WISCONSIN DEPARTMENT OF HEALTH SERVICES

Division of Medicaid Services

1 W. Wilson St.

Madison WI 53703

To: Medicaid Eligibility Handbook Users

From: Bureau of Eligibility and Enrollment Policy

Re: **Medicaid Eligibility Handbook Release 24-01**

Release Date: 04/03/2024

Effective Date: 04/03/2024

EFFECTIVE DATE		The following policy additions or changes are **effective 04/03/2024** unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY UPDATES		
2.5.1.1	**Signatures From Representatives**	Changed who can sign an application on behalf of an incapacitated or incompetent adult. Updated to use the term "agent with power of attorney" to describe a person who has been granted power of attorney.
7.3.3.1	**Qualifying Immigrants**	Updated to add a correction that an immigrant paroled into the U.S. under INA Section 212(d)(5) must be in the U.S. for a least a year to be a Qualifying Immigrant.
7.3.3.5	**Ukrainian Parolees**	Updated to add a correction that primary caregivers of unaccompanied Ukrainian children paroled into the U.S. between 2/24/2022 and 9/30/2023 must also be treated as refugees (in addition to parents and legal guardians).
7.3.8	**Immigration Status Chart**	Updated information for Registration Status Code "06".
15.6.2.2	**By IRS Tax Forms**	Added additional forms and removed forms that were no longer relevant.
15.6.5.1	**IRS Tax Forms and Worksheets**	Removed reference to the discontinued C-EZ form.

15.6.7	**Self-Employment Hours**	Clarified that self-reported monthly hours worked do not need to be verified unless questionable.
15.7.3	**Medical/Remedial Expenses**	Clarified that patient liability and waiver costs share amounts from prior months cannot be deducted as medical expenses.
16.7.2.1	**Reverse Mortgage**	Added note on asset treatment of home equity lines of credit (HELOC).
16.7.5	**Life Insurance**	Section rewritten to reflect changes to how the face value of life insurance is determined for people who are aged 65 or older, blind, or disabled.
16.7.7	**Income Tax Refunds and Credits**	Updated section to align with corrections to the annual joint tax memo.
17.3.2	**Calculating the Penalty Period**	Updated example to reflect increase to average daily nursing home private pay rate. Effective 01/01/2024.
20.3.7	**Power of Attorney, Guardianship, or Conservator**	Updated to use the term “agent with power of attorney” to describe a person who has been granted power of attorney. Effective 02/01/2024.
20.3.8.1.2	**Reasonable Compatibility Thresholds**	Updated income amounts to reflect FPL changes. Effective 02/01/2024.
21.6.5	**Enrollment Exceptions**	Updated the types of transplants subject to enrollment exemptions per HMO contract changes. Effective 01/01/2024.
22.5.5	**Power of Attorney**	Updated to use the term “agent with power of attorney” to describe a person who has been granted power of attorney.
26.3.5	**Health and Employment Counseling (HEC) Program**	Updated incorrect description of the program.
26.3.5.1	**Health and Employment Counseling Processing**	Removed address for the HEC plan and corrected the available information regarding that address.
26.5.1	**Calculation**	Updated MAPP premium calculation example to reflect FPL updates. Effective 02/01/2024.
26.10	**Health and Employment Specialists Contact Information**	Deleted section and marked Reserved.

33.2.5	**Guardian and Power of Attorney**	Updated to use the term “agent with power of attorney” to describe a person who has been granted power of attorney.
34.1.3	**Certification of Emergency Services Eligibility**	Added a link for Process Help Manual Renewal Report.
36.1	**WWWMA Introduction**	Updated for gender inclusivity and other style edits. Clarified the WWWMA definition.
36.2.1	**Administration of Wisconsin Well Woman Medicaid**	Updated for gender inclusivity and other style edits.
36.2.2	**Enrollment through the Wisconsin Well Woman Program**	Updated for gender inclusivity and other style edits.
36.2.2.1	**Temporary Enrollment (TE) / Presumptive Eligibility (PE) Available Only to Persons Enrolling through WWWP**	Updated for gender inclusivity and other style edits.
36.2.3	**WWWP Members Enrolling in WWWMA**	Updated for gender inclusivity and other style edits.
36.2.3.1	**Applications for Wisconsin Well Woman Medicaid through the Wisconsin Well Woman Program**	Updated for gender inclusivity and other style edits. Updated application and enrollment information.
36.2.4	**Enrollment for Family Planning Only Services Members**	Updated to add the correction for the types of cancers that qualify an FPOS member to enroll in WWWMA. Updates for gender-inclusivity and other style edits.
36.2.4.1	**Applications for Wisconsin Well Woman Medicaid through Family Planning Only Services**	Updated for minor style edits.

36.3.2	**Disqualifying Insurance Coverage**	Clarified the criteria for disqualifying insurance coverage. Updates for gender-inclusivity and other style edits.
36.4	**WWWMA Financial Requirements**	Clarified information on financial eligibility for WWWMA.
39.4.1	**Elderly, Blind, or Disabled Assets and Income Tables**	Updated income and asset limits due to COLA. Effective 01/01/2024. Updated FPL numbers. Effective 02/01/2024.
39.4.2	**Disabled Minors Deeming and Allowances**	Updated parental income deeming amounts due to COLA. Effective 01/01/2024.
39.4.3	**LTC Post-Eligibility Allowances**	Updated allowance amounts due to COLA. Effective 01/01/2024.
39.4.4	**LTC Spousal Impoverishment Post-Eligibility Allowances and Community Spouse Asset Share**	Updated community spouse income allocation maximum and CSAS maximum due to COLA. Effective 01/01/2024.
39.4.5	**Family Care, Family Care Partnership, or PACE Group B Plus Cost Share Cap**	Updated cost share cap for managed HCBS participants. Effective 01/01/2024.
39.4.6	**Institutional Cost of Care Values**	Updated institutional cost of care values. Effective 01/01/2024.
39.4.7	**SSI Reference Values**	Updated SSI and SGA amounts. Effective 01/01/2024.
39.5	**FPL Table**	Updated income amounts due to the FPL update. Effective 02/01/2024.
39.11.1	**SeniorCare Income Limits Introduction**	Updated income amounts due to the FPL update. Effective 02/01/2024.
39.11.5.1	**Level 3: Fiscal Test Group of One**	Updated income amounts due to the FPL update. Effective 02/01/2024.
39.11.5.2	**Level 3: Fiscal Test Group of Two**	Updated income limits based on the annual FPL updates. Effective 02/01/2024.
39.12	**Five Percent Copay Limit Tiers**	Updated the table effective date to 2024. No changes to copay limits.

39.13	**VA Allowance Rates**	Updated A&A and housebound allowance amounts. Effective 12/01/2023.

Contents

2.5 Valid Signature

2.5.1 Valid Signature Introduction

2.5.1.1 Signatures From Representatives

[…]

4. **Agent with Durable Power of Attorney for Finances (Wis. Stat. ch. 244)**
   ~~A~~An agent with durable power of attorney for finances 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 an agent with activated 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~~have power of attorney for the purpose of providing a valid signature on the application. ~~A~~An agent with power of attorney for health care is not considered ~~the~~to have power of attorney for the purpose of providing a valid signature on the application.

