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

To: Medicaid Eligibility Handbook Users

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

Re: **Medicaid Eligibility Handbook Release 23-02**

Release Date: 04/17/2023

Effective Date: 04/17/2023

EFFECTIVE DATE		The following policy additions or changes are **effective 04/17/2023** unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY UPDATES		
2.6	**Filing Date**	Updated to explain significance of filing date and clarify policy
2.7	**Application Processing Period**	Updated verification deadlines.
2.9.2	**Denial**	Clarified policy on late submission of verification.
3.1.6	**Late Renewals**	Updated verification deadlines.
5.9	**Presumptive Disability**	Updated impairment categories.
7.2	**Verifying U.S. Citizenship**	Clarified when verification of identity is required.
7.3.3.4	**Afghan Parolees**	Updated dates.
7.3.4	**Public Charge**	Section rewritten.
8.2	**Medical Support**	Updated to align with BadgerCare Plus Handbook.
8.3.2	**Notice**	Updated to align with BadgerCare Plus Handbook
15.3.26.1	**Aid & Attendance (A&A) and Housebound Allowances**	Added a cross reference for allowance amounts.
15.3.30	**Certain Payment Types Related to the COVID-19 Pandemic**	Updated to match federal information.
16.6.6	**Pooled Trusts**	Added Life Navigators Pooled Trust III to list of exempt pooled trusts.
17.2.6.8	**Transfer of Homestead Property**	Clarified policy on date of homestead transfer.
17.2.7.12	**Life Estate - Termination and Payment of Less than FMV**	Clarified the definition of divested amount.
19.1	**Applicant and Member Access Rights**	New section.
19.2	**Releasing Information**	New section.
20.3.1	**Mandatory Verification Items Introduction**	Updated list of items to verify for Medicaid.
20.3.2	**Social Security Number**	Updated list of items to verify for Medicaid.

20.7	**When to Verify**	Updated list of items to verify for Medicaid.
21.6.1	**SSI HMO Enrollment**	Added information about groups restricted from HMO enrollment.
22.2	**Overpayments**	Updated policy to no longer pursue health care member overpayments.
22.5	**Legal Guardians, Conservators, Power of Attorney, and Other Representatives**	Updated section title.
22.5.4	**Legal Guardians and Conservators**	New section.
22.5.5	**Power of Attorney**	New section.
23.2	**Fair Hearings**	Section rewritten.
25.1.3	**Calculating the Cost-of-Living Adjustment Disregard**	Removed instruction to subtract state-paid Medicare premiums from gross OASDI when calculating COLA disregard.
26.3.4	**Work Requirement Exemption**	Clarified exemption policy.
26.4.1.1	**Independence Accounts**	Clarified language about earned and unearned income.
27.11	**Institutions for Mental Disease**	Removed Waukesha County Mental Health Center from IMD list.
32.2.1	**Introduction**	Updated list of members eligible for QMB.
32.11	**Medicare Beneficiaries Adversely Affected**	Section rewritten.
34.1.5	**Emergency Services and Public Charge**	New section.
39.6	**COLA Disregard**	Updated policy for finding OASDI income.
39.13	**VA Allowance Rates**	New section.

2.6 Filing Date

The application filing date helps determine when an applicant can start getting benefits if they meet program rules (see SECTION 2.8 BEGIN DATES).

2.6.1 In Person/Mail/Fax

The filing date is the day a signed, valid application/registration form (F-10101 or F-10182) or registration form (F-10129) is received by the IM agency or the next business day if it is received after the agency's regularly scheduled business hours.

2.6.2 By Telephone

When a request for assistance is made by telephone, the filing date is set when a telephonic signature or signed application/registration form is received by the agency.

2.6.3 By ACCESS

The filing date on an ACCESS application is the date the application is electronically submitted.

2.6.4 Low Income Subsidy Program of Medicare Savings Programs

~~LIS data sent~~ Low Income Subsidy (LIS, also called Extra Help) application information sent to DHS electronically ~~to CARES~~ from the Social Security Administration (SSA) is considered a request for ~~MSP and must be processed using the same processing guidelines that would be followed~~ Medicare Savings Programs (MSP). The filing date for the MSP request is the filing date set by SSA for the LIS application.

Because the LIS data sent by SSA does not provide enough information to determine if ~~a request for MSP was submitted directly by~~ the applicant~~.~~
~~Because the data sent by SSA is not sufficient to determine~~ is eligible for Medicaid or MSP ~~eligibility~~, the LIS data ~~from the LIS application will be~~is used to establish ~~an~~ a request for assistance (RFA ~~in CARES.~~).
The contact date ~~on the RFA~~ is the date when DHS receives the LIS data ~~was received by DHS from SSA. The filing date for the MSP request is the filing date set by SSA for the LIS application.~~
~~A completed, timely application will have to be submitted by the applicant to the local agency in~~from SSA. In order for the agency to determine if the LIS applicant is eligible for Medicaid and MSP ~~eligibility for,~~ the ~~person. If an~~applicant must submit a completed application ~~is not submitted~~ within 30 days of the RFA contact date. If the applicant does not submit a timely application, the RFA ~~will be~~is withdrawn automatically ~~withdrawn and a notice generated~~.

2.6.5 Federally~~-~~ Facilitated Marketplace

The filing date for applications received from the Federally Facilitated Marketplace (FFM) is the date the application was submitted to the FFM.

2.7 ~~Time Frames~~Application Processing Period

~~2.7.1 Time Frames Introduction~~

All applications received by an agency ~~(except those submitted from the FFM)~~ must be processed and eligibility approved or denied as soon as possible ~~but~~. The health care application processing period is 30 days. This means that, as a rule, the agency must process the application, determine eligibility, and issue a notice of decision no later than ~~30~~the 30th calendar ~~days from when the agency receives the application. This includes issuing a Notice of Decision.~~

~~The 30-~~day ~~time frame for processing applications submitted through the FFM begins~~after the date on which the ~~FFM~~ application is ~~submitted to~~received by the agency ~~inbox.~~

~~The 30-day processing time frame must be~~(or the next business day if the 30th day falls on a weekend or holiday). However, the application processing period is extended as needed to ~~allow~~ensure the applicant has at least ~~10~~20 days ~~to provide requested~~from the mailing date of a verification~~.~~

~~Workers may also extend the 30-day processing time up to 10 days to allow the applicant additional time to provide the information. CARES will issue a pending notice indicating the reason for the delay when appropriate entries are made on the Verification Due page.~~

~~For more information on application denials for failure~~ request to provide verification~~, see .~~.

~~Example 1:~~Note	~~A signed application was received on March 15. The worker processed the application on April 7 and requested verification. Verification was due April 17, but was not received by that date. Even though the end of the 30-day application processing period was April 14, the application should not be denied until April 17 to allow at least 10 days to provide verification.~~For applications submitted electronically, the "date received," for purposes of determining when the application processing period begins, may be different from the filing date (see SECTION 2.6 FILING DATE). For ACCESS and Marketplace applications, the date received is the date on which the application is delivered to the agency or the next business day if delivered weekdays after 4:30 p.m., on a weekend, or on a holiday. For MSP applications originating from LIS data sent by SSA, the date received is the contact date of the request for assistance (RFA).

~~If an agency fails to take action (positive or negative) during the 30-day processing period, and the applicant is subsequently found eligible, as a result of his or her most recent Medicaid application, redetermine eligibility using the filing date associated with that most recent application.~~

Example ~~2:~~1	A signed application ~~was~~is received on ~~May~~March 15. The ~~first day of~~ worker processes the ~~30-day period was May 16. The end of the 30-day period would have been June 14. The~~ application ~~was approved~~ on ~~June 20,~~April 7 and requests verification. Verification is due on April 27 but is not received by that date. Even though April 14 is the 30th day after the filing date, the application must not be denied for lack of verification until April 27 to allow the applicant ~~is determined eligible beginning May 1~~at least 20 days to provide verification.

~~2.7.2 Changes~~

Changes that occur between the filing date and the confirmation date should be used in the initial eligibility determination.

For more information on application denials for failure to provide verification, see Section 20.7 When to Verify.

If an agency fails to act on an application within the 30-day application processing period, the agency must still honor the application's filing date when determining eligibility.

Example 2	A signed application was received on May 15. The first day of the 30-day period was May 16. The end of the 30-day period was June 14. The application was approved on June 20, and the applicant is determined eligible beginning May 1.

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~~they 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 an application is denied because required verification is not received by the due date, but verification is later received within 30 days of the application denial date, the IM agency must consider this as the person re-requesting health care. In this situation, the person does not also need to contact the IM agency to directly re-request health care nor is a new signature required.

Example 2	Cameron applied for health care on April 15. The IM agency processed the application on April 20 and pended for verification of income due May 15. Verification was not received, and the application was denied. Cameron submitted the income verification to the IM agency on May 22. The IM agency considers this a re-request for health care with a new filing date of May 22. No new application or new signature is required.

If the person applied for health care and the IM agency initially denied the health care application (or the only 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~~3	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).

3.1 Renewals

3.1.6 Late Renewals

Late renewals are only permitted for ~~individuals~~members whose eligibility ended because of lack of renewal and not for any other reasons for the following EBD programs:

- EBD Medicaid
- HCBWs
- Institutional Medicaid
- MAPP
- MSP (QMB/SLMB/SLMB+/QDWI).

Late renewals and related-renewal verifications should be accepted for up to three calendar months after the renewal date. Members whose health care benefits are closed more than three months due to lack of renewal must reapply.

Consider late submissions of an online or paper renewal form or a late renewal request by phone or in person as a valid request for health care. The new health care certification date should be set based on receipt of the signed renewal. If verification is required to complete the renewal, the member will have ~~10~~20 days to provide it

If the health care renewal was completed timely but the requested verifications were not provided as part of the renewal, the health care program can be reopened without a new application if these verifications are submitted within three months of the renewal month. The verifications must include information for the current month of eligibility. If verification was submitted for a past month, ~~a new Verification Checklist~~the agency must ~~be generated to~~ request current verification. The member will have ~~10~~20 days to provide it

If a gap in coverage occurs because of a late renewal, the member may request coverage of the past month in which the gap occurred. The member must provide all necessary information and verification for those months and must pay any required premiums to be covered for those months. For EBD Medicaid renewals, the member must provide the missing verification and verify assets for the current month if there was a gap in coverage

Note:	QMB coverage is not retroactive. Members cannot request backdated eligibility for this program.

5.9 Presumptive Disability

5.9.1 Presumptive Disability Introduction

Federal SSI law and regulations state that the SSI program can find ~~an individual~~a person to be presumptively disabled, and the person will be treated as a person with a disability until a final disability determination can be completed. To be treated as presumptively disabled by SSI means that the applicant's benefits can begin before SSA, or its contracted agency, has formally determined the ~~individual~~person to be disabled.
Wisconsin's Medicaid program also allows a determination of presumptive disability.

Presumptive ~~Disability (PD)~~ disability is a method for temporarily determining a disability for ~~an individual~~a person while a formal disability determination is being done by Disability Determination Bureau (DDB~~.~~). Presumptive disability is determined either by ~~the~~ DDB, or in some circumstances, ~~by~~ the IM ~~worker~~ agency. The regular disability application process (see Section 5.3 Disability Application Process) must still be completed for persons with a presumptive disability. A presumptive disability decision stands until ~~the~~ DDB makes its final disability determination.

When the regular disability determination is denied by DDB, a new presumptive disability determination cannot be made for that ~~individual~~person unless there has been a change in the person's condition.

5.9.2 ~~PD~~Presumptive Disability Determined ~~By~~by the IM ~~Workers~~ Agency

When ~~a~~ an applicant or member has an urgent need for medical services attested to in writing by a medical professional, and is likely to be found disabled by DDB because of an apparent impairment, the applicant or member may be certified as presumptively disabled by the IM ~~worker~~agency. When the IM ~~worker~~agency is making the ~~PD~~ presumptive disability decision, they should do so as quickly as possible. However, the normal 30-day application processing ~~requirements~~period applies (see Section 2.7 Application Processing Period~~) are still applicable even for PD determinations.~~).
In determining that the applicant is presumptively disabled, the IM ~~worker~~agency will need a "~~"~~medical professional~~"~~ to attest in writing that:

1. The ~~individual's circumstances constitutes~~person has an urgent need ~~(see)~~ for medical services (see Section 5.9.2.1 Definition of Urgent Need).
2. The ~~individual~~person has one of a certain set of impairments (see Section 5.9.2.2 Impairments~~)~~).

A "medical professional" is defined as any health care provider or health care worker who is familiar with the applicant and is qualified to confirm the presence of an ~~'urgent need'~~ urgent need and the presence of one of the impairments. ~~(~~A medical professional ~~is~~ may be a licensed physician, physician's assistant, nurse practitioner, licensed or registered nurse, psychologist, osteopath, podiatrist, optometrist, hospice coordinator, medical records custodian, or social worker~~.)~~. Some urgent need criteria and impairment categories specifically require a physician to make the attestation, which is noted where applicable.

If someone has an impairment but not an urgent need, the normal disability application process must be followed (see SECTION 5.3 DISABILITY APPLICATION).

5.9.2.1 Definition of Urgent Need

~~A~~ To be considered to have an urgent need, a person must be in one of the following situations ~~to be considered to have an urgent need~~due to a physical or mental health condition:

- The applicant is a patient in a hospital or other medical institution.

- The applicant is seriously impaired, and the attending physician states the applicant will be unable to work or return to normal functioning for at least 12 months.
- The applicant will be admitted to a hospital or other medical institution without immediate health care treatment. For example, someone with schizophrenia who will need to be hospitalized if they do not take prescribed medication has an urgent need if such medication is not available without Medicaid coverage.
- The applicant ~~is in need of~~ needs long-term care, and the nursing home will not admit the applicant until Medicaid benefits are in effect.
- The applicant is unable to return home from a nursing home unless in-home service or equipment is available, and this cannot be obtained without Medicaid benefits.

~~Note: In addition to health conditions of a physical nature, the above criteria may also apply to an urgent need resulting from an individual's serious and persistent mental illness.~~

~~Example 1: Example 1: An individual with schizophrenia who will need to be hospitalized if they do not take prescribed medication has an 1; urgent need' if such medication is not available without Medicaid coverage.~~

5.9.2.2 Impairments

When an urgent need for medical services has been identified, the IM ~~worker~~agency can certify the ~~member~~ person as presumptively disabled if ~~the member has~~they have one of the following ~~readily apparent~~ impairments, as attested to in writing by a medical professional~~:~~.

