50% of Fred's $5,000 earned income = $2,500. The $3,000 in deposits - $2,500 = $500 penalty.

26.5 MAPP Premiums

26.5.1 Calculation

MAPP premiums are calculated using only the member's income. A premium is calculated if the member's monthly Premium Gross Income exceeds 100% of the FPL (see Section 39.5 Federal Poverty Level Table) for a group of one.

Tribal members are not exempt from paying MAPP premiums (unlike BadgerCare Plus premiums). Federal statutes for MAPP supersede other parts of the law that exempt tribal members from premiums and copayments for services.

To calculate monthly premium amount:

1. Determine the member's Premium Gross Income by adding together the member's monthly gross earned income and gross unearned income.
2. Determine Countable Net Income by subtracting the following deductions from the member's Premium Gross Income:
    a. The member's own verified monthly impairment-related work expenses (any amount)
    b. The member's own verified monthly out-of-pocket medical/remedial expenses (any amount)
    c. The current COLA disregard from January 1 through the date the FPL is effective in CARES for that year, if applicable
3. Determine Premium Net Income by subtracting 100% of the FPL for a group size of one from the countable net income. If this results in a negative number, change it to zero.
4. Multiply the premium net income by three percent (0.03).
5. Add the $25 Base Premium Amount and round down to the nearest whole dollar.
6. If applicable, add the Independence Account overage amount (see the Medicaid Eligibility Handbook, Section 26.5.1.1 Independence Account Penalty).

The result is the member's monthly premium amount.

Note:	503, DAC, widow or widower disregards allowed in eligibility determinations cannot be allowed in premium calculations.

Example 1:	Shannon applies for MAPP. Her Premium Gross income is under 100% of the FPL. She has no premium.

Example 2:	Michael applies for MAPP. His Premium Gross income is 105 percent of the FPL. Even though his impairment-related work expenses and medical/remedial expenses decrease his Premium Net Income to $0, Michael will still have a $25 monthly MAPP premium.

Example 3:	Susan is a MAPP member whose Premium Gross income is 194% of the FPL. When her allowable deductions are taken in the premium calculation, her Countable Net Income is $1,750. Her monthly MAPP premium will be calculated as shown below: $2,200 Premium Gross Income – $300 monthly IRWE deduction – $150 monthly medical/remedial deduction ---------- $1,750 Countable Net Income – $1,132.50 (100% of the FPL) ----------

	$617.50 Premium Net Income X 0.03 (3%) ---------- $18.53 +$25 Base Premium Amount ---------- $43.53 (round down to nearest whole dollar) Susan’s monthly MAPP premium is $43.

27.1 Institutions

27.1.4 Minors in a Medical Institution

Minor children who reside (or are likely to reside) in a hospital or other medical institution for 30 or more days can be eligible for Institutional Medicaid if they are determined disabled or presumptively disabled (see SECTION 5.2 DETERMINATION OF DISABILITY and SECTION 5.9 PRESUMPTIVE DISABILITY). For Institutional Medicaid, a blind or disabled minor is a one-person fiscal test group. Only the child's income is counted. No parental income is deemed to the institutionalized minor.

Hospitalized children under the age of 19 who have not been determined disabled or presumptively disabled must be tested for BadgerCare Plus with their families.

See Process Help, Section 11.2.4 Health Care Applications for Institutionalized Children for processing instructions.

29.1 Katie Beckett

~~The~~ Katie Beckett ~~Program tests qualified blind and/or disabled minors for~~ Medicaid~~. It~~ is a special eligibility pathway for children under 19 who have certain health care needs and live at home. Katie Beckett provides Medicaid health care coverage for children who qualify. Katie Beckette Medicaid does not deem assets and income from parents or legal guardians.

To qualify for Katie Beckett Medicaid, a child must:

- Be under age 19.
- Meet the ~~Katie Beckett Program, a blind or disabled minor:Must require a level~~Social Security Administration's definition of ~~care provided~~ "disabled."
- Be a U.S. citizen or qualifying immigrant.
- Be a Wisconsin resident.
- Live at home, in a foster care setting, or in another eligible community-based setting.
- Require the kind of care typically provided by a hospital, SNF, ICF, or~~ICF~~ long-term care facility.
- ~~Can appropriately~~Be able to receive ~~this~~safe and appropriate care ~~in their~~at home.
- ~~Would be nonfinancially eligible for Medicaid if they were in a hospital, SNF, or ICF.~~
- ~~Must have~~Have income below the Institutions Categorically Needy income limit (see Section 39.4.1 Elderly, Blind, or Disabled Assets and Income Table). The only income used in this calculation is the child's income. There is no asset test for children.
- Not require care at home that would cost more than the care they would receive in a long-term care facility covered by Medicaid.

Members enrolled in Katie Beckett Medicaid are only subject to estate recovery when they have resided in a hospital or nursing home for 30 or more continuous days. Only the child's estate (not the parent's or legal guardian's) is subject to estate recovery requirements. See SECTION 22.1 ESTATE RECOVERY for the criteria used to determine whether services are recoverable.

Families may contact ~~the~~ Katie Beckett ~~Program~~Medicaid Central Office by:

- Calling 888-786-3246.
- Emailing DHSKatieBeckett@dhs.wisconsin.gov.
- Faxing information to 888-786-3261.
- Writing to the following address:

Katie Beckett ~~Program~~
Division of Medicaid Services
Bureau of Children's Services
1 West Wilson Street, Room 418
Madison, WI 53707