   When a submitted application is signed by someone claiming to be the applicant's agent with activated durable power of attorney for finances, the agency must do both of the following:
   - Obtain a copy of the document the applicant used to designate the signer of the application as ~~the~~an agent with durable power of attorney for finances.
   - Review the document for a reference that indicates the durable power of attorney for finances authority continues notwithstanding any subsequent disability or incapacity of the applicant.

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

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

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

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

~~6.~~**5. A superintendent of a state mental health institute or center for the developmentally disabled**

~~7.~~6. **A warden or warden's designee**
   A warden or warden's designee for an inmate of a state correctional institution who is a hospital inpatient for more than 24 hours.

~~8.~~7. **The superintendent of a county psychiatric institution**
   The superintendent of a country psychiatric institution may sign an application for a resident of the institution provided that the county social or human services director has delegated to them (in writing) the authority to sign and witness applications for residents of the institution. Retain

a copy of this written authorization. The social or human services director may end the delegation when there is reason to believe that the delegated authority is not being carried out properly.

7.3 Immigrants

7.3.3 Immigrants Eligible for Medicaid

7.3.3.1 Qualifying Immigrants

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

[…]

8. An immigrant paroled into the U.S. under INA Section 212(d)(5) for at least one year.*

[…]

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

- Be lawfully residing in Wisconsin and an honorably discharged veteran of the U.S. Armed Forces (see Section 7.3.10 Military Service)
- Be lawfully residing in Wisconsin and on active duty (other than active duty for training) in the U.S. Armed Forces (see Section 7.3.10 Military Service)
- Be lawfully residing in Wisconsin and the spouse~~-~~, unmarried dependent child, or surviving spouse of either an honorably discharged veteran or a person on active duty in the U.S. Armed Forces
- Be a certain Amerasian immigrant defined under §584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988, with Class of Admission codes: AM1, AM2, AM3, AM6, AM7 or AM8~~.~~
- Have resided in the U.S. for at least five years since ~~his or her~~their date of entry (see Section 7.3.6 Continuous Presence).

7.3.3.5 Ukrainian Parolees

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

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

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

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

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

7.3.8 Immigration Status Chart

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

CARES Registration Status Code	Immigration Status	Arrived Before August 22, 1996	Veteran* Arrived Before August 22, 1996	Arrived On or After August 22, 1996	Veteran* Arrived On or After August 22, 1996	Children Under 19 and Pregnant ~~Women~~Persons; Arrived on or after August 22, 1996
01	Lawfully admitted for permanent residence	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009 Eligible
02	Permanent resident under color of law (PRUCOL)	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
03	Lawfully present under Section 203(a)(7)	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009 Eligible
04	Lawfully present under Section 207(c)	Eligible	Eligible	Eligible	Eligible	Eligible
05	Lawfully present under Section 208	Eligible	Eligible	Eligible	Eligible	Eligible
06	Lawfully present under Section 212(d)(5) and paroled for at least one year	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009 Eligible

[…]

15.6 Self-Employment Income

15.6.2 Ways to Identify

15.6.2.2 By IRS Tax Forms

A self-employed person who earns more than $400 net income must file an end-of-year return with the IRS. A person who will owe more than $400 in taxes at the end of the year must file quarterly estimates.

IRS tax forms for reporting self-employment income are listed below.

- Form 1065 - Partnership or multi-member LLC
  - Schedule K-1 (Form 1065) -- Partner's Share of Income, Deductions, Credits, etc
- ~~Form 1120 - Corporation or LLC electing to be taxed as a corporation~~
- Form 1120S - S Corporation
- Form 4562 - Depreciation & Amortization
- Form 1040 - Sole Proprietorship ~~or single member LLC~~
  - Form 4797 - Sales of Business Property
  - Schedule C (-Form 1040) - Business (non-farm)
  - Schedule E (-Form 1040) - Rental and Royalty
  - Schedule F (-Form 1040) - Farm Income
  - Schedule SE (-Form 1040) - Social Security Self-Employment
- Other Forms
  - Schedule D (Form 1040) - Capital Gains and Losses
  - Schedule 1 (Form 1040) - Additional Income and Adjustments to Income
  - Form 1040 - U.S. Individual Income Tax Return

15.6.5 Calculating Income Maintenance Income

15.6.5.1 IRS Tax Forms and Worksheets

[…]

1. Sole Proprietor - Farm and Other Business
   There is no worksheet for Sole Proprietor. See Process Help, Section 16.2.2.3.2 Entering Information for a Sole Proprietorship to identify which lines need to be entered in CWW for each of the following IRS tax forms:
   a. IRS Form 4797 - Capital & Ordinary Gains
   b. IRS Schedule C ~~or C-EZ~~ (Form 1040) - Profit or Loss From Business
   c. IRS Schedule E (Form 1040) - Rental and Royalty Income
   d. IRS Schedule F (Form 1040) - Farm Income

[…]

15.6.7 Self-Employment Hours

Count the time a self-employed person puts in on business-related activities involving planning, selling, advertising, and management along with time put in on production of goods and providing of services as hours of work.

Verification of self-reported monthly hours worked is not required unless questionable (see Section 20.4 Questionable Items).

15.7 Income Deductions

15.7.3 Medical/Remedial Expenses

Medical/remedial expenses are used in all the following:

- HCBW programs
- Patient liability calculations for residents of a medical institution
- Cost share and MAPP premium calculations
- MAPP eligibility calculation if expenses are over $500 monthly (see Section 26.4.2.1 Deduction for Medical and Remedial Expenses over $500 for more information on this MAPP specific deduction)

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

The following are examples of medical expenses:

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

Medicaid overpayments, unpaid patient liabilities~~.~~, and unpaid cost shares are not medical expenses. They ~~and~~ cannot be deducted ~~used as an~~ from income ~~deduction~~ to lower a current or future patient liability or~~,~~ cost share~~,~~ or used to meet a deductible.

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

Some examples of remedial expenses are:

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

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

16.7 Liquid Assets

16.7.2 Loans (including Home Equity Loans), Reverse Mortgages, and Promissory Notes

16.7.2.1 Reverse Mortgage

A reverse mortgage loan is a loan, or an agreement to lend, that is secured by a first mortgage on the borrower's principal residence. The terms of the loan specify regular payments to the borrower. Repayment (through sale of the residence) is required at the time all the borrowers have died or when they have sold the residence or moved to a new one.

Treat reverse mortgage loan payments to the borrower as assets in the month after the month received ~~and thereafter~~. Do not count undisbursed funds (not yet paid to the borrower) as assets. They are considered equity in the borrower's residence.

Note	Home equity lines of credit (HELOCs) are treated like reverse mortgages. The available balance of the HELOC is not an asset. The equity value of the property that secures the HELOC is reduced by the HELOC's outstanding balance because it is secured with a lien just like a reverse mortgage.