1. Amputation of a leg at the hip
2. ~~Allegation of total~~Total deafness
3. ~~Allegation of total~~Total blindness
4. ~~Allegation of bed~~Bed confinement or immobility without a wheelchair, walker, or crutches due to a longstanding condition ~~that's expected to last 12 months or longer~~, excluding recent accident and recent surgery
5. ~~Allegation of a stroke~~Stroke (cerebral vascular accident) more than three months in the past and ~~continued~~ marked difficulty in walking or using a hand or arm
6. ~~Allegation of cerebral~~Cerebral palsy, muscular dystrophy, or muscle atrophy and marked difficulty in walking (~~e.g.,~~for example, the use of braces), speaking, or coordination of the hands or arms
7. ~~Allegation of Down's~~Down syndrome

~~1. Allegation of severe intellectual disorder made by another individual filing on behalf of a claimant who is at least seven years of age. For example, a mother filing for benefits for her child states that the child attends (or attended) a special school, or special classes in school, because of an intellectual disability or is unable to attend any type of school (or if beyond school age, was unable to attend), and requires care and supervision of routine daily activities~~

~~Note: "Intellectual disorder" means an intellectual disability. This category pertains to individuals whose dependence upon others for meeting personal care needs (e.g., hygiene) and in doing other routine disability activities (e.g., fastening a seat belt) grossly exceeds age appropriate dependence as a result of an intellectual disability.~~

8. Intellectual disability or another neurodevelopmental impairment (for example, autism spectrum disorder) with complete inability to independently perform basic self-care activities (such as toileting, eating, dressing, or bathing) (this category only pertains to persons who are at least four years old)

9. A child has not attained their first birthday and had a birth weight under 1200 grams (2 pounds, 10 ounces)
10. A child has not attained their first birthday and had a gestational age (GA) at birth and corresponding birth weight within one of the ranges below:
    1. GA of 37-40 weeks and birth weight under 2000 grams (4 pounds, 6 ounces)
    2. GA of 36 weeks and birth weight of 1875 grams (4 pounds, 2 ounces) or less
    3. GA of 35 weeks and birth weight of 1700 grams (3 pounds, 12 ounces) or less
    4. GA of 34 weeks and birth weight of 1500 grams (3 pounds, 5 ounces) or less
    5. GA of 33 weeks and birth weight of 1325 grams (2 pounds, 15 ounces) or less
    6. GA of 32 weeks and birth weight of 1250 grams (2 pounds, 12 ounces) or less

~~8.~~11. A physician ~~or knowledgeable~~confirms that the person has a terminal illness with a life expectancy of six months or less; or a physician or hospice official (hospice coordinator, staff nurse, social worker, or medical records custodian) confirms ~~an individual~~that the person is receiving hospice services because of a terminal ~~condition, including but not limited to terminal cancer~~illness

~~9.~~12. ~~Allegation of spinal~~Spinal cord injury producing an inability to ambulate without the use of a walker or bilateral hand-held devices for more than two weeks~~, with confirmation of such status from an appropriate medical professional~~

~~10.~~13. End stage renal disease (ESRD) requiring chronic dialysis ~~confirmed by a medical professional~~

~~2. The applicant's attending physician states the applicant will be unable to work or return to normal functioning for at least 12 months or the condition will result in death within the next 12 months~~

~~3. The member has a positive diagnosis of HIV with other serious health conditions and will be unable to work or return to normal functioning for at least 12 months or the condition will result in death within the next 12 months~~

14. Symptomatic human immunodeficiency virus (HIV) infection or acquired immunodeficiency syndrome (AIDS)
15. Amyotrophic lateral sclerosis (ALS), also known as Lou Gehrig's disease

5.9.2.3 Presumptive Disability Certification Process

A medical professional must complete and sign the Medicaid Presumptive Disability (F-10130) form, attesting to both the urgent need and the impairment, before an IM worker may certify the applicant as presumptively disabled. The worker should not require any additional documentation from the medical professional beyond the Medicaid Presumptive Disability form. Once completed, ~~place~~ a copy of this form will be saved in the case file to document the Medicaid Presumptive Disability decision. If the applicant is otherwise eligible for EBD Medicaid, ~~certify~~ Medicaid eligibility will be certified (see Section 5.9.5 Eligibility).

Changes in Urgent Need Prior to Presumptive Disability Medicaid Certification

Sometimes~~, an individual's~~ a person's medical condition improves between the date of the presumptive disability Medicaid application and the date of the presumptive disability Medicaid certification. This improvement results in the ~~individual~~person no longer meeting the urgent need criteria at the time of the presumptive disability Medicaid eligibility determination. The most common example of this situation is that of a person who is hospitalized on the date of the presumptive disability Medicaid application~~,~~ but then released from the hospital prior to being certified by the IM worker for presumptive disability Medicaid eligibility. Under these circumstances, if the presumptive disability

applicant no longer has an urgent need as of the date that ~~you are~~the IM agency is making the presumptive disability Medicaid eligibility determination/certification, the presumptive disability request must be denied~~. Follow the procedures described in when notifying~~, and the applicant must be notified that their request for a presumptive disability eligibility determination has been denied.

Example ~~2:~~1	Bob is 55 years old and has been hospitalized since February ~~01, 2008~~1, after suffering his second stroke in the last ~~4~~four months. Bob applies for Medicaid on February ~~07, 2008~~7. His physician attests in writing that Bob has an urgent need (he is hospitalized~~),~~) and that he has one of the impairments listed on the Medicaid Presumptive Disability (F-10130~~form (F-10130~~). The IM ~~worker~~agency has requested verification of Bob's non-~~-~~exempt assets and completion of the Medicaid Disability Application (MADA) (F-10112~~.~~). On February 14, ~~2008~~ Bob returns the completed MADA and asset verification information to his IM ~~worker~~agency. He also indicates that he was released from the hospital on February 11~~, 2008~~ and is recuperating at home. On February 14, ~~2008,~~ the IM ~~worker~~agency has all the necessary information to make a presumptive disability Medicaid eligibility determination. Since Bob no longer has an urgent need on that date, his request for presumptive disability Medicaid must be denied.

Regardless of whether the IM ~~worker makes the presumptive disability determination~~agency or DDB makes the presumptive disability determination, the Medicaid Disability Application (MADA) (F-10112~~(F-10112)~~) must be completed before the IM ~~worker certifies~~ agency can certify the member ~~for~~ based on a presumptive disability.

The following forms are required for the presumptive disability process:

- Wisconsin Medicaid for the Elderly, Blind or Disabled Application Packet (F-10101)
- Medicaid Disability Application (MADA) (F-10112)
- Medicaid Presumptive Disability (F-10130)
- ~~•~~ Authorization to Disclose Information to Disability Determination Bureau (DDB) (F-14014
- ~~•~~
- ~~•~~
- ~~•~~
- ~~•~~)
- Appoint, Change, or Remove an Authorized Representative (F-10126A Person or F-10126B Organization) (if applicable)

Once a presumptive disability decision has been made, the IM ~~worker~~agency must still follow the disability application process (see Section 5.3 Disability Application Process and Process Help, Section 9.4 Automated Medicaid Disability Determination). The Medicaid Disability Application (MADA) (F-10112~~(F-10112)~~) must be completed and sent to ~~the~~ DDB along with the necessary copies of the Authorization to Disclose Information to Disability Determination Bureau (DDB) (F-14014~~(F-14014).~~).

~~The~~ DDB will ~~then~~ process the disability application and make a final disability determination.

5.9.3 Presumptive Disability Determined ~~By~~by DDB

If the applicant has an urgent need~~,~~ but does not have one of the listed impairments, the IM ~~worker~~agency must ~~request~~ ask DDB to make a presumptive disability determination. ~~The IM worker must take the following actions once a medical professional has attested in writing, with the , that there is an urgent need for medical services.~~

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

1. DocumentAll the urgent need by placing the in the case file.
2. Complete, with assistance from the applicant as necessary, the following two forms:
    1. The MADA form (, formerly DES 3071).
    2. .

See for submissions of the forms, if necessary. This process is now automated. However, if the automated process isn't working, send via fax (608-266-8297) each of the three forms listed above toin Section 5.9.2.3 are still required when DDB for both a is making the presumptive and final disability determination (see Process Help, Section 9.4 Automated Medicaid Disability Determination. for more information).

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

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

5.9.4 Deceased Applicants

While a deceased person can be eligible for Medicaid in the months prior to his or hertheir death, presumptive disability determinations are not allowed for individuals thatpersons who are deceased. Process suchSuch requests for a final disability determination are processed through the regular disability process through DDB.

5.9.5 Eligibility

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

Example 3:1	Jane contacted her IM agency and applied for Medicaid on July 3. She reported being in urgent need of medical services due to muscular dystrophy. The IM worker determines that Jane would be eligible based on presumptive disability, but and requests that a medical professional complete and sign the Medicaid Presumptive Disability (F-10130) form (F-10130) to attest to the urgent need and impairment. Jane's physician completes and returns the form to the IM agency on July 12. AThe IM worker processes the verification on July 14. Jane is found presumptively disabled and eligible for Medicaid effective July 12.

Example 4:2	Bob is Jack's son and authorized representative. Bob applied for Medicaid on behalf of his father by telephone on June 20. He reported to the IM worker that Jack had a stroke six weeks ago and is in urgent need of medical services. The IM worker determines that Jack may be

	eligible based on presumptive disability~~,~~ but requests that a medical professional complete and sign the Medicaid Presumptive Disability (F-10130) form ~~(F-10130)~~ to attest to the urgent need and impairment. Bob also needs to verify Jack's assets. The completed Medicaid Presumptive Disability form, attesting to the impairment and urgent need, is received by the IM agency on July 2, and verification of Jack's checking account is received July 12. The IM worker processes the verification on July 15. The worker determines that Jack is presumptively disabled and eligible for Medicaid effective July 2.

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

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

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

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

5.9.6 Disability Application Denials

5.9.6.1 DDB Returns a Negative Presumptive Disability Decision

If ~~the~~ DDB returns a negative Presumptive Disability decision, the IM worker must send a manual notice of decision to the applicant. The notice must state:

"Your request for Medicaid is based upon your statement that you are disabled. The final decision on your disability has not yet been made, however we have determined that you cannot be considered presumptively disabled. This means that you cannot be certified as eligible for Medicaid as a person with a disability until a final disability decision has been made. You will be informed when the Disability Determination Bureau makes the final disability decision. (Wis. Stats. ss. 49.46 and 49.47)"

5.9.6.2 ~~Member~~ Ineligible for Non-Medical Reasons

If a member is determined ineligible for non-medical reasons, ~~you may terminate~~ eligibility based on a presumptive disability may be terminated with timely notice without waiting for DDB's final disability

decision. In such a case, the IM agency will notify DDB immediately ~~at, (608) 266-1565,~~ that a medical determination is no longer needed.

5.9.6.3 DDB Reverses Presumptive Disability Decision Made by DDB or by the IM ~~Worker~~Agency

If ~~the~~ DDB denies a disability application, their decision reverses a presumptive disability decision made by the IM ~~worker~~agency or by DDB. ~~Terminate~~ Medicaid eligibility is terminated following timely notice requirements. Medicaid eligibility based on a presumptive disability decision does not continue during the period a person is appealing DDB's decision that they are not disabled.

Benefits received while the disability decision was pending are not subject to recovery~~,~~ unless the ~~individual~~person made misstatements or omissions of fact at the time of the presumptive disability determination.

7.2 ~~Documenting~~Verifying U.S. Citizenship ~~and Identity~~

7.2.1 Citizenship Verification Introduction

U.S. citizenship must be verified for persons applying for or receiving Medicaid (MA), BadgerCare Plus, or FPOS benefits and who have declared that they are a U.S. citizen, unless they are exempt from this requirement (See Section 7.2.1.2 Exempt Populations). Citizenship verification for health care must first be attempted using the real-time data exchange with the Social Security Administration before requesting documentation of citizenship from applicants. (See Section 7.2.3 Citizenship Verification through Data Exchange). Only those who are not exempt and for whom verification was not available through a data exchange may be required to submit documentation of their citizenship (See Section 7.2.4 Citizenship Verification through Documentation). Once citizenship has been verified for a person, verification may never again be required to receive health care benefits unless previously verified information becomes questionable.

7.2.1.1 Covered Programs

The U.S. citizenship ~~and identity documentation~~verification requirement ~~covers~~ applies to all non-exempt applicants and members of the following programs:

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

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

If U.S. citizenship has been verified for any of these programs, U.S. citizenship is considered verified for all programs.

7.2.1.2 Exempt Populations

The following populations are exempt from the ~~new~~ U.S. citizenship ~~and identity documentation~~verification requirement:

- Anyone currently receiving SSDI or a Disabled Adult Child benefit (SSDC)
- Anyone who is currently receiving ~~SSI~~Supplemental Security Income (SSI) benefits
- Anyone currently receiving Medicare
- Anyone currently receiving Foster Care (Title IV-E and Non IV-E)
- Anyone currently receiving Adoption Assistance
- Anyone who has been eligible for Wisconsin Medicaid or BadgerCare Plus as a Continuously Eligible Newborn (CEN) at any time on or after July 1, 2006~~. This includes~~ (including CENs born on or after July 1, 2005)

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

Identity verification is only required in certain situations as part of citizenship verification. Persons not applying for or receiving any health care benefits and persons who are not claiming to be a U.S. citizen are not required to verify identity (see Section 7.2.4.3 Evidence of Identity).

Former Supplemental Security Income and Medicare Recipients

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

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

7.2.3 U.S. Citizenship Verification Through Data Exchange

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

~~Only persons meeting all of the following criteria will~~To be selected for this data exchange, a person must:

- ~~Requesting Medicaid, BadgerCare Plus, or Family Planning Only Services~~
- ~~Declaring to be~~Be requesting health care.
- Have declared they are a U.S. citizen or national.
- ~~Provides~~Have provided an SSN.
- ~~Is not a member of~~ Not belong to an exempt population listed in Section 7.2.1.2 Exempt Populations.
- ~~Citizenship/nationality has not~~ Not have already ~~been~~had their U.S. citizenship verified through other means.

Non-exempt Medicaid applicants~~/members~~ who do not provide an SSN, or whose SSN cannot be verified, cannot have their U.S. citizenship verified through the data exchange. They must meet the U.S. citizenship verification requirement by providing documentation as defined in Section 7.2.4 Citizenship Verification Through Documentation.

7.2.4 Citizenship Verification Through Documentation

7.2.4.1 Stand-Alone Documentation of U.S. Citizenship

Stand-alone documentation is a single document that verifies U.S. citizenship, such as a United States Passport. Stand-alone documentation of U.S. citizenship is the most reliable way to establish that the person is a U.S. citizen. If ~~an individual~~a person presents a stand-alone document, no other U.S. citizenship verification is required. See the chart below or Process Help, Section 68.3.2 Stand-Alone Documentation of Citizenship for a list of ~~stand-alone~~acceptable documents.

An applicant or member who does not provide a stand-alone document must provide documentation of both U.S. citizenship and identity (see Section 7.2.4.2 Evidence of Citizenship and Section 7.2.4.3 Evidence of Identity~~.~~).

Stand-Alone Document	Description/Explanation
Certificate of	Form N-550 or N-570. Issued by the Department of Homeland Security for

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

7.2.4.2 Evidence of U.S. Citizenship

~~If an~~ For applicants whose U.S. citizenship has not been verified by the Social Security Administration (SSA), if the person was born in Wisconsin, the agency should attempt to verify U.S. citizenship through the online birth query before requesting documentation of U.S. citizenship from the applicant.

If an applicant whose U.S. citizenship has not been verified by SSA is unable to provide stand-alone documentation of U.S. citizenship (see Section 7.2.4.1 Stand-alone Documentation of U.S. Citizenship~~(), he or she~~), they must provide other documentation proving U.S. citizenship.

Any document used to establish U.S. citizenship must show either a birthplace in the U.S.~~,~~. or that the person is otherwise a U.S. citizen~~. (See~~ (see the chart below or Process Help, Section 68.3 Acceptable Citizenship and Identity Documentation ~~for a list of acceptable documents of citizenship.)~~). If an applicant is unable to provide any of the acceptable documents of U.S. citizenship, ~~he or she~~they may submit an affidavit signed by another ~~individual~~person under penalty of perjury, who can reasonably attest to the applicant's U.S. citizenship~~, and that~~. The affidavit must contains the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized.

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

~~For any applicant born in Wisconsin, attempt to verify~~Applicants whose U.S. citizenship cannot be verified by SSA or through ~~the on-line birth query before requesting~~stand-alone documentation of U.S. citizenship must also provide documentation of identity (see Section 7.2.4.3 Evidence of Identity~~from the applicant.~~).

Acceptable Documentation of Citizenship Only	Description/Explanation
Final Adoption Decree	The adoption decree must show the child's name and U.S. place of birth. Where an adoption is not finalized and the state in which the child was born will not release a birth certificate prior to final adoption, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.
Birth Certificate	A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986). The birth record document may be recorded (previously 'issued') by the State, Commonwealth, Territory or local jurisdiction. Note: A Puerto Rican birth certificate used to verify U.S. citizenship of anyone applying for health care benefits must have been issued on or after July 1, 2010. Older birth certificates that were used to verify citizenship for persons when they previously applied for any IM program before October 1, 2010, are still considered valid.
Birth Query	A birth record query confirms a person's birth in Wisconsin.
U.S. birth record amended more than 5 years after person's birth	An amended U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986). Must show a U.S. birthplace.
Acquired citizenship through parent(s) as outlined in the Child Citizenship Act 2000 (CCA)	An individual demonstrates that s/he has gained his/her U.S. Citizenship through the Child Citizenship Act of 2000.
US Citizen ID Card or Northern Mariana Card	U.S. Citizen ID Card The Immigration and Naturalization Service (INS) issued the I-179 and the I-197 from 1960 until 1983 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings.

	Northern Mariana Card Form I-873. Issued by INS for those born in the Northern Mariana Islands before November 4, 1986.
State or Federal census record	Must show birthplace and citizenship. Census records from 1900 through 1950 contain certain citizenship information. To secure this information, the applicant, member, or State should complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested." Also add that the purpose is for Medicaid eligibility. This form requires a fee.
Education Document	The school record must show a U.S. birthplace and the name of the child.
Evidence of civil service employment by U.S. government	The document must show employment by the U.S. government before June 1, 1976. Persons employed with the U.S. Government prior to that date had to be U.S. citizens.
Hospital record	Extract of a hospital record on hospital letterhead established at the time of the person's birth and that indicates a U.S. place of birth. This is not a souvenir "birth certificate" issued by the hospital.
Life, health or other insurance record	Must show a U.S. place of birth.
Medicaid Birth Claim	When the Wisconsin Medicaid program pays the costs associated with the birth of an infant who either: • Did not qualify as a CEN, or • Was a CEN, but born before July 1, 2006, The infant will be considered a U.S. citizen who has met the citizenship documentation requirement. If citizenship is not verified through a data exchange, identity documentation is still required.
Medical record (doctor, clinic, hospital)	The document must show a U.S. birthplace. An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.
Official Military record of service	The document must show a U.S. birthplace.
Admission papers from nursing home, skilled nursing care facility or other institution	The document must show a U.S. birthplace.
Other MA Program Verified Citizenship	An individual has already provided proof of citizenship while they were receiving Wisconsin Medicaid outside of CARES. For example, use this for members previously enrolled through the Katie Beckett program.
Birth Certificate Paid by IM Agency	A U.S. public birth certificate (paid for by the Income Maintenance agency) showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986). The birth record document may be recorded (previously 'issued') by the

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

7.2.4.3 Evidence of Identity

If an applicant whose U.S. citizenship is not verified by SSA is unable to provide stand-alone documentation of citizenship ~~(), in addition to providing evidence of citizenship (~~(see Section 7.2.4.1 Stand-alone Documentation of Citizenship), they must ~~also~~ provide- evidence of both citizenship (see Section 7.2.4.2 Evidence of Citizenship) and identity.

As a reminder, for health care, verification of identity must not be requested or required for:

- U.S. citizens who are exempt from the verification requirement (see Section 7.2.1.2 Exempt Populations-).
- U.S. citizens whose citizenship is verified by SSA or stand-alone documentation of citizenship.
- Persons who have not declared they are U.S. citizens.
- Non-U.S. citizens.

The applicant may provide any documentation of identity listed in the chart below or Process Help, Section 68.3 Acceptable Citizenship and Identity Documentation to ~~prove~~verify identity, provided such document has a photograph or other identifying information sufficient to establish identity such as name, age, sex, race, height, weight, eye color, or address.

In addition, ~~you~~the IM agency may accept proof of identity from a Federal agency or another State agency, including but not limited to a law enforcement, revenue, or corrections agency, if the agency has verified and certified the identity of the ~~individual~~person. If the applicant does not have any documentation of identity and identity is not verified by another Federal or State agency, ~~he or she~~they may submit an affidavit, signed under penalty of perjury, by a person other than the applicant who can

reasonably attest to the applicant's identity. Such affidavit must contain the applicant's name and other identifying information establishing identity, as described above. The affidavit does not have to be notarized. The applicant may submit a Statement of Citizenship and/or Identity (F-10161) or another affidavit.

Acceptable Documentation of Identity Only	Description/Explanation
State or Territory Driver's license	Driver's license issued by a U.S. State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight or eye color. REAL IDs only provide documentation of identity, not citizenship.
Education Document	For children under age 19, school records providing the name and other identifying information. School records would include, but not be limited to report cards, daycare or nursery school records.
FoodShare Identification Requirement met	Verifying the identity of the primary person is a requirement for a FoodShare application. Once this requirement is met for FoodShare, it is also met for the identity verification requirement for health care.
Identification card issued by Federal, State, or local government	Must have the same information as is included on driver license.
Institutional Care Affidavit (Form F-10175)	If the applicant cannot produce the accepted documents verifying identity, a signed Statement of Identity for Persons in Institutional Care Facilities (F-10175) may be used. A residential care facility administrator signs this form under penalty of perjury attesting to the identity of a disabled individual in the facility.
U.S. Military card or draft record, Military dependent's identification card, or US Coast Guard Merchant Mariner card	Must show identifying information that relates to the person named on the document.
Medical record	Doctor, clinic, or hospital records for children under age 19 only.
Motor Vehicle Data Exchange	This is a data exchange update with the Division of Motor Vehicles or when verifying an individual's identity through the DOT Driver License Status Check website.
Multiple Identity documents	An individual may provide 2 or more corroborating ID documents to verify his/her identity. Examples include marriage license, divorce decree, high school or college diploma, or an employer ID card.
Other MA Program Verified Identity	An individual has already provided proof of identity while they were receiving Wisconsin Medicaid outside of CARES. For example, use this for members previously enrolled through the Katie Beckett program.
State ID Paid by Agency	Must have the same information as is included on driver license.
School Identification card	School identification card with a photograph of the individual and/or other identifying information.
Written Affidavit for Children	If the applicant cannot produce the accepted documents verifying

(Form F-10154)	identity for children under 18 years of age, a Statement of Identity for Children Under 18 Years of Age (F-10154) is acceptable. The affidavit must be signed under penalty of perjury by a parent, guardian or caretaker relative stating the date and place of birth of the child. The affidavit does not have to be notarized.
Written Affidavit **(Form F-10161)**	If the applicant cannot produce the accepted documents verifying identity, then a Written Affidavit may be used. If the documentation requirement needs to be met through an affidavit, the following rules apply: • It must be signed by an individual other than the applicant, who can reasonably attest to the applicant's identity, and • That contains the applicant's name, and other identifying information such as, age, sex, race, height, weight, eye color, or address. • The affidavit must be signed under penalty of perjury. • The affidavit does not have to be notarized. A signed Statement of Citizenship and/or Identity (F-10161) may be used for individuals who are unable to obtain any level of acceptable documentation.

7.2.4.4 Reasonable Opportunity Period for Verification of U.S. Citizenship

Applicants who are otherwise eligible for Medicaid or other health care benefits and are only ~~pending~~waiting for verification of U.S. citizenship ~~(and identity when needed)~~ must be certified for health care benefits within the normal application processing timeframe (see Section 2.7 Application Processing Period~~30 days from the filing date).~~). They ~~are able to~~can continue receiving health care benefits for which they are eligible~~,~~ while the IM agency waits for U.S. citizenship verification. Applicants have 90 days after receiving a request for U.S. citizenship verification to provide the requested documentation. This 90-day period is called the reasonable opportunity period (ROP). The 90-day ROP starts on the date after the member receives the notice informing them of the need to provide U.S. citizenship verification by the end of the reasonable opportunity period. Federal regulations require that ~~we~~states assume a minimum five-day time frame for applicants to receive notices. For this reason, ~~we must set~~ the end of the ROP must be no less than 95 days after the date on the notice, even when the member receives the notice in less than ~~5~~ five days. If a member shows that a notice was received more than ~~5~~ five days after the date on the notice, ~~we must extend~~ the deadline must be extended to 90 days after the date the member received the notice.

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

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

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

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

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

7.2.7 Situations which Require Special Documentation Processing

7.2.7.4 Child Citizenship Act of 2000

Certain foreign-born ~~individuals~~persons have derivative U.S. citizenship as a result of the Child Citizenship Act~~. Within the context of the Medicaid citizenship verification requirement, this means that for any applicant or member claiming citizenship through the Child Citizenship Act,~~ (CCA) (see SECTION 7.1.2 CHILD CITIZENSHIP ACT OF 2000).

IM workers should not request citizenship documentation for ~~that person.~~persons claiming U.S. citizenship through the CCA. In these cases, IM workers ~~need to acquire documentation proving~~must instead verify the U.S. citizenship ~~and identity~~ of ~~at least~~ one ~~U.S. citizen~~ parent. The parent's U.S. citizenship is the basis for the child receiving derivative citizenship.

~~For persons who meet the~~The parent's U.S. citizenship ~~verification requirement through the means allowed in the Child Citizenship Act, this~~ is considered evidence of ~~citizenship. Therefore this counts for~~the child's citizenship only ~~and the individual needs to~~. The child must provide another document to verify their identity (see SECTION 7.2.4.3 EVIDENCE OF IDENTITY~~.~~).
~~See Section 7.1.2 Child Citizenship Act of 2000.~~

7.2.7.5 Non-U.S. Citizens

~~As a reminder, do~~IM agencies must not request or require citizenship ~~and identity documentation~~ verification from ~~individuals~~persons who have not declared that they are U.S. citizens. Non-U.S. citizens who apply for IM programs are not subject to this policy. Legal non-U.S. citizens are subject to the verification process through Federal Data Services Hub (FDSH ~~and~~) and Systematic Alien Verification for Entitlements (SAVE), and undocumented non-U.S. citizens do not have any status that can be verified~~. (See , for instructions on using FDSH and~~ (see Process Help, Chapter 82 SAVE~~, for instructions on using SAVE.)~~) Undocumented non-U.S. citizens can apply for Emergency Medicaid or BadgerCare Plus Prenatal Program and ~~should~~are not ~~be~~ subject to the citizenship ~~and identity~~ verification policy. They also do not have to verify their identity.

When ~~an individual~~a person who had legal non-U.S.-citizen status subsequently gains U.S. citizenship, this is recorded in SAVE. Therefore, SAVE can be used to verify these ~~individuals'~~persons' U.S. citizenship. The verification result from SAVE will be "individual is a US Citizen" (see Process Help, Chapter 82 SAVE~~." See for instructions on using SAVE.~~). These ~~individuals~~persons still ~~need to~~must provide proof of identity.

7.2.7.6 ~~Individuals~~Persons in Institutional Care Facilities

~~Disabled individuals~~ Applicants with a disability in institutional care facilities may have their identity (if required) attested to by the facility director or administrator when nothing else is available. Use the Statement of Identity for Persons in Institutional Care Facilities (F-10175) for this purpose. A medical institution can be, but is not limited to, ~~an SNF, ICF, IMD~~skilled nursing facilities, intermediate care facilities, institutes for mental disease, and hospitals.

7.3 Immigrants

7.3.3 Immigrants Eligible for Medicaid

7.3.3.4 Afghan Parolees

Afghans and persons with no nationalities who were residing in Afghanistan and subsequently paroled into the United States ~~between~~on July 31, 2021~~, and~~ through September 30, ~~2022~~2023, are to be treated ~~like they are~~as refugees when determining their eligibility for Medicaid.

In addition, Afghans and persons with no nationalities who were residing in Afghanistan and subsequently paroled into the United States after September 30, 2022, are to be treated ~~like they are~~as refugees when determining their eligibility for Medicaid if they are one of the following:

- The spouse or child of ~~an individual~~a person paroled ~~between~~on July 31, 2021~~, and~~ through September 30, ~~2022~~2023
- The parent or legal guardian of ~~an individual~~a person paroled ~~between~~on July 31, 2021~~, and~~ through September 30, ~~2022~~2023, who is determined to be an unaccompanied child

All of the above ~~individuals~~persons are to continue to be treated ~~like they are~~as refugees until either March 31, 2023, or the date their parole status expires, whichever is later.