16.7.5 Life Insurance

~~Count the~~The cash surrender value (CSV) of ~~all~~ life insurance ~~policies.~~is a countable asset. However, there is a limited exception to this rule: For ~~persons~~a person who is aged 65 ~~years old~~ or older, blind, or disabled, ~~count it~~the CSV of their life insurance is only ~~when~~counted if the total face value (FV) of all life insurance policies~~, including riders and attachments,~~ owned by ~~each~~that person exceeds $1,500. ~~Do this calculation for each elderly, blind, or disabled person. In determining the face value, do not include any life insurance which has no cash value.~~

~~Face value~~The CSV is the ~~basic death benefit~~amount that the insurer will pay upon cancellation of the policy ~~including the value of riders and other attachments.~~

~~Cash value means~~ before death of the ~~net amount~~insured or before maturity of ~~cash for which~~ the policy ~~could be surrendered after deducting any loans or liens against it.~~

~~Workers should enter the total of the face value plus any riders or other attachments as the "Face Value" on the Life Insurance Assets page.~~

~~Life insurance policies always have a face value, but do not always have a cash value. Term~~ . The FV is the amount that is contracted for when the life insurance ~~is limited to a defined time period as stated in the~~ policy ~~and does not usually have cash value. Group life insurance is usually term insurance and usually has no cash value. An endowment insurance plan generally has cash value.~~is purchased. It may be described on the policy as the "face value," "amount of insurance," "amount of this policy," "sum insured," or a similar term.

For each person who is aged 65 or older, blind, or disabled, it must be determined if the total FV of all life insurance policies owned by that individual is greater than $1,500. When the total FV is determined, **must not be** included:

- The FV of any insurance policy that has no CSV, such as burial insurance and most term life insurance.
- The value of any dividend additions. Dividend additions are increases in coverage purchased using dividends generated by the policy. They are often referred to as "paid-up additions" or "paid-up additional insurance."
- Additional sums payable because of special provisions or riders. Riders are modifications the policy owner adds to the life insurance policy at the time of purchase. A common example is accidental death.

If the total FV of the life insurance owned by a person who is aged 65 or older, blind, or disabled is $1,500 or less, the CSV of any life insurance policy owned by that person is an exempt asset, including the CSV of any dividend additions.

For life insurance policies that cannot be excluded under the limited exception, the CSV of the policy, including the CSV or any dividend additions, is a countable asset.

Example 1

Steve (aged 67) and Mary (aged 63) are married. Steve is applying for Medicaid. Both individuals have whole life policies in which dividends are used to purchase individual coverage on the policy ("paid-up additions").

Policy	Owner	Face Value	Cash Surrender Value	Dividends	Riders
Whole Life	Steve	$1,500	6,700 (including CSV of paid-up addition)	Used to purchase additional coverage on the policy	$25,000 accidental death
Term life	Steve	$250,000	$0	N/A	N/A
Whole life	Mary	$5,200	$12,700 (including CSV of paid-up additions)	Used to purchase additional coverage on the policy	$15,000 accidental death

The total FV of life insurance ~~on term policies. When a veteran chooses this option to purchase paid-up~~policies owned by Steve is not greater than $1,500, so the $6,700 CSV of Steve's whole life insurance ~~with~~must be disregarded for his eligibility determination. The accidental death rider and Steve's term life policy are not counted when determining the total FV.

Mary is under the age of 65 and is not blind or disabled. Therefore, it is not necessary to calculate the total FV of her ~~term~~life insurance~~, the policy at that point has a CSV. The cash value amount~~ policies because the limited exception does not apply to her assets. Her whole life insurance policy's CSV of $12,700 is a countable asset for Steve's eligibility determination unless all or part of it can be excluded under other provisions, such as a burial fund.

Example 4

Siobhan is disabled and has one life insurance policy. The dividends from her policy are deposited into a separate, interest-bearing account.

Policy	Owner	Face Value	Cash Surrender Value	Dividends	Riders
Whole life	Siobhan	$1,500	$545	Accumulated in a separate account ($1,200)	N/A

The total FV life insurance policies owned by Siobhan is not greater than $1,500, so the $545 of CSV of the whole life insurance policy is not a countable asset. However, the $1,200 dividend accumulations held in a separate, available account are treated as a separate asset from life insurance.

~~**Note**:~~	~~In calendar year 2000, some VA Term Life Insurance Policies were assigned a cash value. The VA put into effect a regulation to provide~~

16.7.7 Income Tax Refunds and Credits

~~State~~Disregard all federal income tax refunds ~~are available assets.~~

~~Federal income tax refunds are disregarded in the month received~~ and credits for ~~the~~ 12 months following the month of receipt.

~~After~~ If there is a remaining, unspent portion of the of the refund or credit after the 12-month disregard period has passed, count ~~any remaining federal income tax refund~~ that portion as an available~~, non-exempt~~ asset.

All state income tax refunds and credits are considered available assets starting in the month after the month of receipt.

17.3 Penalty Period

17.3.2 Calculating the Penalty Period

The divestment penalty period is calculated in days by dividing the divested amount by the average daily nursing home private pay rate in effect at the time of the application (see Section 39.4.6 Institutional Cost of Care Values). This rate is updated annually on January 1.

Example 3:	Jeff moved to a nursing home and applied for Medicaid on February 1, ~~2023~~2024. One month earlier, Jeff transferred $18,500 in cash to his son, and it is determined to be a divestment that is not allowed resulting in a penalty period. At the time of application, Jeff is otherwise eligible for LTC Medicaid. Since $18,500 divided by the average daily nursing home private pay rate at the time Jeff applied ($~~308.71~~315.61) equals ~~59.93~~58.62 days, Jeff will have a divestment penalty period of ~~59~~58 days.

For divestments that occur after long term care eligibility is established or subsequent divestments that occur when a person is already in a divestment penalty period, the additional penalty period is calculated using the average daily nursing home private pay rate in effect at the time the divestment penalty period is being determined (see Section 17.3.6 Divestments During a Penalty Period).

20.3 Mandatory Verification Items

20.3.7 Power of Attorney, Guardianship, or Conservator

If the applicant or member states they have an agent with power of attorney, documentation of the power of attorney appointment is required. Only an agent with durable power of attorney for finances is considered to ~~be the~~have power of attorney for health care programs. “Durable” means that the power of attorney continues even if the applicant or member becomes incapacitated.

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

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

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

20.3.8 Income

20.3.8.1 Reasonable Compatibility for Income for Health Care

20.3.8.1.2 Reasonable Compatibility Thresholds

The reasonable compatibility test will apply to each AG for which earned income is reported, has not already been verified, and for which SWICA and/or Equifax data is available. Because different AGs are subject to different income and premium thresholds, the thresholds described below will be used by population as the first step in determining whether reported information is reasonably compatible.

- EBD Categorically Needy SSI-Related MA and Medically Needy MA thresholds are based on the income limits shown in Section 39.4.1 Elderly, Blind, or Disabled Assets and Income.
- MAPP and MSP thresholds are based on the income limits shown in Section 39.5 FPL Table.
- MAPP Premium thresholds are based on 100% FPL for a group of one as shown in Section 39.5 FPL Table. and described in the table below.

If both the total countable income using information reported by the applicant or member and the total countable income using information from the electronic data source are less than the threshold, the reasonable compatibility standard is met, and no further verification is required.

If the total countable income using information reported by the applicant or member is less than the threshold and the total countable income using information from the electronic data source is greater than the threshold, a second step occurs.

In this second step, the total countable income using information from the electronic data source is compared to a threshold that is equal to 120% of the total countable income using information reported by the applicant or member. If the total countable income using information from the electronic data source is equal to or less than 120% of the total countable income using information reported by the applicant or member, the reasonable compatibility standard is met, and no further verification is required.