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
SQ4, SQ5	Special Immigrant Parolee (SI Parolee)	Code 04
DT, OAR, OAW, PAR	Humanitarian Parolee	Code 04

7.3.4 Public Charge

~~The receipt of Medicaid by an undocumented, non-qualifying, or qualifying immigrant or by the children or spouse for whom the individual is legally responsible does not establish the person as a public charge. Undocumented, non-qualifying, or qualifying immigrants are considered to be a public charge if, while receiving Medicaid, they are in a medical institution for more than the length of a rehabilitative stay. Undocumented, non-qualifying, or qualifying immigrants concerned about being considered a "public charge," should be directed to contact the to seek clarification of the difference between rehabilitative and other types of institutional stays.~~

Public charge determinations are part of longstanding immigration policy that can impact a non-U.S. citizen's ability to gain entry to the United States or obtain lawful permanent resident status (get a green card). A public charge is someone who the government believes is likely to rely on cash assistance or government-funded institutionalization for long-term care to survive.

Many non-U.S. citizens are exempt from public charge determinations. These include lawful permanent residents, also known as green card holders (unless they travel outside the U.S. for six months or more), asylees, refugees, special immigrant juveniles, survivors of trafficking, and other protected groups.

For non-U.S. citizens who are subject to public charge determinations, enrolling in Medicaid does not make them a public charge.

The **only** category of Medicaid-funded services considered in public charge determinations is **long-term institutionalization paid for by Medicaid**. The following institutionalization situations are not considered in public charge determinations:

- Short-term institutionalization for rehabilitative purposes
- Sporadic or intermittent periods of institutionalization, even on a recurring basis.

Medicaid Home and Community Based Services (HCBS) is not considered in public charge determinations.

8.2 Medical Support/Child Support Agency Cooperation

~~CSA Cooperation~~

~~8.2.1 Medical Support/~~

8.2.1 Introduction

Unless the person is exempt~~,~~ or has good cause for refusal to cooperate (see Section 8.2.2 Exemptions from Cooperation and Section 8.3 Claiming Good Cause), each applicant or member ~~that~~who is referred, must, as a condition of eligibility, cooperate in both the following:

- Establishing the paternity of any child born out of wedlock for whom BadgerCare Plus or Medicaid, including Medicare Savings Programs, is requested or received
- Obtaining medical support for the applicant and for any child for whom Medicaid, including Medicare Savings Programs, is requested or received

Cooperation includes any relevant and necessary action to achieve the above. As a part of cooperation, the applicant may be required to:

1. Provide verbal or written information known to, possessed by, or reasonably obtainable by the applicant.
2. Appear as a witness at judicial or other hearings or proceedings.
3. Provide information, or attest to the lack of information, under penalty of perjury.
4. Pay to the Child Support Agency (CSA) any court-ordered medical support payments received directly from the absent parent after support has been assigned.
5. Attend office appointments as well as hearings and scheduled genetic tests.

~~Note: The applicant or member is only required to cooperate if the child under their care is eligible for benefits funded under Title XIX. If the child's Medicaid benefit is funded through any other source (Title XXI or GPR) the caretaker is not required to cooperate and can not be sanctioned for non-cooperation. Check the Medical Status codes to determine funding source. The CSA will monitor the child's Medicaid funding source.~~

8.2.2 Exemptions from Cooperation

The parent or caretaker relative is exempt from the requirement to cooperate and from any sanction for non-cooperation if:

1. The child under their care is eligible for benefits funded under any source other than Title 19, such as Title 21 (Separate CHIP) or General Purpose Revenue (that is, state funds). Information on children's categories funded by Separate CHIP or state funds is available in BadgerCare Plus, Section 51.1 BadgerCare Plus Categories. The CSA will monitor the child's Medicaid Eligibility funding source.
2. The child under their care is on SSI.
3. The parent or caretaker relative is one of the following:
    a. Eligible for the BadgerCare Plus Eligibility Extension.,
    b. A pregnant person, until the end of the month in which the 60th day after the termination of pregnancy occurs.
    c. Under 18 years old.
    d. Age 18 and receiving CHIP coverage under BadgerCare Plus (income is over 156% FPL).
4. Both absent parents are now living in the home with the child.
5. The absent parent is deceased.

8.2.~~2~~3 Failure to Cooperate

The CSA determines if there is non-cooperation for ~~individuals~~persons required to cooperate. The IM agency determines if good cause exists (see Section 8.3.7 Determination) and whether the applicant or member is exempt (see Section 8.2.2 Exemptions from Cooperation~~).~~). If there is a dispute, the CSA makes the final determination of cooperation~~.~~ while the IM agency makes the final determination of exemptions or good cause. The member remains ineligible until ~~he~~they cooperate, establish good cause, or ~~she cooperates, establishes good cause, or~~their cooperation is no longer required.

~~The following individuals are not sanctioned for non cooperation:~~

~~1. Pregnant women.~~
~~2. Minors.~~
~~3. Parents or caretaker relatives while the family is in a BadgerCare Plus Extension.~~

~~For a pregnant woman, failure to cooperate cannot be determined prior to the end of the month in which the 60th day after the termination of pregnancy occurs.~~

Note:	If the local CSA determines that a parent is not cooperating because court ordered birth costs are not paid, the parent or caretaker is not sanctioned.

Example 1:	Mary, a disabled parent, is applying for Medicaid for her and her son, Michael. She refuses to cooperate in obtaining medical support for Michael. Mary meets all other non-financial and financial criteria for Medicaid and EBD Medicaid. Mary is not eligible for EBD Medicaid or Medicaid, because she will not cooperate in obtaining medical support for Michael. Even though Mary has not cooperated in obtaining medical support for Michael, he remains eligible for Medicaid.

8.3 Claiming Good Cause

8.3.2 Notice

~~The IM agency~~An applicant or member must ~~provide~~receive a Good Cause Notice (DCF-P-5600~~, to all applicants and to members~~) whenever a child with an absent parent is ~~added to~~ part of the Medicaid application or case. The notice describes the right to refuse to cooperate for good cause in establishing paternity and securing medical support from the absent parent.

~~The IM worker and the parent or caretaker must sign and date the notice. File the original in the case record and give the applicant/member a copy. The CSA refers anyone who wants to claim good cause back to the IM agency for a determination of whether or not good cause exists.~~

Applicants and members are not required to sign the Good Cause Notice in order to be eligible for Medicaid.

15.3 Exempt/Disregarded Income

15.3.26 VA Allowances

15.3.26.1 Aid & Attendance (A&A) and Housebound Allowances

For veterans and surviving spouses who need help with activities of daily living or are housebound due to disability, a Department of Veterans Affairs (VA) benefit may include a monetary amount referred to as an "Aid & Attendance" (A&A) or "housebound" allowance. (see SECTION 39.13 VA ALLOWANCE RATES).

Disregard A&A and housebound allowances when determining eligibility for any category of Medicaid. Disregard A&A and housebound allowances when determining the patient liability or cost share amount for Institutional Medicaid and Community Waivers. This rule does not apply to State Veterans Home residents without dependents ((see Section 15.3.26.3 Patient Liability Calculation for State Veterans Home Residents Without Dependents).

Example 3	Jack is a single veteran living in his home. He receives a $2,051 monthly need-based VA pension. His VA pension includes an A&A allowance of $821 per month. The A&A allowance is disregarded for Medicaid eligibility. $2,051 VA pension - $821 A&A allowance (disregarded) _____ = $1,230 budgetable income

Example 4	Donald is a married veteran living with his spouse and two children. He is disabled (as determined by the VA) and receives VA disability compensation benefits in the amount of $1,963 per month. He does not receive A&A or housebound allowances and the VA did not consider any unreimbursed medical expenses when calculating the VA disability compensation benefit amount. The full $1,963 is budgetable income to the household.

When a single veteran or a surviving spouse without dependents is in a nursing home and enrolled in Medicaid, the VA is required to reduce the pension amount to no more than $90, except when the member is in a State Veterans Home. These reduced pensions of $90 or less are always considered A&A, so the full amount of these reduced pensions is disregarded for Medicaid eligibility as well as cost share or patient liability determinations.

Example 5	Patrick is a single veteran with no dependents who is in a nursing home and open for Institutional Medicaid. He receives a $90 monthly VA pension. The entire $90 VA pension amount is A&A and is disregarded for both his Medicaid eligibility and patient liability determinations.

15.3.30 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 income and some payment types are not counted as income. The criteria used to evaluate whether a payment type is counted as income 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 do not count as income 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.
- Federal Pandemic Unemployment Compensation (FPUC) payments.
- Retroactive Pandemic Unemployment Assistance (PUA) payments.
- Retroactive Pandemic Emergency Unemployment Compensation (PEUC) payments.
- Retroactive Extended Benefits (EB) unemployment compensation payments.
- We're All In Small Business Grants.
- Child Care Counts supplementary payments. These payments are 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.
- Housing Assistance and Supporting Services Programs for Native Americans.
- Education Stabilization Fund (ESF) payments, which include payments from the following funds:
    - Elementary and Secondary School Emergency Relief (ESSER) Fund
    - Governor's Emergency Education Relief (GEER) Fund
    - Emergency Assistance to non-Public School (EANS) Fund
    - Higher Education Emergency Relief (HEER) Fund ~~(HEERF)~~ payments
- Economic relief payments paid directly from a tribal government to a tribal member using local government relief funds provided through the CARES Act.
- A Paycheck Protection Program (PPP) loan. The loan itself is not counted as income. However, if the loan is being used to pay employee wages, the wages are counted as income for the employee who receives them.

See Section 15.4.25 Certain Payment Types Related to the COVID-19 Pandemic for countable types of pandemic-related unemployment compensation benefits.

16.6 Non-Burial Trusts

16.6.6 Pooled Trusts

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~~)~~), and the person has had their disability determined by DDB or SSA.
3. The account in the trust is established by the disabled ~~individual's~~ individual, their 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
- Life Navigators ~~Community~~Pooled Trust II
- Life Navigators Pooled Trust III

17.2 Evaluation of Transfers for Divestment

17.2.6 Allowed Divestments

17.2.6.8 Transfer of Homestead Property

The transfer of homestead property by an institutionalized person or their spouse for less than FMV is an allowed divestment and doesn't result in a penalty period when the transfer is to:

- The institutionalized person's spouse.
- The institutionalized person's child~~,~~ if ~~the child meets~~ at least one of the following criteria is met:
    - The child is under the age of 21.
    - The child is blind or permanently and totally disabled.
    - The child resided in the institutionalized person's home for at least two years immediately before the institutionalized person moved to a medical institution, and provided care that allowed the institutionalized person to reside at home rather than in the institution for the entire two years immediately before the institutionalized person moved to a medical institution. The child's provision of care must be verified by a notarized statement from the institutionalized person's physician or someone else who has personal knowledge of the circumstances. A notarized statement from the child is not sufficient. The homestead transfer does not have to take place after the provision of care in order to be an allowed divestment.
- The institutionalized person's sibling~~, if the sibling meets~~ if both of the following criteria are met:
    - The sibling resided in the institutionalized person's home for at least one year immediately before the institutionalized person moved to a medical institution.
    - The sibling has a verified equity or ownership interest in the home. The equity or ownership interest must be verified by documentation such as a copy of the deed or land contract. The sibling's name on the document is not sole proof, so other documentation such as canceled checks and receipts may be needed.

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

17.2.7.12 Life Estate – Termination and Payment of Less than FMV

The termination of a life estate by its holder before their death without receiving the FMV of the life estate is an unallowable divestment and results in a penalty period.

The divested amount is the ~~FMV of the property~~ life estate value at the time of termination minus the amount received by the life estate ~~value~~holder. To determine the life estate value, ~~multiply~~ the FMV of the property is multiplied by the number ~~from 39.1 Life Estate and Remainder Interest table~~ corresponding to the age of the life estate holder at the time the life estate was terminated~~.~~ (see Section 39.1 Life Estate and Remainder Interest).

Example 8:	Marion, age 83, gave her home to her son John, retaining a life estate. The FMV of the house at the time of the transfer was $87,000. Two years later, Marion applied for Long Term Care Medicaid. Since the transfer of her home occurred in the look back period, it is an unallowable divestment and results in a penalty period. Marion served a divestment penalty period for this divestment.

	Marion is the life estate holder. John is the remainder person. John sold the home for the current FMV of $102,000, and Marion terminated the life estate. John took the proceeds from the home and bought another house. He did not pay Marion for the value of the life estate which is an unallowable divestment and results in a penalty period. The divestment amount is the life estate value at the time the life estate was terminated. To determine the life estate value, multiply $102,000 (value of the house at the time the life estate was terminated) by .33764. (The number is from the table in Section 39.1 Life Estate and Remainder Interest corresponding to Marion's age, 86, at the time the life estate was terminated.) $102,000 X .33764 = $34,439.28 The divested amount is $34,439.28 (see Section 17.3.4 Penalty Period Begin Date for Members).

Example 9:	When James was 75 years old, he sold his home to his son Robert. The home was worth $95,000. Robert paid James $50,000 for the home and James retained a life estate. The life estate value is $49,541.55 (95,000 X .52149~~). (See~~) (see Section 39.1 Life Estate and Remainder Interest ~~for this value.)~~). Since James received both $50,000 from Robert and retained a life estate worth $49,541.55, the total value he received is more than the FMV of the home. Because the value he received is greater than the FMV of the home, it is not a divestment.

19.1 Applicant and Member Access Rights

19.1.1 Introduction

An applicant or member has the right to see their entire case record to verify that its content is accurate with respect to their statements and that documentation of facts about them from other sources is correct.

When an applicant or member requests access to the record for reasons not related to preparation for a fair hearing, the agency does not have to show them the entire record. The agency can show the applicant or member only the parts of the record relevant to the request.

19.1.2 Fair Hearings

Agencies cannot withhold any part of the record from the applicant or member when they are preparing for a fair hearing (see SECTION 23.2.3 PRIOR TO THE HEARING).

19.1.3 Sensitive Medical Information

The Confidential Information Release Authorization to Agency (F-82009) form does not promise the medical reporting source that information won't be revealed to the person if they request to see it. In most cases, the applicant or member has direct access to the information.

Agencies may determine, in some cases, that the requested medical information is of a "sensitive" nature and that its release directly to the applicant or member may not be in their best interest. When this occurs, the agency can request that the applicant or member name, in writing, a representative. This representative may be a physician or other responsible person (for example, a clergyman or attorney). The agency will release the requested information to the representative with the instruction that they review it and inform the applicant or member of the content at the representative's discretion.

Agencies must retain the applicant or member’s authorization to release this information to their representative in the case record.

19.1.4 Access by Someone Else

An applicant or member may authorize someone else to act on their behalf in gaining access to their case record. This authorized entity has the same right of access to the case record as that of the applicant or member.

This authorized entity can be an attorney but does not need to be an attorney. The applicant or member must complete a release of information form, such as F-02340, if the entity is not an attorney. The applicant or member does not need to complete a release of information form to authorize their attorney to access their case record. The agency can request proof of the attorney’s licensure if the person’s statement that they are an attorney is questionable.

Note	A person or entity who is already known on the Medicaid case as a legal guardian, conservator, power of attorney, or authorized representative can access the case record. They do not need additional authorization to access the case record (see Section 22.5 Legal Guardians, Power of Attorney, and Other Representatives).

19.2 Releasing Information

19.2.1 Disclosure Without Consent

DHS and its contractees may disclose information from the agency record to other programs routinely and without the person's consent for a purpose compatible with the data's collection.

Income Maintenance (IM) agencies may disclose information from that record to the following compatible agencies:

1. County child support agencies.
2. County departments of social or human services.
3. DHS-contracted county, tribal, and private W-2 agencies.
4. Weatherization agencies under contract with the Wisconsin Department of Administration (DOA) providing weatherization services to low income persons.
5. Tribal agencies administering DHS programs.
6. General relief/assistance agencies.
7. State of Wisconsin DCF staff for administering W-2.
8. FSET agencies administering the FoodShare Employment and Training program.
9. Any fiscal agent of the state administering benefit payments under the BadgerCare Plus program (currently Gainwell Technologies).
10. The Social Security Administration for administering the Supplemental Security Income (SSI) benefits.
11. Local public housing authorities where the member applies for public housing or for federal rent assistance.
12. DWD, Division of Unemployment Insurance (DUI) for computer matching to Unemployment Insurance Benefit payments.
13. Job Training Partnership Act (JTPA) agencies to the extent that the information is necessary to determine JTPA program eligibility.
14. Any other federally assisted program providing cash or in-kind assistance or services directly to persons on the basis of need. Federally-assisted school food service programs are included in this category. Families may apply for free or reduced meals in that program. Do not provide a school or school district with a list of students receiving FoodShare. However, if the school requests you to confirm the recipient status of a child or a list of children who have applied for free or reduced meals, provide the confirmation.
15. US Comptroller General's Office.
16. Any official conducting an investigation, prosecution, or civil proceeding in connection with the administration of an Income Maintenance program. They must submit to the agency a written request to obtain information. The request must include the identity of the person requesting the information, their authority to request, the violation being investigated, and identify the person being investigated. Do not apply this restriction to the agency’s District Attorney or fraud investigator.
17. Persons directly connected with the administration or enforcement of the programs which are required to participate in the state income and eligibility verification system (IEVS), to the extent that the information is used to establish or verify eligibility or benefit amounts under those programs.
18. Staff of any public or private agency for the administration of the:
    1. Federal Title IV-E Foster Care program
    2. Adoption Assistance program.

No other routine disclosure from client records is approved. The applicant, member, or their legal guardian, conservator, or power of attorney must authorize all other disclosures. See Chapter 22.5 Legal Guardians, Conservators, Power of Attorney, and Other Representatives for more information on the entities that can act on behalf of an applicant or member.

19.2.2 Disclosure with Consent

Applicants and members may authorize the disclosure of information of record about themselves to a third party in writing. Forms such as F-02340 or F-82009 may be used for this purpose. The authorization must specify the information to be disclosed, to whom it is to be disclosed, and for what period of time.

19.2.3 Emergencies

Other circumstances may arise when disclosure must be given without consent because a person's health or safety is in imminent danger. When there's reason to believe a health or safety emergency exists, the agency director (or designee) may authorize disclosure. The agency must notify the applicant or member in writing within 72 hours of this disclosure.

19.2.4 Special Circumstances

19.2.4.1 Legislative Committees

Agencies cannot disclose information for the broad investigatory purposes of legislative committees. Federal legislation prohibits disclosure to any committee or committees legislative body (federal, state, or local) of any information that identifies by address or name any applicant or recipient.

19.2.4.2 Crime Victim's Compensation Program

The Crime Victim's Compensation (CVC) Program is administered by the Wisconsin Department of Justice (DOJ), Crime Victims Services. Its intent is to provide financial support to victims of crime within Wisconsin.

DOJ is required to determine a person's W-2, CTS, FoodShare, BadgerCare Plus, and Medicaid eligibility status and benefit amount before it may dispose of someone's application for CVC. As part of the application process for CVC, the applicant must sign an authorization of release of confidential information.

Agencies can release information to CVC program staff about CVC applicants and recipients only when the CVC applicants and recipients have signed a release of confidential information for the CVC program. Information that can be released are about eligibility and the amount of benefits in the W-2, CTS, FoodShare, BadgerCare Plus, and Medicaid programs.

19.2.4.3 Subpoenas and Records Requests

If a court issues a subpoena for a case record or for any agency representative to testify concerning an applicant or member, the IM Agency must inform the court of the applicable statutory provisions, policies, and regulations restricting disclosure of information.

19.2.5 Prohibited Disclosure

Examples in which disclosure is prohibited are:

1. Requests from an official not connected with the agency for privileged information.
2. Requests from private persons for case information frequently related to business or personal matters, such as the collection of bills from the recipient.

3. IM agencies are not authorized to provide information about the receipt of benefits or the dollar amount of those benefits to the U.S. Citizenship and Immigration Services (USCIS), the U.S. State Department, or immigration judges unless that information will assist Wisconsin in collecting outstanding debts. Even if the request is for documentation of the amount of benefits received, this information is not to be released as the disclosure is not directly connected to the administration of the program about which information is requested.

19.2.6 Data Exchanges

19.2.6.1 Data Exchanges Introduction

CWW Data Exchanges provide query access to databases that store employment, unemployment income, and Social Security and SSI income (including social security number, citizenship/identification, and Medicare verification) information.

The rules of confidentiality apply to all data obtained from the query. In addition, because of the sensitive nature of the data available, rules have been established for accessing the data as well as release of data obtained from the query.

19.2.6.2 Use of Data

Data exchanges can only be accessed for official program purposes. No one is permitted to browse the records in any query, even if there are no intentions to share the data.

19.2.6.3 Query Access

Agencies must take all precautions necessary to ensure that only authorized agency staff have access to the online queries.

19.2.6.4 Release of Data

Only release data received from a query to:

- The person who is the subject of the data.
- The person's attorney or other duly authorized representative who needs the data in connection with that person's fair hearing.
- Another county, state, or federal agency administering the FS, child support, SSI, BadgerCare Plus, or Medicaid programs.
- A criminal or civil authority that agrees in writing to protect the confidentiality of the data provided.

19.2.7 Documents

19.2.7.1 Date Stamping Documents

All paper documents received by an agency must have the received date on the face or first page of each document. If you do not have a date stamp, write out the date the document was received on the front of the document prior to scanning.

19.2.7.2 Photocopying Vital Records

Wis. Stats. §69.30 permits DHS, county, W-2, and tribal social and human service agencies to photocopy vital records for administrative use. Vital records include:

- Birth certificates
- Death certificates
- Marriage documents

- Divorce and annulment certificates
- Data related to any of the above documents

This statute exempts agencies from its restrictions if there is an administrative need for the copy and it's marked "For Administrative Use." Penalties for improperly photocopying vital records include fines and imprisonment.

20.3 Mandatory Verification Items

20.3.1 Mandatory Verification Items Introduction

The following items must be verified for Medicaid:

- SSN
- ~~Citizenship and Identity~~U.S. citizenship (see Section 7.2 Verifying U.S. Citizenship)
- Immigrant status
- Disability and incapacitation
- Income
- Assets for the Elderly, Blind, and Disabled (see Section 16.1 Assets Introduction).
- Divestment, for Medicaid long-term care programs
- Medical expenses, for deductibles only
- Medical/remedial expenses for noncovered services for an institutionalized person (see Section 27.7.7.2 Disallowed Expenses)
- Documentation for power of attorney and guardianship
- Migrant worker's eligibility in another state (see Section 31.2 Simplified Application), if applicable
- For the home maintenance allowance income deduction (see Section 15.7.1 Maintaining Home or Apartment), physician certification (verbally or in writing) that an applicant or member who resides in a medical institution is likely to return to their home within six months
- Temporary hardship for MAPP premium waiver
- Huber Law participation, for incarcerated individuals qualifying for the Huber Law exemption (see Section 13.8.3 Huber Law)

Unless determined questionable, self-declaration is acceptable for all other items.

20.3.2 Social Security Number

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

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

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

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

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

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

In cases where an application for SSN has been filed with the Social Security Administration, an SSN must be provided by the time of the next health care renewal for the case or health care eligibility will be terminated for that ~~individual~~person. In addition, if eligibility for another program pends for provision of an SSN and the SSN application date on file is six months or older, eligibility for health care will also pend. Members ~~must be given a minimum of 10~~will have 20 days to provide an SSN, but if they do not, health care eligibility must be terminated.

Even when U.S. citizenship cannot be verified due to a lack of a verified SSN, health care benefits should not be ~~pended~~delayed for lack of an SSN during the reasonable opportunity period for verification of U.S. citizenship (see Section 7.2.4.4 Reasonable Opportunity Period for Verification of Citizenship).

20.7 When to Verify

20.7.1 Application and Renewal

20.7.1.1 Application

The time period for processing an application for Medicaid is 30 days. ~~Advise the applicant of the specific verifications required within the 30-day processing time. Give the applicant a minimum of 10 calendar~~Applicants must be given at least 20 days to provide any necessary verification.

~~Do~~ Eligibility must not ~~deny eligibility~~be denied for failure to provide the required verification until the later of:

1. The ~~10th~~20th day after ~~requesting~~ the request for verification~~, or~~ is sent.
2. The 30th day after the application ~~filing date~~is received by the agency.

If you request verification more than ~~ten~~20 days prior to the 30th day you must still allow the applicant 30 days from the application filing date to provide the required verification.

20.7.1.3 Late Renewals

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

This policy ~~will apply~~applies to the following programs:

- BadgerCare Plus (BC+)
- Family Planning Only Services (FPOS)
- SSI-related Medicaid
- Home and Community-Based Waivers (HCBW)
- Institutional Medicaid
- MAPP
- MSP (QMB/SLMB/SLMB+/QDWI)

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

Late submission of an online or paper renewal form, or a late renewal request by phone or in person, is a valid request for health care. The new certification period should be set based on the receipt date of the signed renewal. If verifications are required during the completion of a late renewal, the member will have ~~10~~20 days to provide it.

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

Example 4:	Jenny's renewal is due on January 31, 2015. She submits an online renewal via ACCESS on March 15, 2015. If the renewal is processed on the same day, and verification is requested, the verification will be due on March 25, 2015. If Jenny does not provide verification until May, she will need to reapply after the three-month period that started with her January renewal date. If a member has a gap in coverage because of his or her late renewal, he or she may request coverage of the past months in which the gap occurred and must provide all necessary information and verifications of income and assets for the current month and the gap months and must pay any required premiums to be covered for those months. Because QMB coverage is not retroactive, the ability to request coverage for past months does not apply for this program.

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

20.7.2 Changes

~~Advise~~When a change is reported that requires verification, the member must be notified in writing of the specific verification required and ~~allow~~allowed a minimum of ~~10~~20 days to provide it.

21.6 HMO Enrollment

21.6.1 SSI HMO Enrollment

SSI Medicaid and SSI-Related Medicaid are mandatory HMO enrollment programs, meaning most members are required to enroll in an HMO. ~~Individuals who are eligible for suspended benefits or enrolled in a long-term care managed care organization (MCO) cannot enroll in an HMO. Certain individuals may enroll in an HMO on a voluntary basis (see SECTION 21.6.1.1 VOLUNTARY HMO ENROLLMENT) or qualify for an exemption from HMO enrollment (see SECTION 21.6.5 EXEMPTIONS).~~However, the following persons cannot enroll in an HMO:

- Persons who are enrolled in a long-term care managed care organization (MCO)
- Persons who live in a nursing home or medical facility
- SSI Medicaid members who are under the age of 19
- Persons who are eligible for suspended benefits (see Chapter 13 Inmates)

Certain persons may enroll in an HMO on a voluntary basis (see SECTION 21.6.1.1 VOLUNTARY HMO ENROLLMENT) or qualify for an exemption from HMO enrollment (see SECTION 21.6.5 EXEMPTIONS).

HMO enrollment always begins the 1st of a month. The month in which enrollment begins depends on the time of the month when eligibility was established or when the member's enrollment status changed:

- If eligibility was established prior to the 10th of the month, HMO enrollment will begin the 1st of the following month.
- If eligibility was established on the 10th of the month or later, HMO enrollment will begin the 1st of the month following the next month.

Until a member's HMO enrollment has started, the member will receive their services on a fee-for-service basis, which means they can receive covered services from any Medicaid-certified provider.

If the member's enrollment status changes during the month (for example, going from being exempt from HMO enrollment to no longer being exempt), the member will be enrolled in an HMO effective the 1st of the following month.

Retroactive enrollment (backdating HMO enrollment) may be allowed in some circumstances but may also require approval from the HMO. Members who would like to request backdated enrollment should contact ~~the~~an HMO Enrollment Specialist at 800-291-2002. The HMO Enrollment Specialist will review retroactive enrollment backdating requests and coordinate with the HMO if necessary.

The list of medical status codes under which a member is eligible for SSI HMO enrollment can be found on the ForwardHealth Enrollment information page. This list does not differentiate between voluntary or mandatory HMO enrollment. It is only a compilation of all medical status codes that could be enrolled in an HMO.

22.2 Overpayments

~~22.2.1 Overpayments Introduction~~

An overpayment occurs when any of the following occur:

- Medicaid benefits are incorrectly paid for a person who was not eligible for them~~,~~.
- A MAPP member should have paid a higher premium~~, or~~.
- A long-term care member did not pay as much as they should have for their nursing home patient liability or waiver cost share.

~~The dollar amount of an~~ Effective April 1, 2023, DHS and IM agencies will not establish new Medicaid overpayment claims for members.

Income maintenance (IM) agencies may ~~not exceed~~ refer suspected fraudulent activity to the ~~amount of~~DHS Office of Inspector General (OIG), the ~~Medicaid benefits incorrectly provided, the amount of underpaid premiums,~~district attorney (DA), or ~~the patient liability~~corporation counsel for investigation. The DA or ~~cost share, whichever is less~~corporation counsel may prosecute for fraud.