Reasonable Compatibility Test for MAPP Premiums		
If total gross income using the monthly earnings amount reported by the member is:	And total gross income using the monthly earnings reported by SWICA or Equifax is:	Is it reasonably compatible?
Equal to or below the MAPP premium threshold (100% of the FPL)	Equal to or below the MAPP premium threshold (100% of the FPL)	Yes. Eligibility will be based on the member-reported earnings amount, and a premium will not be owed.
Equal to or below the MAPP premium threshold (100% of the FPL)	Above the MAPP premium threshold (100% of the FPL)	The 20% threshold test occurs. • If the total gross income using the monthly earnings reported by

		SWICA or Equifax is equal to or less than 120% of the total gross income using the monthly earnings amount reported by the member, the amounts are reasonably compatible. Eligibility will be based on the member-reported earnings amount, and a premium will not be owed. • If the total gross income using the monthly earnings reported by SWICA or Equifax is greater than 120 % of the total gross income using the monthly earnings amount reported by the member, the amounts are not reasonably compatible. Further verification must be requested.
Above the MAPP premium threshold (100% of the FPL)	Above the MAPP premium threshold (100% of the FPL)	A reasonable compatibility test was not done. Income must be verified for the correct premium amount to be determined.
Above the MAPP premium threshold (100% of the FPL)	Equal to or below the MAPP premium threshold (100% of the FPL)	A reasonable compatibility test was not done. Income must be verified for the correct premium amount to be determined.

Because different thresholds are used for different populations, individual members of a household or a given AG may pass the reasonable compatibility test while others do not.

Example 4	Leonard is applying for EBD Medicaid. He is not married and has no children. The SSI-Related Medically Needy monthly income limit is $1,~~215~~255. Leonard reports monthly earned income of $1,200; this is his only income, and it is below the income limit. The State Wage Information Collection Agency (SWICA) reports that Leonard's monthly earned income is $1,300. This income amount is above the income limit. Therefore, the reasonable compatibility test using the 20% threshold will be applied.

	The 20% threshold amount is the amount that is 20% greater than the total income that includes the earned income reported by the applicant or member. In this example, the 20% threshold amount is $1,440. The total income that includes the earned income reported by SWICA ($1,300) is less than the 20% threshold amount ($1,440). Therefore, the amounts are determined to be reasonably compatible. Leonard does not need to verify the earned income.

21.6 HMO Enrollment

21.6.5 Enrollment Exceptions

Members with specific needs can disenroll or opt out of HMO enrollment and receive their health care under fee-for-service if they meet the rules for an enrollment exemption. Most exemption requests must come from the member, the member's family, or legal guardian. They may need to be approved by either the HMO Enrollment Specialist, an HMO Ombuds, or state Nurse Consultant. Exemptions apply to individuals, not households.

Exemptions will generally be effective the first day of the next month after the month in which the exemption was requested, unless otherwise specified. Exemption requests will not be backdated unless an exception is granted by the Department. The duration of the exemption may vary depending on the type of exemption. Members should be directed to the HMO Enrollment Specialist for assistance in requesting an exemption and/or choice counseling.

Note:	The state Nurse Consultant provides consultation and technical assistance on topics related to health needs and complex care. The Nurse Consultant may need to make decisions on enrollment exemptions related to complex health care needs.

Types of Enrollment Exemptions

Exemption	Description
[…]	[…]
Transplants	~~The member had a transplant that is considered experimental, such as liver, heart, lung, heart-lung, pancreas, pancreas-kidney,~~ The member had a stem cell~~,~~ or bone marrow transplant. The member will be permanently exempted from HMO enrollment effective the first of the month in which the surgery is performed. Transplant exemption requests may be made by the HMO and directed to the state Nurse Consultant.

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

22.5.5 Power of Attorney

A person may ~~appoint a~~ grant power of attorney~~. A~~ to an agent. An agent with power of attorney may act within the scope of authority granted in the power of attorney appointment.

~~A~~ An agent with durable power of attorney for finances 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 an agent with ~~activated~~ 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~~have power of attorney for Medicaid purposes.

If a person has an ~~activated~~ agent with 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 agent with 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 agent with 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~~an agent with power of attorney.

26.3 Nonfinancial Requirements

26.3.5 Health and Employment Counseling Program

~~The~~ Health and Employment Counseling (HEC ~~Program~~) is a ~~program certified by the DHS to arrange services that help an applicant or member reach his or her~~ pre-employment ~~goals.~~program for MAPP members who are not employed but are looking for work. HEC participation is one way to meet the MAPP work requirement.

Applicants and members who are interested in HEC can call 866-278-6440 to learn more about the program.

HEC participation can occur for up to nine months with a three-month extension, for a total of 12 months. After six months, members can re-enroll in HEC to meet the eligibility criteria for MAPP as long as they have not already participated two times within a five-year period. HEC participation is limited to twice within a five-year period, and there must be six months between any two HEC participation periods.

26.3.5.1 Health and Employment Counseling Processing

Applicants or members wishing to enroll in HEC are required to complete the ~~Health and Employment Counseling (~~ HEC~~)~~ Application (F-00004) and send it to the ~~HEC Coordinator at the following~~ address~~:~~ listed on the application.

~~Employment Initiatives Section~~
~~HEC Coordinator~~
~~Room 527~~
~~1 W. Wilson St.~~
~~Madison, WI 53708~~

~~Fax: 608-223-7755~~
~~Phone: 866-278-6440~~

The HEC Coordinator will make a final approval or disapproval decision within 10 working days. If the application is not approved, the member will be informed that he or she has not been approved and that he or she has the right to file a fair hearing. If the application is approved, the HEC Coordinator will send the member an approval letter and send a copy to the CDPU/MDPU. IM workers should give the Health and Employment Counseling (HEC) Application along with the Medicaid Purchase Plan Fact Sheet (P-10071) to any MAPP applicant who requests HEC. The applicant can complete the application on his or her own or with the assistance of the HEC Coordinator or an advocate. IM workers are not expected to assist with filling out or submitting the form to the HEC Coordinator.

26.5 MAPP Premiums

26.5.1 Calculation

[…]

Example 3	Susan is a MAPP member whose Premium Gross income is ~~181~~175% of the FPL. When her allowable deductions are taken in the premium calculation, her Countable Net Income is $1,750. Her monthly MAPP premium will be calculated as shown below: $2,200 Premium Gross Income – $300 monthly IRWE deduction – $150 monthly medical/remedial deduction ---------- $1,750 Countable Net Income – $1,~~215~~255 (100% of the FPL) ---------- $~~535~~495 Premium Net Income X 0.03 (3%) ---------- $~~16.05~~14.85 +$25 Base Premium Amount ---------- $~~41.05~~39.85 (round down to nearest whole dollar) Susan's monthly MAPP premium is $~~41~~39.

26.10 Reserved

~~For more information about the HEC Program, call 866-278-6440.~~

33.2 Application

33.2.5 Guardian and Power of Attorney

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

Copies of guardianship or POA documentation must be submitted to the SeniorCare Program before information about the applicant or member can be released to the guardian or POA, unless the POA is the authorized representative. The SeniorCare Authorization of Representative form (F-10080) will be accepted in lieu of the POA papers.

34.1 Emergency Services

34.1.3 Certification of Emergency Services Eligibility

Individuals enrolled in Emergency Services will be eligible until:

- For adults age 19 and older, the last day of the emergency.
- For children under age 19, the end of a 12-month period.
- For a child who is turning 19 in the next 12-month period, the last day of the emergency or the last day or the month the child turns 19, whichever is later.