~~Overpayments can only be recovered if the member received a benefit they weren't entitled to receive, more benefits than they were entitled to receive, or a lower premium, patient liability, or cost share than they should have been charged because the member did one or more of the following:~~

- ~~Provided incorrect or incomplete information at application~~
- ~~Provided incorrect or incomplete information at renewal~~
- ~~Failed to report a change they were required to report~~

~~Overpayments not caused by the member, which includes overpayments caused by the agency, system issues, or timely notice requirements, may not be recovered, although they may be subject to estate recovery (see Section 22.1 Estate Recovery).~~

~~Use the best available information to determine whether an overpayment exists in situations where verification has been requested but has not been provided (see Section 20.1.4 General Rules for more information on best available information).~~

Note	This policy on member overpayment claims does not include provider overpayments where there is an error in a claims payment to a provider or repayments that are part of the Estate Recovery Program (see Section 22.1 Estate Recovery).

~~22.2.1.1.2 Overpayment Claims Minimum Threshold~~

~~The minimum threshold for each claim is $500 for recoverable health care overpayments. If the overpaid amount is less than $500, no claim will be established unless it meets one~~5 Legal Guardians, ~~Conservators, Power~~ ~~of the following criteria:~~

- ~~Health care overpayments based on fraud convictions~~
- ~~Overpayments related to a member receiving duplicate benefits~~

~~Duplicate benefits are defined as situations in which a member moved out of state and enrolled in another state's Medicaid program, and then BadgerCare Plus or Wisconsin Medicaid paid HMO capitation fees or fee-for-service claims that were incurred more than two months after the member moved out of state.~~

~~Example 2:~~	~~John was determined eligible for SSI-Related Medicaid starting January 1. John moved to South Carolina on July 20. Since John was no longer a Wisconsin resident, he was no longer eligible for Medicaid. John enrolled in Medicaid in South Carolina starting August 1. John did not report his move to South Carolina to his IM agency in Wisconsin, so capitation payments continued to be made for John. John did not complete a Medicaid renewal, so~~

	~~Medicaid closed December 31. His case would have closed August 31 if he had reported the move timely. Two years later, the IM agency discovered that John had duplicate benefits in Wisconsin and South Carolina for more than two months after the move. Since this is a duplicate benefits situation, the look back period is six years, and the minimum threshold does not apply. Fee-for-service claims and any HMO capitation payments for September, October, November, and December are recoverable.~~

~~22.2.1.1.3 Recoverable Overpayment Types~~

~~Medicaid overpayments resulting from any of these reasons are subject to recovery:~~

- ~~Applicant or member error~~

  ~~Applicant or member error occurs when an applicant, member, or any other person responsible for giving information on the applicant's or member's behalf unintentionally misstates or omits facts at application or renewal, and this results in the member receiving a benefit that they are not entitled to or more benefits than they are entitled to. This can include having lower premiums, patient liability, or cost share amounts than the member should have had.~~

  ~~Applicant or member error also occurs when the member, or any person responsible for giving information on the member's behalf, fails to report changes in financial or nonfinancial information (see that would have adversely affected eligibility, the benefit plan, or premium, patient liability, or cost share amounts.~~

  ~~See for information about when members with eligibility or premium determinations based on income that was reasonably compatible can be subject to overpayments after failing to report required changes in financial information.~~

~~Example 3:~~	~~Ed applied for EBD Medicaid and was found eligible effective November 1, 2020. Ed originally reported $1,800 of nonexempt assets (checking and savings accounts), which were subsequently verified. At the time of his application, Ed failed to disclose ownership of several nonexempt vehicles with an equity value of $1,000. The agency discovers Ed's ownership of these vehicles on February 10, 2021. On February 20, 2021, the agency receives verification that the equity value of Ed's nonexempt vehicles and other nonexempt assets has continuously exceeded the $2,000 Medicaid asset limit since the Medicaid application date. The agency sends Ed a Notice of Decision on February 22, 2021, advising him that his eligibility is being discontinued effective March 31, 2021. The overpayment amount that is subject to recovery is the total of all Medicaid benefits that were received by Ed from November 1, 2020, through March 31, 2021, as long as they exceed the minimum threshold of $500.~~

~~Example 4:~~	~~Sally was determined eligible for a HCBW in January with a cost share. She experienced a reduction in her health insurance expense as of July 1 but did not report that to her worker until her November review. The worker made the changes in CARES and increased her cost share for December.~~ ~~Had Sally reported timely, her cost share would have increased beginning in August. The overpayment is the difference between the new cost share and the old cost share for August, September, October, and November.~~

Example 5:	Shana was determined eligible for WWWMA in February. She had private insurance that covered treatment of breast or cervical cancer, but due to a waiting period for preexisting conditions, her treatments were not covered. The waiting period ended July 31, and the private insurance began to cover Shana's treatment effective August 1. Shana did not report this to her worker, so Medicaid continued to pay some service costs for Shana until the worker closed the case effective November 30. Since her case would have closed August 31 if she had reported the change timely, Shana has an overpayment for September through November. The fee-for-service claims paid for September, October, and November are recoverable.

Example 6:	Joe has been a Medicaid member since January 1, 2021. During a December 2022 eligibility review, the agency discovered that Joe won a $10,000 lottery that was paid to him on June 12, 2021. Joe never reported the receipt of these lottery winnings and still has about $8,000 from the lottery proceeds. The agency verified that Joe's nonexempt assets have been in excess of the $2,000 Medicaid asset limit since June 12, 2021, and sent him a Notice of Decision, advising him that his Medicaid eligibility is ending effective January 31, 2023. The overpayment amount that is subject to recovery is the total of all Medicaid benefits that were received by Joe from August 1, 2021, through January 31, 2023. June and July of 2021 are not included in the overpayment period because Joe had 10 days to report the change that he had won a lottery. If Joe had reported this change timely (no later than June 22, 2021), the earliest that the agency could have terminated Joe's eligibility with proper notice would have been July 31, 2021.

- Fraud

  Fraud exists when an applicant, member, or any other person responsible for giving information on the member's behalf does any of the following:

  - Intentionally makes or causes to be made a false statement or representation of fact in an application for a benefit or payment.
  - Intentionally makes or causes to be made a false statement or representation of a fact for use in determining rights to benefits or payments.
  - Having knowledge of an event affecting initial or continued right to a benefit or payment and intentionally failing to disclose such event.
  - Having made application to receive a benefit or payment and intentionally uses any or all of the benefit or payment for something other than the intended use and benefit of such persons listed on the application.

  If there is suspicion that fraud has occurred, the case may need to be referred to the District Attorney (DA) (see).

  Overpayments based on fraud convictions have a look back period of six years preceding the date of discovery, and the minimum threshold does not apply.

- Member loss of an appeal

  Benefits a member receives as a result of a fair hearing request order can be recovered if the member loses the appeal.

  A member may choose to continue to receive benefits pending an appeal decision. If the appeal

decision is that the member was ineligible, the benefits received while awaiting the decision can be recovered. If an appeal results in an increased patient liability, cost share, or premium, recover the difference between the initial amount and the new amount of the amount of claims and any HMO capitation payments the state paid for each month, whichever is less.

22.2.1.2 Unrecoverable Overpayments

22.2.1.2.1 Date of Discovery and look back Period

Overpayments for periods prior to the look back period are not recoverable (see).

22.2.1.2.2 Overpayment Claims Minimum Threshold

Claims under $500 can only be recovered if the claim meets one of the following criteria:

- Health care overpayments based on fraud convictions
- Overpayments related to a member receiving duplicate benefits

Duplicate benefits are defined as situations in which a member moved out of state, enrolled in another state's Medicaid program, and received services under BadgerCare Plus or Wisconsin Medicaid more than two months after the move occurred.

22.2.1.2.3 Non-Member Errors

Overpayments resulting from a non-member error are not recoverable, including the following situations:

- The member reported the change timely, but the case could not be closed or the benefit reduced due to the 10-day notice requirement
- Agency error (keying error, math error, failure to act on a reported change, etc.)
- Normal prospective budgeting projections based on best available information

Example 7:	Susan is open for HCBW. Susan reported a change in income on April 1. The worker didn't process the change until April 28, so it wasn't effective until June 1. There is no overpayment for May since the change was reported timely but not acted on by the worker until after adverse action.

Overpayments for any months when rules preventing health care terminations during the COVID-19 public health emergency were in effect are not recoverable. This means benefits issued March 2020 and any months after March 2020 for which continuous coverage due to the COVID-19 public health emergency is in effect for that member. This includes individuals whose health care was granted, extended, or both due to agency or state error.

22.2.1.2.4 Eligibility and Premium Determinations Based on Reasonable Compatibility

If a member is not required to verify their earned income at the eligibility or premium determination due to reasonable compatibility and then verifies their earned income at a later date (for example, because verification is required for another program), the verified earnings must be used to determine eligibility and premium amounts. The member cannot be subject to an overpayment because the initial determination was based on income that was reasonably compatible with a data exchange.

If a member is not required to verify their earned income at the eligibility or premium determination due to reasonable compatibility and subsequently fails to report a required income change, the member can only be subject to an overpayment if their new income amount is more than 20% greater than the total income amount that was used to make the eligibility or premium determination.

Example 8:	Cameron is a disabled adult with an income limit of $1,132.50 for SSI-Related Medicaid. He applies for Medicaid in January and reports that his earnings are $1,100 per month. The monthly earned income amount reported by Equifax is $1,200 per month. Because

	Cameron's reported income is below the income threshold and the Equifax-reported income is above the income threshold, the 20% threshold test is applied. The income reported by Equifax ($1,200) is less than the 20% threshold amount (120% of $1,100, or $1,320), so his reported information is reasonably compatible, and he does not need to verify his earned income. In April Cameron applies for FoodShare. Cameron must provide verification of his earned income when applying for FoodShare. His verified earned income is $1,300, and it is discovered that he failed to report in February that his income increased to $1,300. This amount is over the SSI-Related Medicaid income limit of $1,132.50, so Cameron is no longer eligible for SSI-Related Medicaid. However, this amount is not more than 20% greater than the income amount of $1,100 that was used to determine that he was eligible for SSI-Related Medicaid in January. Therefore, he cannot be subject to an overpayment. The amount that is 20% greater than $1,100 is $1,320. If Cameron's income had increased to an amount greater than $1,320 and he failed to report the increase, he could have been subject to an overpayment.

22.2.2 Overpayment Calculation

22.2.2.1 Overpayment Period

Misstatement or Omission of Fact

If the overpayment is a result of a misstatement or omission of fact during an initial Medicaid application or renewal, the period for which the benefits were determined incorrectly and the appropriate overpayment amount must be determined (see) within the applicable look back period (see).

Failure to Report

For ineligible cases, if the overpayment is a result of failure to report a required change, the date the change should have been reported and the month the case would have closed or been adversely affected if the change had been reported timely must be calculated.

Fraud

For ineligible cases, if the overpayment was the result of fraud, the date the fraudulent act occurred must be determined. The period of ineligibility should begin the date the case would have closed or been adversely affected allowing for proper notice, within the applicable look back period (see).

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 and), 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.

See the following sections for more information about overpayment amounts for different subprograms:

-
-
-
-

22.2.2.2.1 Long Term Care Overpayments

If a member is still eligible for long-term care benefits but a misstatement or omission of fact resulted in a patient liability or waiver cost share that is lower than it should be, the overpayment amount is the difference between the correct patient liability or cost share amount and the one the member originally paid. See for instructions on how to complete the forms reporting the overpayment amount.

Note:	Patient liability should not be subtracted from the claims paid by Medicaid when determining the overpayment amount. Nursing Home bills paid by Medicaid are already reduced by the patient liability amount.

If a member failed to report a divestment that would have resulted in a penalty period and the member is still otherwise eligible for long-term care, any benefits Medicaid paid during the time in which the penalty period would have been served are not recovered. Instead, a penalty period is imposed for ongoing eligibility as outlined in .

22.2.2.2.2 Deductible-Related Overpayments

If a member error increases the deductible before the deductible is met, there is no overpayment.

If the member met the incorrect deductible and Medicaid paid for services after the deductible had been met, there is an overpayment. Recover the lesser of:

- The difference between the correct deductible amount and the previous deductible amount
- The difference between the correct deductible amount and any fee-for-service claims and HMO capitation payments Medicaid paid over the six-month period

If the member prepaid the deductible but was actually ineligible for the deductible, the amount prepaid toward the deductible is deducted from the overpayment amount.

Example 6:	Sean had a deductible of $2,000 for a six-month period. He met the deductible by paying $1,000 and sending in verification of $1,000 in outstanding medical bills. An IM worker discovers an undisclosed bank account that puts Sean over the asset limit for the program. After determining his overpayment amount, the IM worker must decrease the amount overpaid by the $1,000 that Sean prepaid toward his deductible. The IM worker will not decrease the overpayment amount by any of the medical bills that helped Sean meet his deductible.

If a deductible is prepaid with a check that is returned for insufficient funds, the member's eligibility is terminated. The overpayment amount is any fee-for-service claims and HMO capitation payments Medicaid paid during the deductible period.

22.2.2.2.3 Medicaid Purchase Plan Overpayments

If a person was ineligible for MAPP, the overpayment amount is the amount of fee-for-service claims and any HMO capitation payments paid by the state. Deduct any amount the person paid in premiums for each month in which an overpayment occurred from the overpayment amount.

If a MAPP member was still eligible for the time frame in question, but there was an increase in the premium, there is an overpayment. The overpayment amount is the lesser of:

- The difference between the premiums paid and the premium amount owed
- The difference between the premiums paid and the amount of any fee-for-service claims and HMO capitation payments Medicaid paid for each month in question

Premium adjustments are only made on months where there is an overpayment. If there is a month without an overpayment, then the premium calculation for that month should not be adjusted.

Example 7:	Stephanie was eligible for MAPP with a premium of $50. She forgot to report a part-time job that would have increased her MAPP premium to $75 a month. During the overpaid months, the state paid a monthly capitation rate of $200. For the months during the overpayment time period, the overpayment each month is $150, which is the difference between the $200 monthly capitation payment and the $50 monthly premium payment.

22.2.2.2.4 Qualified Medicare Beneficiary Overpayments

The overpayment amount for QMB cases is both the following:

- Medicare Part A premium, if paid by the state (Some are free, and others are paid by the state.)
- Medicare Part B premium

22.2.2.3 Liable Individual

Collect overpayments from the Medicaid member, even if the member has authorized a representative to complete the application or renewal for him or her. Join liability for married couples is as follows:

- Legally married spouses living in the household at the time the overpayment occurred are jointly liable for overpayments.
- For cases for which spousal impoverishment rules have been applied, the legally married spouses who signed the application or renewal are jointly liable even though one of the spouses may be institutionalized.

Example 8:	Sofie applied for Medicaid in December and at that time designated her daughter, Lynn, as

	her authorized representative. Lynn did not report some of her mother's assets when she applied, which would have resulted in Sofie being ineligible for Medicaid. Sofie was determined to be ineligible for Medicaid from December through March. Benefits that were provided to Sofie from December through March are recovered. Even though Lynn failed to report the information as the authorized representative, Lynn is not liable.

Example 9:	Mary and Herman are married, living together, and eligible for SSI-related Medicaid without a deductible. At their annual renewal, the IM worker discovers an undisclosed pension that would have pushed the couple above the income limit for the program, requiring them to meet a deductible before being eligible. Because they are married and were living in the same household at the time of the overpayment, Mary and Herman will be jointly liable for the entire overpayment that is calculated for the time period in question.

Example 10:	Jill and Samuel are married and living together. Jill is eligible for SSI-related Medicaid. Samuel receives federal and state SSI. At renewal, the IM worker discovers that Jill receives disability income from her former employer. This income was not disclosed at application. Because they are married and were living in the same household at the time of the overpayment, both Jill and Samuel are jointly liable for any overpayment calculated for the benefits incorrectly paid to Jill.

Members under age 18 are not liable for overpayments. Dependent 18-year-olds are not liable for overpayments in cases where their parent or other caretaker relative is the primary person for the case. If a member age 18 or younger received Medicaid in error, the member's parent(s) or non-legally responsible relative is liable for the overpayment if the parent or non-legally responsible relative was living with the member at the time of the overpayment.
, and Other household members who were not enrolled in Medicaid on the same case during the time the overpayment occurred are not jointly liable for overpayments.

22.2.3 Member Notice

The member or the member's representative must receive a notice of the overpayment that includes the period of ineligibility, the reason for their ineligibility, the amounts incorrectly paid, and information on arranging for repayment within a specified period of time.

22.2.4 Refer to District Attorney

Overpayments involving suspected fraudulent activity by the member may be referred to the Department of Health Services (DHS) Office of the Inspector General (OIG). If the investigation reveals a member may have committed fraud, the case may be referred to the district attorney or corporation counsel for investigation. The district attorney or corporation counsel may prosecute for fraud under civil liability statutes. The agency may seek recovery through an order for restitution by the court of jurisdiction in which the member or former member is being prosecuted for fraud.

22.2.5 Fair Hearing

The IM agency's decision concerning ineligibility and amounts owed may be appealed through a fair hearing. During the appeal process, the agency may take no further recovery actions pending a decision.

22.5 Legal Guardians, Conservators, Power of Attorney, and Other Representatives

22.5.4 Legal Guardians and Conservators

Persons or interested parties may petition a court to appoint a guardian or conservator. There are a variety of reasons that an appointment may be sought including but not limited to:

- Inability to manage finances
- Inability to manage personal health
- Inability to function safely without supervision
- Parent or guardian of minor is now deceased

Some of these appointments might be an emergency or temporary reason, or for the purposes of succession after the death of the previous guardian or conservator.

A judge grants the guardian or conservator powers based on the circumstances of the person. A legal guardian of the person and the estate, legal guardian of the estate, or legal guardian in general is considered to be the applicant or member's legal guardian for Medicaid purposes. If a person or entity is one of these legal guardian types or the conservator, the applicant or member does not need to separately appoint them as the authorized representative. The legal guardian or conservator appointment grants them the powers that an authorized representative would have on the Medicaid case.

A person or entity with the guardian type legal guardian of the person is not considered to be the applicant or member's legal guardian for Medicaid purposes. The applicant or member must appoint the legal guardian of the person as an authorized representative if the applicant or member would like the legal guardian of the person to act on their behalf.

Depending on their court appointed powers, a guardian or conservator can apply for and act in the same capacity as an authorized representative for the household. It is possible the court appointed powers will give the guardian or conservator sole authority to manage the person's eligibility.

The legal guardian or conservator should be familiar with the applicant or member's household situation and is expected to fulfill their responsibilities to the same extent as the person being represented. The legal guardian or conservator can take any action on the application or case on behalf of the applicant or member unless the guardianship or conservatorship court order limits their powers.

Applicant and member notices and other communications from the agency will be sent to the legal guardian or conservator.

See Section 20.3.7 Power of Attorney, Guardianship, or Conservator for information on verification requirements. See Section 2.5 Valid Signature for information on valid application signatures by legal guardians or conservators.

22.5.5 Power of Attorney

A person may appoint a power of attorney. A power of attorney may act within the scope of authority granted in the power of attorney appointment.

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 Medicaid purposes.

If a person has a durable power of attorney for finances, the applicant or member does not need to separately appoint them as an authorized representative. The durable power of attorney for finances appointment grants them the powers that an authorized representative would have on the Medicaid case.

The durable power of attorney for finances should be familiar with the applicant or member's household situation and is expected to fulfill their responsibilities to the same extent as the person being represented. The durable power of attorney for finances can take any action on the application or case on behalf of the applicant or member unless the power of attorney appointment limits their powers.

See Section 20.3.7 Power of Attorney, Guardianship, or Conservator for information on verification requirements. See Section 2.5 Valid Signature for information on valid application signatures by a power of attorney.

23.2 Fair Hearings

Applicants and members have the right to a fair hearing, timely case decisions, and accurate notices of decision. Hearings are conducted by the Wisconsin Department of Administration, Division of Hearings and Appeals (DHA) for Medicaid.

Hearings serve to:

1. Interpret the program to applicants and members who disagree with the agency's action.
2. Bring the applicant or member and the agency into discussion for a better understanding of problems.
3. Resolve factual disputes.
4. Clarify policies and their application in relation to laws and regulations.
5. Review policies in program administration and reveal those which require clarification or revision.
6. Promptly remedy unfair treatment, mistaken or arbitrary action and negligence.

23.2.1 Resolution Prior to Hearing

When an applicant or member disagrees with an agency's action, the applicant or member may contact their agency to attempt to resolve the issue. This may be done through the normal modes of communication between the applicant or member and the agency, such as a phone call or in-person visit. It also may be done through an agency conference where the applicant or member meets with the worker responsible for the agency's action or other agency representatives.

This contact with the agency does not affect the applicant or member's right to a fair hearing or the time limit for requesting a fair hearing. The agency must advise the applicant or member that to have an agency conference is the applicant or member's choice and doesn't delay or replace a fair hearing. The applicant or member may request a hearing without first contacting the agency.

Note	If the applicant or member requested a fair hearing, the fair hearing process will continue unless the applicant or member voluntarily withdraws the hearing request in writing to DHA (see Section 23.2.8 Withdrawal of Fair Hearing Request).

23.2.~~1~~ 2 Fair Hearing Request

For Medicaid, the applicant, member, or representative may request a fair hearing in writing by filling out the Request for a Fair Hearing (DHS-28~~-~~) form or writing a letter with the request and sending it to the ~~Division of Hearings and Appeals (~~DHA~~).~~.

Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875

Fax (608) 264-9885

Email: DHAMail@wisconsin.gov

DHA will schedule a hearing upon receipt of the hearing request. DHA has jurisdiction to conduct hearings for Medicaid if the request is received by DHA within 45 days of the action effective date. DHA

may dismiss a request if the action being appealed is a result of a change in federal or state law or policy affecting a significant number of members, unless the member questions its application specific to their case. When a hearing request is dismissed, DHA will notify the applicant or member.

A hearing request from an applicant or member who plans to move from Wisconsin before a decision would normally be issued, such as a migrant worker, will be expedited so the applicant or member can receive a decision and any restored benefits before they leave the state.

A group of ~~individuals may~~peoplemay request a group hearing if individual issues of fact are not disputed, and the sole issue being appealed is a state or federal law or policy. DHA may also consolidate several hearings on the same topic into one, but only on questions of policy. Procedures for group hearings are the same as in individual hearings. Each applicant or member must be notified of the right to withdraw from a group hearing and pursue an individual hearing.

23.2.~~2~~ 3 Prior to the Hearing

The agency must prepare for the hearing by reviewing the appropriate case records and determine the cause of the contested action. The agency must submit a detailed summary to DHA and the applicant, member, or their representative that explains the action(s) under appeal within 10 days of receiving notification of the hearing request.

The agency must also gather relevant testimonies, exhibits, and materials from the case record and other sources. This information must be submitted to DHA and the applicant, member, or their representative as early as possible prior to the hearing.

At least 10 days prior to the hearing, DHA sends a Notice of Scheduled Hearing to the applicant or member, their representative, ~~or both.~~if applicable, and the agency. This allows the applicant or member and agency 10 days to prepare for the hearing. The applicant or member may request less advance notice to expedite scheduling the hearing.

The notice states that:

- DHA will dismiss the request if the applicant, member, or any representative fails to appear without good cause.
- The name, address, and phone number of whom to notify if the applicant, member, or representative cannot attend.
- The applicant or member and any representative may examine the case record prior to the hearing. Agencies must allow the applicant, member, or representative access to their case record and the opportunity to photocopy, free of charge and at a reasonable time before the hearing, all documents they would like to introduce as an exhibit at the hearing. Questions relating to the examination of sensitive information can be directed to DHA.

23.2.~~3~~ 4 Continued Benefits

DHA may order a member's Medicaid benefits to continue while a decision on the hearing is pending. The IM agency must comply with DHA's initial order until otherwise notified or the member waives this continuation of benefits. The IM agency must inform members that they may have to pay back any continued benefits received if they lose the hearing decision and of their right to waive continued benefits.

DHA can reverse its continuance order only when the hearing was not requested prior to the action's effective date. If DHA does not order benefits reinstated and the agency believes that the member is entitled to them, the agency must notify DHA.

Once benefit continuation has begun, the IM agency must maintain those benefits until DHA orders a change or some other change in eligibility occurs.

23.2.5 Hearing

Hearings are conducted by an Administrative Law Judge (ALJ). The ALJ is an impartial official who:

- Is familiar with relevant federal and state policies and procedures.
- Was not involved in the action being contested.
- Was not the immediate supervisor of the worker who took the action.
- Does not have a personal stake or involvement in the case.

ALJs are duly appointed and qualified agents of DHA.

The ALJ's powers and duties are to:

- Administer oaths or affirmations.
- Ensure all relevant issues are considered.
- Request, receive, and place in the record all evidence necessary to decide the issue.
- Regulate the hearing's conduct and course consistent with due process to ensure an orderly hearing.
- Provide a hearing record and decision.

The hearing record is available for copying and inspection by the applicant, member, representative, or agency at any reasonable time. All hearing records and decisions are available for public inspection and copying, so long as applicant and member identity is safeguarded.

23.2.~~4~~ 6 Time Limits

DHA must conduct the hearing and issue its decision and the IM agency must implement the decision within 90 days of the date DHA receives the hearing request.

When a decision is favorable to the applicant or member, the IM agency must carry out the decision's orders within 10 days of the order or 90 days of the date DHA receives the hearing request, whichever comes first.

When the decision is not favorable to the applicant or member, the decision notice is the final notice for the case, with the exception of overpayment notices. No further timely or adequate notice requirement applies for the issue that was appealed. Medicaid benefits will be discontinued or reduced immediately.

The DHA decision includes a description for the applicant or member of their right to rehearing, judicial review, or both. It is not necessary to request a rehearing before going to circuit court.

~~23.2.5 Recoupment~~

~~If an agency's adverse action is upheld, or the fair hearing is withdrawn or is abandoned, any overpayments caused by benefits having been continued may be subject to recovery based on the overpayment policies in .~~

23.2.7 Hearing Decision

23.2.7.1 Final Decision

The ALJ will issue a final decision for most hearings. Agencies must follow a final decision for the case involved in the hearing, even if the final decision conflicts with existing policies and procedures. Agencies should continue to follow the written policies and procedures in all other cases.

23.2.7.2 Proposed Decisions

The ALJ will sometimes issue a proposed decision, such as if there are questions about Medicaid policy or if it conforms to state and federal law. All parties are able to send written comments to DHA within 15 days of receipt of the proposed decision. After the 15-day comment period, DHA will send the proposed decision and all comments received to the Secretary of the Department of Health Services. The Secretary will review the proposed decision and make the final decision. The final decision will then be communicated to all parties.

23.2.7.3 Abandoned Hearing

If the applicant, member, or representative fails to appear at the hearing without good cause, the hearing request will be dismissed. This type of dismissal is called an Abandoned Hearing. DHA will notify the applicant, member, or representative and the agency when a hearing is dismissed.

A fair hearing thought to be abandoned may be rescheduled by DHA.

23.2.8 Withdrawal of Fair Hearing Request

Only the applicant, member, or their representative may withdraw a fair hearing request for Medicaid. Applicants, members, and representatives can fill out the Voluntary Withdrawal (DHA-17) form or send a written and signed letter to DHA:

Division of Hearings and Appeals
P.O. Box 7875
Madison, WI 53707-7875
Fax (608) 264-9885
Email: DHAMail@wisconsin.gov

Only DHA has the authority to grant or deny a withdrawal request. DHA will notify the agency if a fair hearing request is withdrawn.

23.2.9 Cost Motion

When the applicant or member wins a hearing, their attorney may file a cost motion with DHA. A cost motion is a request for payment of attorney fees and other costs associated with the hearing.

The agency has 15 days from the filing of the cost motion to submit a written response to DHA.

The ALJ will review the cost motion and agency response to DHA and decide if:

- The agency's position at the hearing was not "substantially justified" and costs associated with the cost motion must be paid from state funds.
- The agency was "substantially justified" or special circumstances exist which would make the award of the cost motion unjust.

- The costs motion was frivolous (that is, submitted in bad faith) for the purpose of harassing or maliciously injuring the state agency, the hearing officer may award costs to the state agency. The agency should include facts relating to harassment in its response to DHA if such conduct occurred.

23.2.10 Rehearing

An applicant or member may request a rehearing by DHA. The request must be made within 20 days of the date of the decision. DHA may grant or refuse the request. A rehearing will be held only when there has been:

- An error of law.
- An error of important fact.
- New evidence discovered which could not have been presented at the first hearing.

DHA will usually not grant a rehearing unless the error or new evidence is sufficiently important to change the decision. If DHA neither grants nor denies a rehearing request within 30 days, the request is deemed denied.

Note	Even if a rehearing is granted, the agency must continue to comply with the final decision unless and until a decision from the rehearing reverses it.

23.2.11 Judicial Appeals

An applicant or member that disagrees with the final decision may appeal to the Circuit Court of their residence. They must do this within 30 days of the date of the decision or rehearing denial, whichever is later.