For adults age 19 and older, if the last day of the emergency is not known, they are eligible through the last day of the month in which the emergency is expected to end.

For information on manually processing applications, see Process Help, Section 9.3 Health Care (BC+ and MA) Emergency Services Manual Application Processing. For information on manually processing renewals for members who have an ongoing emergency condition, see Process Help, Section 26.1 Manual Renewal Report.

A person eligible for Emergency Services will not receive a ForwardHealth card because Emergency Services eligibility typically ends when the emergency ends.

36.1 WWWMA Introduction

~~WWWMA is administered by the DHSDMS and provides eligible women with access to full-benefit Medicaid through non-HMO providers.~~

~~**Wisconsin Well Woman Medicaid Eligibility**~~

~~WWWMA enrollment is limited to the following groups.~~ Wisconsin Well Woman Medicaid (WWWMA) is a full-benefit Medicaid plan. It covers people under age 65 who have been diagnosed with and need treatment for breast or cervical cancer or certain precancerous conditions of the breast or cervix. WWWMA is a fee-for-service Medicaid program. Members are not enrolled in an HMO.

A ~~woman~~person must be enrolled in one of the following ~~ForwardHealth~~ programs before ~~she~~they can initially enroll in WWWMA:

- ~~WWWP~~
- ~~FPOS~~
- Well Woman Medicaid Program (WWWP)
- Family Planning Only Services (FPOS)
- BadgerCare Plus

The individual must also meet all requirements in Section 36.3.1 Introduction~~As long as~~.

Once the ~~woman~~person is enrolled in WWWMA, ~~she does~~they do not have to reapply for any of the above programs~~. She~~, as they will have full-benefit ~~fee-for-service~~ Medicaid ~~health care~~ coverage through WWWMA.

~~Effective October 2009, all WWWMA enrollments and renewals are administered by EM CAPO. The local certifying agencies have no role in recertifications or new WWWMA enrollments (see).~~

36.2 WWWMA Enrollment

36.2.1 ~~EM CAPO Administrating Enrollment for~~Administration of Wisconsin Well Woman Medicaid

~~All initial~~ WWWMA is administered by the DHS DMS Enrollment Management Central Application Processing Operation (EM CAPO). EM CAPO handles all enrollments and renewals ~~for continuous WWWMA are now processed by EM CAPO.~~.

Temporary Enrollment/Presumptive Eligibility enrollment is ~~still~~ processed by the fiscal agent.

Any applications received in local IM or tribal agencies should be faxed to the EM CAPO at ~~(~~608~~)~~ 267-3381 immediately upon receipt to prevent any delay in eligibility determination or treatment for the applicant.

CONTACTS:

EM CAPO: DHSEMCAPO@dhs.wisconsin.gov

Fax: ~~(~~608~~)~~ 267-3381

Phone: 1-877-246-2276

Customer line: ~~(~~608~~)~~ 266-1720

36.2.2 Enrollment through the Wisconsin Well Woman Program

The WWWP is administered by the DHS Division of Public Health (DPH). WWWP provides eligible ~~women~~persons with various health screenings (including breast and cervical cancer screening), referrals, education, and outreach.

The WWWP performs the financial and initial non-financial screening for WWWMA for WWWP enrollees. A WWWP enrollee must have a health screening through WWWP, be diagnosed, and need treatment for breast or cervical cancer to be considered for WWWMA.

WWWP ~~LCAs~~ Local Coordinating Agencies (LCA) enroll ~~women~~persons in WWWP and perform some of the basic non-financial and all financial data gathering, and verification for WWWMA. They also coordinate the WWWP member's referral to a health care provider for breast and cervical cancer screening.

1. The WWWP LCA will complete the F-44818 (formerly DPH-4818) with the assistance of the applicant prior to the applicant's health care screening. The F-44818 enrolls the ~~woman~~person in WWWP. ~~Her~~ Their WWWP eligibility will be ~~recorded~~ in interChange ~~as "Med Stat~~ under medical status code "CS~~".~~."
2. The WWWP member will receive a breast and cervical cancer screening from a WWWP provider. If the WWWP member is diagnosed with breast or cervical cancer, ~~her~~their provider will complete the F-10075 recording the diagnosis and indicating that treatment is required. The provider will sign and date the F-10075. The WWWP member will also sign and date the F-10075. The signature dates do not have to be the same date.
3. The provider will fill in the beginning and end dates of the temporary enrollment/presumptive eligibility for WWWMA on the F-10075.
4. The provider will forward a copy of the F-10075 to the WWWP LCA.
5. The WWWP LCA will provide the member with a copy of the signed F-10075 and F-44818 forms.
6. The WWWP LCA will check to be sure correct temporary eligibility dates (if appropriate) are entered on the F-10075 and explain that the member's temporary enrollment for WWWMA will end on the last day of the following calendar month.

36.2.2.1 Temporary Enrollment (TE~~)~~/) / Presumptive Eligibility (PE) Available Only to ~~Women~~Persons Enrolling through WWWP

Temporary Enrollment (TE), also known as Presumptive Eligibility (PE), is a streamlined eligibility determination for temporary enrollment in Wisconsin Well Woman Medicaid (WWWMA). It allows eligible applicants immediate access to cancer treatment for a short period until an application for ongoing coverage is completed and processed. TE is only available to ~~individuals~~persons who are enrolling through the Wisconsin Well Woman Program (WWWP). An applicant may only be temporarily enrolled once in a rolling 12-month period.

The provider doing the medical screening enters the TE dates in the section "Temporary Eligibility Begin Date" and "Temporary Eligibility End Date" on the F-10075. The dates should cover the time period beginning on the date of diagnosis through the last day of the following calendar month.

The WWWP Local Coordinating Agency (LCA) should then fax a copy of the completed F-10075 to the fiscal agent at 608-221-8815 within five days of the diagnosis date. The fiscal agent will enter the temporary enrollment data in ForwardHealth interChange (with a medical status code of "CB~~)~~") and

send the member a ForwardHealth card with the temporary enrollment dates activated on the card. If the member had a previous ForwardHealth card, it will be reactivated.

Until the ForwardHealth card arrives or is reactivated, the new WWWMA member may receive services by presenting both of the following completed forms to any Medicaid provider:

1. WWWP Enrollment Form (F-44818)
2. WWWMA Determination Form (F-10075)

To continue receiving WWWMA, the member or the WWWP LCA must submit an F-10075 to the EM CAPO. If the member does not apply, their WWWMA benefits will end at the end of the month following the month of diagnosis.

The TE period extends from the date of diagnosis on the F-10075 through the following month. A new TE period would only occur if a new cancer diagnosis was established for the same member and only if it has been at least 12 months since the first day of their last TE period.

Note	If the member applies during their TE certification period and the EM CAPO is not able to process their application~~,~~ within the 30-day processing time frame, the EM CAPO will extend the members' eligibility for an additional 30 days from the last day of their Wisconsin Well Woman Medicaid TE with a medical status of "CB." Submit an F-10110 (formerly DES 3070) to extend the Well Woman Medicaid TE for an additional calendar month.

36.2.3 WWWP Members Enrolling ~~for Continuous~~ in WWWMA

36.2.3.1 Applications for Wisconsin Well Woman Medicaid through the Wisconsin Well Woman Program

The standard Medicaid application form is not used to enroll in WWWMA. To apply for WWWMA through the WWWP, the applicant or the WWWP LCA must send or fax the completed F-44818 and F-10075 forms to the EM CAPO. The applicant may apply for WWWMA at any time after the WWWP screening and diagnosis. Eligibility may only be backdated to the first of the month up to three months prior to the application date or from the date of diagnosis, whichever is most recent. ~~(For requests to back-date farther than three months, refer to the policy analyst.)~~

~~Use the F-44818 and in place of the standard application forms. This program requires manual determination. Do not enter the woman's information into CARES as an application.~~

The date of receipt of the F-10075 is the filing date. ~~Use the verification policy listed in~~ See Chapter 20 for ~~any items requiring~~ verification policies.

~~Complete the~~The following steps are completed to ~~certify~~enroll the member ~~for~~in WWWMA:

1. Review the F-44818. There should be a "No" answer to the following questions~~: If the applicant answered "Yes" to any of these questions in a-c, the applicant is ineligible for WWWMA. The EM CAPO will refer her back to the Well Woman Program and send a manual negative notice~~.
    a. Does the applicant have any health insurance? (Item #32 on F-4818)
    If the applicant answers "Yes", determine if the insurance is one of those listed in section 36.3.3 Non-Disqualifying Insurance Coverage Non-Disqualifying Insurance Coverage that covers treatment for ~~her~~ breast or cervical cancer. If ~~she~~the applicant has coverage for the treatment, ~~she is~~they are ineligible for WWWMA.
    b. Does the applicant have Medicare Part B? (Item #33 on F-4818)
    c. Does the applicant have Medicare Part A.

    If the applicant answered "Yes" to any of these questions in a-c, the applicant is ineligible for WWWMA. The EM CAPO will refer the applicant back to the Well Woman Program and send a manual negative notice.

2. Review the F-44818 to ensure that the following fields have been completed: 1-5, 9-13, 16-25, and 27-45.
    If the form is incomplete, the EM CAPO will request that the applicant provide any missing information. If the applicant does not provide all necessary information, there may be a delay in ~~eligibility determination and benefits~~enrollment.
3. Review F-10075 for an SSN. If the SSN is missing from the F-10075 and is not present on the F-44818 (# 6a); the EM CAPO will ask the applicant to provide ~~her~~ their Social Security Number (SSN~~.~~). Providing an SSN for the Well Woman Program is voluntary, but providing an SSN, or applying for one, is required for WWWMA.

    If the applicant fails to provide an SSN, or fails to apply for an SSN within the 30-day application processing time or within ~~ten~~10 days (whichever is later), the EM CAPO will send a manual negative notice to the applicant indicating that ~~the she is~~ they are not eligible for WWWMA because ~~she~~they did not provide an SSN.
4. Ask the applicant if ~~she is~~ they are a U.S. citizen.
    If the applicant is not a U.S. citizen, ask ~~her~~them what ~~her~~their immigration status is and to

provide ~~her~~their immigrant registration card. Verify that the applicant is in a qualified immigration status using the ~~SAVE~~ Systematic Alien Verification for entitlement (SAVE) system.

Note:	Some applicants with breast and cervical cancer who do not meet the immigration-related eligibility criteria may be eligible to receive emergency services. If a non-qualifying immigrant has been screened by ~~Well Woman Program~~WWWP, determine ~~her~~their eligibility for emergency services using the criteria in 7.1 US Citizens and Nationals.

5. If there are any questionable items, contact the Wisconsin Well Woman Program Local Coordinating Agency (WWP LCA).
6. EM CAPO will update interChange with the WWWMA eligibility information using a medical status code of "CB" to certify any member who has met the criteria listed above. Submit the completed Medicaid/BadgerCare Plus Eligibility Certification form (F-10110) to the fiscal agent by fax to 608-221-8815, through interChange, or by mail to:

   ForwardHealth
   Attn~~:~~ Eligibility Lead Worker WWWMA
   313 Blettner Blvd
   Madison WI
   53714-2405

7. Certify the member for 12 months from the filing date and backdate to whichever is more recent:
   a. Up to three months prior to the filing date~~, or~~
   b. To the date of the diagnosis (F-10075)~~,~~

~~Never certify a woman for Well Woman Medicaid~~A person cannot be enrolled in WWWMA prior to ~~her~~their date of diagnosis.

Example 1:	Gina applies for Wisconsin Well Woman Medicaid (WWWMA) at the Local Coordinating Agency (LCA) on September ~~20th 2009~~20. The LCA submits the F-44818 and F 10075 to EM CAPO. The F-10075 indicates that Gina is enrolled in Wisconsin Well Woman Program (WWWP). The ~~LCA provides a copy of the F-4818 documenting Gina's~~F-44818 confirms Gina's enrollment in the WWWP. ~~Gina's~~Gina's date of diagnosis on the F-10075 is August ~~6th 2009~~6. Gina meets the following non-financial requirements: citizenship/ID documentation, provides a valid SSN and has no public or private insurance that will cover her cancer treatment and she is under 65 years of age. EM CAPO will certify Gina ~~-~~in interChange (iC) effective August ~~6th, 2009~~6 through July 31 ~~2010~~ with a CB medical status code. EM CAPO will send Gina a notice indicating her eligibility dates. About ~~one month from~~45 days before the end of Gina's eligibility period, EM CAPO will send Gina a ~~recertification~~renewal notice indicating she needs to ~~recertify for~~renew her WWWMA.

For initial WWWMA certifications, if the applicant applies during ~~her~~their WWWMA TE certification period and EM CAPO is not able to process ~~her~~their application within the 30~~-~~-day processing time frame, EM CAPO will extend the applicant's eligibility for an additional 30 days from the last day of

herthier WWWMA TE in iC with a medical status of "CB." NoteEM CAPO will note this extension in the CARES Comments section if appropriate.

To contact the WWWP LCA, refer to #27 of F-44818.

36.2.4 Enrollment for Family Planning Only Services Members

WomenPersons enrolled in FPOS who meet one of the following criteria (regardless of age), will be eligible for WWWMA:

- Are screened for, and diagnosed with, breast or cervical cancer or a precancerous condition of the breast or cervix
- Receive a clinical breast exam through a FPOS provider and through follow up medical testing (independent of the FPOS) and
    - Are found to be in need of treatment for breast or cervical cancer or precancerous cervical condition- of the breast or cervix and
    - Do not have other insurance that would cover their cancer treatment.

36.2.4.1 Applications for Wisconsin Well Woman Medicaid Through Family Planning Only Services

A Wisconsin Well Woman MedicaidWWWMA Determination form (F-10075) submitted by a Famliy Planning Only Services (FPOS-) member or their representative is a request to enroll in WWWMA and disenroll from FPOS. Individuals who are enrolled in FPOS in CARES and meet the criteria above (see Section 36.2.4 Enrollment for Family Planning Only Services Members) may be eligible for WWWMA.