25.1 503 Eligibility

25.1.3 Calculating the Cost-of-Living Adjustment Disregard

To calculate the COLA disregard amount, do the following:

1. Find the assistance group's current gross OASDI income. The gross OASDI income is the amount of the OASDI check plus any amount that has been withheld for a Medicare premium plus any amount withheld to repay an earlier overpayment.
   ~~Do not include in the gross income any Medicare Plan B premiums, which the state has paid for the assistance group.~~
2. On the COLA Disregard Amount Table (see SECTION 39.6 COLA DISREGARD), find the last month in which the person was eligible for and received a check for both OASDI (or retroactive OASDI) and SSI.
3. Find the decimal figure that applies to this month.
4. Multiply the person's current gross OASDI income by the applicable decimal figure. The result is the COLA disregard amount.

Example 2~~:~~	Newby's current gross OASDI income is $820. He is not currently receiving SSI benefits. The last month in which he was eligible for both OASDI and SSI and received benefits from both was April 2013. On the COLA Disregard Amount Table (see SECTION 39.6 COLA DISREGARD), April 2013 falls between January–December 2013. The decimal figure that applies to April 2013 is 0.~~031247~~382657. Multiply 0.~~031247~~ 382657 by $820 to find Newby's COLA disregard amount of $~~25.62~~313.78. Subtract the $~~25.62~~318.78 disregard amount from ~~the~~ $820 ~~OASDI~~. Newby's countable OASDI is $506.22.~~income is then $794.38. This amount is below the EBD income limit of $816.78, which makes him eligible.~~

Periods of Medicaid ineligibility do not affect this disregard. When the person reapplies, give the disregard again.

26.3 Nonfinancial Requirements

26.3.4 Work Requirement Exemption

If ~~there is a~~ serious mental or physical illness or hospitalization that causes the member to be temporarily unable to work or participate in the HEC program, the work requirement can be suspended for up to six months. ~~He or she can continue~~The IM agency may grant up to ~~be MAPP eligible.~~two non-consecutive work requirement exemptions (up to six months each) within any three-year period. The member must contact the IM agency to request the exemption~~. Have the member complete~~ using the Medicaid Purchase Plan (MAPP) Work Requirement Exemption (F-10127~~-~~) form ~~(). This provision is not available unless he or she:~~.

The agency may grant a work requirement exemption if the MAPP member:

- Has been enrolled in MAPP for at least six months and has paid any applicable premiums prior to the request of an exemption.
- Is expected to be able to return to work ~~in~~within the next six months.
- ~~Provides an expected date of recovery.~~
- ~~Provides the reason that an exemption is needed (e.g., illness or hospitalization).~~
- Provides a doctor's statement as proof of the mental or physical health-related hardship making them unable to work or participate in the Health and Employment Counseling program.
- Has ~~had no more than~~not already been granted two exemptions ~~(maximum of six months each) to~~in the past three years.

The MAPP member must continue to pay all applicable premiums during the work requirement ~~in a three-year time~~ exemption period. ~~The two exemptions cannot be consecutive.~~

~~Based on the criteria outlined above, the IM agency will approve or deny the request.~~ DHS may also grant a temporary waiver of the work requirement for good cause.

Example 1	A MAPP member who has already been granted two work requirement exemptions by the IM agency within the last three years has a car accident and will be unable to work for three months. The agency cannot grant a third exemption but can refer the request to DHS for consideration.

If a work exemption request is denied, the member has appeal rights in accordance with the Medicaid program.

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

In the ~~sixth~~last month of an exemption, ~~mail~~ the ~~member~~agency must send a notice to the member indicating the date the ~~medical~~ work requirement exemption will end ~~as well as~~and any steps the member ~~may~~must take to continue MAPP eligibility.

26.4 MAPP Financial Requirements

26.4.1 Assets

26.4.1.1 Independence Accounts

~~Someone who has been determined eligible for~~ MAPP members can establish ~~an~~one or more Independence ~~Account after MAPP eligibility has been confirmed~~Accounts. These accounts are an exempt asset. There is no limit to the number of ~~accounts~~ Independence Accounts a MAPP member may have 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~~A member's deposits into an Independence Account may total no more than 50% of their gross earnings over the 12-month certification period. If the member's deposits exceed 50% of their actual gross earnings during the same 12-month certification 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 1:	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 not counted 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

Independence Account Registration

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

1. Registered with the IM Agency. To register an Independence Account, the member must submit a completed Medicaid Purchase Plan (MAPP) Independence Account Registration (F-10121) form to the IM agency. The IM agency must save a copy of the completed form in the member's case file and provide a copy to the member.
2. A separate financial account owned solely by the MAPP member (Cash, escrow accounts for a home sale, money owed, prepaid debit cards, and tax refunds may not be registered as Independence Accounts.)
3. Opened with a financial institution after MAPP eligibility is confirmed, with the following exceptions:
    1. Pension and retirement accounts
    2. Non-retirement accounts that were registered as Independence Accounts before August 1, 2020

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 Accounts

MAPP members may register their existing retirement~~/~~ or 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~~/~~ or pension account before it was ~~designated~~registered 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~~/~~ or pension account ~~designated~~that has been registered 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.

Example 2:	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 a countable asset for 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 remains a countable asset.

Example 3:	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 assets 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.

Non-Retirement Accounts

In order for a non-retirement~~/pension accounts may only~~ account to be ~~opened and~~ registered as an Independence ~~Accounts~~Account, it must be opened with the financial institution after the applicant has been approved for MAPP. The amount the MAPP member opens the account with is part of the Independence ~~account~~Account balance and is not counted.~~-~~

Example 4:	Mac is approved for MAPP in October. He fills out the Independence Account form to register his existing savings account as an Independence account. The IM worker cannot approve this account as an Independence Account because it was opened and established with funds before Mac enrolled in MAPP.

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 account balance will be considered a countable asset.

Example 5:	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.

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.
    1. Completing the Medicaid Purchase Plan (MAPP) Independence Account Registration form registers the Independence Account with the IM agency.
    2. Scan the completed 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:
    1. Pension and retirement accounts (see)
    2. 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.

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.

Example 5:

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.

27.11 Institutions for Mental Disease (IMDs)

Some institutions for mental disease (IMD) provide residential substance use disorder (SUD) treatment, and special eligibility rules apply to IMD residents receiving residential SUD treatment (see Section 27.1.2 Institutions for Mental Disease and Section 27.4.1 Institutionalized Person). Therefore, the IMDs that provide residential SUD treatment are specified below.

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

Dane
5 Door Recovery/Hope Haven/Rebos United, Madison (provides residential SUD treatment)
Mendota Mental Health Institute, Madison

Eau Claire
Lutheran Social Services – Affinity House, Eau Claire (provides residential SUD treatment)
Lutheran Social Services – Fahrman Center, Eau Claire (provides residential SUD treatment)

Fond du Lac
Fond du Lac County Health Care Center

Milwaukee
Aurora Psychiatric Hospital, Milwaukee
Genesis Behavioral Services Inc. – Jeanetta Robinson House, Milwaukee (provides residential SUD treatment)
Matt Talbot Recovery Services, Milwaukee (provides residential SUD treatment)
Rogers Memorial Hospital Inc., Brown Deer
Rogers Memorial Hospital Inc., Milwaukee
Milwaukee County Behavioral Health, 144 bed psychiatric hospital - license #229, Milwaukee

Oneida
Options Counseling Services, LLC, Rhinelander (provides residential SUD treatment)

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

Washington
Exodus Transitional Care Facility, Kewaskum (provides residential SUD treatment)

Waukesha
Lutheran Social Services – Aspen Center, Waukesha (provides residential SUD treatment)
Rogers Memorial Hospital Inc., Oconomowoc
~~Waukesha County Mental Health Center, Waukesha~~

Winnebago

Winnebago Mental Health Institute, Winnebago

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

32.2 QMB

32.2.1 Introduction

To be eligible for QMB the person must:

1. Meet non-financial Medicaid requirements
2. Be entitled to Medicare Part A (as defined in Section 32.2.2 Entitled to Medicare).

The following Medicaid members are categorically eligible for QMB benefits:

- People who are receiving or are eligible to receive SSI Medicaid
- People who are eligible for Special Status Medicaid as a~~:~~ 503 assistance group DAC
  - ~~503 assistance group (as defined in Section 25.1 503 Eligibility).~~
  - ~~DAC (as defined in Section 25.2 Disabled Adult Child).~~
  - ~~Widow or widower (as defined in Section 25.3 Widows and Widowers).~~

~~Note:~~ ~~If a member is not eligible for SSI Medicaid or Special Status Medicaid, they are not automatically eligible for QMB benefits.~~

Example 1:	Kate receives ~~an SSDC payment~~SSDI Disabled Adult Child (DAC) benefits from Social Security. Due to other unearned income, ~~however,~~ Kate is not eligible for Special Status Medicaid as a DAC. Therefore, she is not categorically ~~or medically needy SSI-related Medicaid as a DAC. Even~~eligible for QMB even though she receives a ~~"DAC" payment, she is not automatically eligible for QMB because she is not eligible for Medicaid through the receipt of SSI Medicaid or Special Status Medicaid~~DAC payment.

~~Special Status Medicaid members have the option of not taking the QMB benefit.~~

32.11 Medicare Beneficiaries Adversely Affected

When a member is found eligible for one of the MSP programs and the state pays ~~a person's~~their Part B premium, ~~his or her Social Security payment will increase by~~they can no longer use the ~~same amount as the Medicare Part B~~ premium~~.~~ payment as an expense. This ~~increase in the Social Security payment~~ may result in the ~~person either losing Medicaid eligibility, or~~ member experiencing a reduction in benefits (for example, FoodShare may decrease) or an increase in a premium, cost share, or patient liability (for themselves or a community spouse). Additionally, members eligible for SLMB+ cannot have any other form of Medicaid.

When a person would be adversely affected ~~in this way, he or she~~, they may choose to opt out of MSP eligibility. If their MSP eligibility is ~~allowed~~SLMB+ and they have other Medicaid benefits, they will need to choose between either losing ~~his or her~~their full-benefit Medicaid ~~current benefits~~coverage and keeping free Medicare Part B enrollment~~,~~ (through SLMB+) or ~~giving up the~~losing free Medicare Part B enrollment and keeping their full-benefit Medicaid coverage (see Process Help, Section 61.4 Manual Updates to MSP on Forward Health interChange~~his or her Medicaid benefits. All but 503, DACs, and widow/widowers can opt out of the QMB buy-in through CARES. See for processing instructions when a 503, DAC, or widower requests to opt out of MSP.~~).

34.1 Emergency Services

34.1.5 Emergency Services and Public Charge

Emergency Services is not considered in public charge determinations (see Section 7.3.4 Public Charge).

39.6 COLA Disregard

To calculate the COLA disregard amount, do the following:

1. Find the current gross OASDI income, which is the sum of:
    a. The amount of the OASDI check
    b. Any amount being deducted from the OASDI check for Medicare premiums ~~(do not include Medicare Part B premiums that are paid for by the state)~~
    c. Any amount being withheld from the OASDI check to recover a previous overpayment
2. In the table below, find the decimal figure that corresponds to the last month when the person received an SSI payment.
3. Multiply the gross OASDI income by the applicable decimal figure and round to the nearest whole dollar. The result is the historical COLA disregard amount.

Month SSI Last Received	**Multiply 2023 OASDI by:**	**Multiply 2022 OASDI by:**
Jan 2022 - Dec 2022	0.080037	--
Jan 2021 - Dec 2021	0.131291	0.055713
Jan 2020 - Dec 2020	0.142439	0.067831
Jan 2019 - Dec 2019	0.155944	0.082511
Jan 2018 - Dec 2018	0.178934	0.107501
Jan 2017 - Dec 2017	0.195033	0.125001
Jan 2016 - Dec 2016	0.197441	0.127618
Jan 2015 - Dec 2015	0.197441	0.127618
Jan 2014 - Dec 2014	0.210856	0.142201
Jan 2013 - Dec 2013	0.222518	0.154877
Jan 2012 - Dec 2012	0.235515	0.169004
Jan 2011 - Dec 2011	0.262080	0.197881
Jan 2010 - Dec 2010	0.262080	0.197881
Jan 2009 - Dec 2009	0.262080	0.197881
Jan 2008 - Dec 2008	0.302533	0.241853
Jan 2007 - Dec 2007	0.318214	0.258899
Jan 2006 - Dec 2006	0.339994	0.282574
Jan 2005 - Dec 2005	0.365989	0.310830
Jan 2004 - Dec 2004	0.382657	0.328948
Jan 2003 - Dec 2003	0.395354	0.342750
Jan 2002 - Dec 2002	0.403703	0.351825
Jan 2001 - Dec 2001	0.418813	0.368250
Jan 2000 - Dec 2000	0.438467	0.389614
Jan 1999 - Dec 1999	0.451628	0.403920
Jan 1998 - Dec 1998	0.458665	0.411569
Jan 1997 - Dec 1997	0.469800	0.423672
Jan 1996 - Dec 1996	0.484742	0.439915
Jan 1995 - Dec 1995	0.497799	0.454108
Jan 1994 - Dec 1994	0.511478	0.468976
Jan 1993 - Dec 1993	0.523858	0.482433
Jan 1992 - Dec 1992	0.537726	0.497508

Jan 1991 - Dec 1991	0.554220	0.515437
Jan 1990 - Dec 1990	0.577059	0.540263
Jan 1989 - Dec 1989	0.596044	0.560900
Jan 1988 - Dec 1988	0.611581	0.577789
Jan 1987 - Dec 1987	0.627237	0.594807
Jan 1986 - Dec 1986	0.632021	0.600007
Jan 1985 - Dec 1985	0.643085	0.612034
Jan 1984 - Dec 1984	0.655155	0.625153
Jul 1983 - Dec 1983	0.666816	0.637829
Jul 1982 - Jun 1983	0.689773	0.662783
Jul 1981 - Jun 1982	0.721019	0.696748
Jul 1980 - Jun 1981	0.755922	0.734687
Jul 1979 - Jun 1980	0.777909	0.758587
Jul 1978 - Jun 1979	0.791464	0.773321
Apr 1977 - Jun 1978	0.803082	0.785950

39.13 VA Allowance Rates

Benefit Type	PENSION Based on need		COMPENSATION Based on service-related disability or death		
Beneficiary	VETERAN	SURVIVING SPOUSE	VETERAN	SURVIVOR Dependency and Indemnity Compensation (DIC)	
				SPOUSE	PARENT
Aid & Attendance	$893	$537	Benefit could include A&A for the spouse. Amount depends on veteran's disability rating.	$387.15	$420
Household Allowance	$297	$200	N/A	$181.37	N/A

Note	For need-based VA benefits, the allowance amounts given above or the monthly UME amount could be greater than the total benefit amount. In this situation, the entire VA benefit amount is disregarded.