36.3 WWWMA Nonfinancial Requirements

36.3.2 Disqualifying Insurance Coverage

A ~~woman~~person is ineligible for WWWMA if ~~she is~~ they are currently covered by any one of the following:

- Group health plans that cover treatment for ~~her~~their breast or cervical cancer or precancerous condition of the breast or cervix
- Full benefit health insurance that covers treatment for ~~her~~their breast or cervical cancer or precancerous condition of the breast or cervix
- Medicare Part A
- Medicare Part B
- BadgerCare Plus without a premium or any other category of full benefit Medicaid that covers ~~her~~their treatment for breast or cervical cancer or precancerous condition of the breast or cervix

Note:	An unmet deductible is not full-benefit Medicaid.

- Veteran's benefits/TRICARE that cover treatment for ~~her~~ their breast or cervical cancer or precancerous condition of the breast or cervix
- Federal employee health plans
- Peace Corps health plans
- Other full-benefit private or public health care plans that provide cancer treatment as determined by ~~her~~their health care team

36.4 WWWMA Financial Requirements

Because enrollment in~~-~~ Wisconsin Well Woman Medicaid WWWMA is dependent on financial eligibility for a gatepost program, there are no financial requirements for WWWMA.

~~Do not~~There is no asset or income test for ~~assets or income.~~ WWWMA enrollment. Financial requirements are addressed through the~~-~~ Wisconsin Well Woman Program (WWWP~~,~~~~-~~), Family Planning Only Services (FPOS~~,~~), or BadgerCare Plus enrollment process. ~~See the BadgerCare Plus Handbook Chs.16-20 for BadgerCare Plus and Ch. 40 for FPOS. See the BadgerCare Plus Handbook~~For BadgerCare Plus, see~~-~~ BadgerCare Plus Handbook, ~~Chs.~~Section 16 Income, Section 17 Deductibles, Section 18 BadgerCare Plus Extensions, Section 19 Premiums, and Section 20 Assets.~~ for BadgerCare Plus~~ For FPOS see Badger~~and~~ Care Plus ~~h~~Handbook, Section~~. 40 for FPOS~~ 40 Family Planning Only Services (FPOS).

Once a ~~woman~~person is enrolled in WWWMA, ~~she~~they may not be financially tested as a condition of ~~her~~their continuing eligibility in WWWMA.

39.4 Elderly, Blind, or Disabled Assets and Income Tables

39.4.1 Elderly, Blind, or Disabled Assets and Income Table

Category	Limit	Group Size 1	Group Size 2	Effective	Updated Annually?
SSI-Related Categorically Needy	Asset	$2,000.00	$3,000.00	1/1/1989	No
	Income	$~~997~~1026.78	$1,~~503~~547.05	1/1/~~2023~~2024	Yes
SSI-Related Medically Needy	Asset	$2,000.00	$3,000.00	1/1/1989	No
	Income	$1,~~215~~255.00	$1,~~643~~703.33	2/1/~~2023~~2024	Yes
MAPP	Asset	$15,000.00	N/A	3/1/2000	No
	Income	Less than 250% FPL (see Section 39.5 FPL Table)		2/1/~~2023~~2024	Yes
Institutions Categorically Needy	Income	$2,~~742~~829.00	N/A	1/1/~~2023~~2024	Yes
Group B Community Waivers	Income	$2,~~742~~829.00	N/A	1/1/~~2023~~2024	Yes
QMB	Asset	$9,~~090~~430.00	$~~13,630~~14,130.00	1/1/~~2023~~2024	Yes
	Income	At or below 100% FPL (see Section 39.5 FPL Table)		2/1/~~2023~~2024	Yes
SLMB	Asset	$9,~~090~~430.00	$~~13,630~~14,130.00	1/1/~~2023~~2024	Yes
	Income	At least 100% FPL but less than 120% FPL (see Section 39.5 FPL Table)		2/1/~~2023~~2024	Yes
SLMB+	Asset	$9,~~090~~430.00	$~~13,630~~14,130.00	1/1/~~2023~~2024	Yes
	Income	At least 120% FPL but less than 135% FPL (see Section 39.5 FPL Table)		2/1/~~2023~~2024	Yes
QDWI	Asset	$4,000.00	$6,000.00	7/1/1990	No
	Income	$2,~~430~~510.00	$3,~~286~~406.66	2/1/~~2023~~2024	Yes

39.4.2 Disabled Minors Deeming and Allowances

Item	Amount	Effective	Updated Annually?
SSI-Related Deeming Amount to an Ineligible Minor	$~~457~~472.00	1/1/~~2023~~2024	Yes
Parental living allowance - 1 Parent	$~~914~~943.00	1/1/~~2023~~2024	Yes
Parental living allowance - 2 Parents	$1,~~371~~415.00	1/1/~~2023~~2024	Yes

39.4.3 LTC Post-Eligibility Allowances

Item	Amount	Effective	Updated Annually?
Institutions Personal Needs Allowance	$45.00	7/1/2001	No
Institutions Home Maintenance Allowance Maximum	$1,~~093~~122.77	1/1/~~2023~~2024	Yes
Non-Spousal-Impoverishment Family Maintenance Allowance Maximum	$1,~~093~~122.77	1/1/~~2023~~2024	Yes
Community Waivers Basic Needs Allowance	$1,~~094~~123.00	1/1/~~2023~~2024	Yes
Community Waivers Personal Maintenance Allowance Maximum	$2,~~742~~829.00	1/1/~~2023~~2024	Yes

39.4.4 LTC Spousal Impoverishment Post-Eligibility Allowances and Community Spouse Asset Share

Description	Amount	Effective	Updated Annually?
Community Spouse Lower Income Allocation Limit	$3,286.66	7/1/2023	Yes
Shelter Base Amount	$986.00	7/1/2023	Yes
Community Spouse Income Allocation Maximum	$3,~~715~~853.50	1/1/~~2023~~2024	Yes
Dependent Family Member Income Allowance Maximum	$821.67	7/1/2023	Yes
Dependent Family Member Income Allowance Standard	$2,465	7/1/2023	Yes
Community Spouse Asset Share (CSAS) Maximum	$~~148,620~~154,140	1/1/~~2023~~2024	Yes

39.4.5 Family Care, Family Care Partnership, or PACE Group B Plus Cost Share Cap

Item	Amount	Effective	Updated Annually?
Cost Share Cap for Group B Plus Family Care, Family Care Partnership, or PACE	$3,~~213.15~~347.75	1/1/~~2023~~2024	Yes

39.4.6 Institutional Cost of Care Values

Item	Amount	Effective	Updated Annually?
Daily Average Private Pay Nursing Home Rate	$~~308.71~~315.61	1/1/~~2023~~2024	Yes
Monthly Average Private Pay Nursing Home Rate	$9,~~389.93~~599.80	1/1/~~2023~~2024	Yes
Monthly Rate for State Centers for Persons with Developmental Disabilities	$~~30,599.17~~42,689.79	1/1/~~2023~~2024	Yes

39.4.7 SSI Reference Values

Item	Group Size 1	Group Size 2	Effective	Updated Annually?
Federal SSI Payment Level	$~~914~~943.00	$1,~~371~~415.00	1/1/~~2023~~2024	Yes
State Supplementary Payment (SSP)	$83.78	$132.05	1994	No
SSI E Supplement	$95.99	$345.36	1994	No
Substantial Gainful Activity Threshold for Non-Blind Disabled Individuals	$1,~~470~~550.00	N/A	1/1/~~2023~~2024	Yes
Substantial Gainful Activity Threshold for Blind Individuals	$2,~~460~~590.00	N/A	1/1/~~2023~~2024	Yes

39.5 FPL Table

Group Size	Annual FPL	100% FPL	120% FPL	133% FPL	135% FPL	150% FPL	156% FPL	160% FPL	185% FPL	191% FPL	200% FPL	201% FPL	240% FPL	250% FPL	300% FPL	306% FPL	~~30% of 200% FPL~~
1	$~~14,580~~15,060.00	$1,~~215~~255.00	$1,~~458~~506.00	$1,~~615.95~~669.15	$1,~~640~~694.25	$1,~~822~~882.50	$1,~~895.40~~957.80	$~~1,944~~2,008.00	$2,~~247~~321.75	$2,~~320.65~~397.05	$2,~~430~~510.00	$2,~~442.15~~522.55	$~~2,916~~3,012.00	$3,~~037~~137.50	$3,~~645~~765.00	$3,~~717.90~~840.30	
2	$~~19,720~~20,440.00	$1,~~643~~703.33	$~~1,972~~2,044.00	$2,~~185.63~~265.43	$2,~~218~~299.50	$2,~~465~~555.00	$2,~~563.59~~657.19	$2,~~629~~725.33	$3,~~040~~151.16	$3,~~138.76~~253.36	$3,~~286~~406.66	$3,~~303.09~~423.69	$~~3,943~~4,087.99	$4,~~108~~258.33	$~~4,929~~5,109.99	$5,~~028.59~~212.19	~~$986.00~~
3	$~~24,860~~25,820.00	$2,~~071~~151.67	$2,~~486~~582.00	$2,~~755.32~~861.72	$2,~~796~~904.75	$3,~~107~~227.51	$3,~~231.81~~356.61	$3,~~314~~442.67	$3,~~832~~980.59	$~~3,956.89~~4,109.69	$4,~~143~~303.34	$4,~~164.06~~324.86	$~~4,972~~5,164.01	$5,~~179~~379.18	$6,~~215~~455.01	$6,~~339.31~~584.11	
4	$~~30,000~~31,200.00	$2,~~500~~600.00	$3,~~000~~120.00	$3,~~3254~~58.00	$3,~~375~~510.00	$3,~~750~~900.00	$~~3,9004~~,056.00	$4,~~000~~160.00	$4,~~625~~810.00	$4,~~7759~~66.00	$5,~~000~~200.00	$5,~~0252~~26.00	$6,~~000~~240.00	$6,~~250~~500.00	$7,~~500~~800.00	$7,~~6509~~56.00	
5	$~~35,140~~36,580.00	$~~2,928~~3,048.33	$3,~~514~~658.00	$~~3,894.68~~4,054.28	$~~3,953~~4,115.25	$4,~~392~~572.50	$4,~~568.19~~755.39	$4,~~685~~877.33	$5,~~417~~639.41	$5,~~593.11~~822.31	$~~5,856~~6,096.66	$~~5,885.94~~6,127.14	$7,~~027~~315.99	$7,~~320~~620.83	$~~8,784~~9,144.99	$~~8,960.69~~9,327.89	

6	$40,280 41,960.00	$3,356 496.67	$4,028 196.00	$4,464.37 650.57	$4,531 720.50	$5,035 245.01	$5,236.41 454.81	$5,370 594.67	$6,209 468.84	$6,411.24 678.64	$6,713 993.34	$6,746.917 ,028.31	$8,056 392.01	$8,391 741.68	$10,070 490.01	$10,271.41 699.81	
7	$45,420 47,340.00	$3,785 945.00	$4,542 734.00	$5,034.05 246.85	$5,109 325.75	$5,677 917.50	$5,904.606 ,154.20	$6,056 312.00	$7,002 298.25	$7,229.35 534.95	$7,570 890.00	$7,607.85 929.45	$9,084 468.00	$9,462 862.50	$11,355 835.00	$11,582.10 12,071.70	
8	$50,560 52,720.00	$4,213 393.33	$5,056 272.00	$5,603.73 843.13	$5,688 931.00	$6,320 590.00	$6,572.79 853.59	$6,741 7,029.33	$7,794 8,127.66	$8,047.46 391.26	$8,426 786.66	$8,468.79 830.59	$10,111 543.99	$10,533 983.33	$12,639 13,179.99	$12,892.79 13,443.59	
9	$55,700 58,100.00	$4,641 841.67	$5,570 810.00	$6,173 439.42	$6,266 536.25	$6,962 7,262.51	$7,241 53.01	$7,426 746.67	$8,587 957.09	$8,8659 ,247.59	$9,283 683.34	$9,3297 31.76	$11,140 620.01	$11,604 12,104.18	$13,925 14,525.01	$14,203 815.51	
10	$60,840 63,480.00	$5,070 290.00	$6,084 348.00	$6,743.107 ,035.70	$6,844 7,141.50	$7,605 935.00	$7,909.208 ,252.40	$8,112 464.00	$9,379 786.50	$9,683.70 10,103.90	$10,140 580.00	$10,190 .70632.90	$12,168 696.00	$12,675 13,225.00	$15,210 870.00	$15,514 .2016,187.40	
11	$65,980 68,860.00	$5,498 738.33	$6,598 886.00	$7,312.78 631.98	$7,422 746.75	$8,247 607.50	$8,577.39 951.79	$8,797 9,181.33	$10,171 615.91	$10,501 .81960.21	$10,996 11,476.66	$11,051 .64534.04	$13,195 771.99	$13,745 14,345.83	$16,494 17,214.99	$16,824 .8917,559.29	
12	$71,120 74,240.00	$5,926 6,186.67	$7,112 424.00	$7,882.478 ,228.27	$8,001 352.00	$8,890 9,280.01	$9,245.61 651.21	$9,482 898.67	$10,964 11,445.34	$11,319 .94816.54	$11,853 12,373.34	$11,912 .6112,435.21	$14,224 848.01	$14,816 15,466.68	$17,780 18,560.01	$18,135 .61931.21	
13	$76,260 79,620.00	$6,355 635.00	$7,626 962.00	$8,452.15 824.55	$8,579 957.25	$9,532 952.50	$9,913.80 10,350.60	$10,168 616.00	$11,756 12,274.75	$12,138 .05672.85	$12,710 13,270.00	$12,773 .5513,336.35	$15,252 924.00	$15,887 16,587.50	$19,065 905.00	$19,446 .3020,303.10	

14	$81,400 85,000.00	$6,783 7,083.33	$8,140 500.00	$9,021 420.83	$9,157 562.50	$10,175 625.00	$10,581 11,049.99	$10,853 11,333.33	$12,549 13,104.16	$12,956 13,529.16	$13,566 14,166.66	$13,634 14,237.49	$16,279 9999.99	$16,958 17,708.33	$20,349 21,249.99	$20,756 21,674.99	
15	$86,540 90,380.00	$7,211 531.67	$8,654 9,038.00	$9,591.52 10,017.12	$9,735 10,167.75	$10,817 11,297.51	$11,250 .21749.41	$11,538 12,050.67	$13,341 933.59	$13,774 .2914,385.49	$14,423 15,063.34	$14,495 .4615,138.66	$17,308 18,076.01	$18,029 829.18	$21,635 22,595.01	$22,067 .7123,046.91	
16	$91,680 95,760.00	$7,640 980.00	$9,168 576.00	$10,161 .20613.40	$10,314 773.00	$11,460 970.00	$11,918 .4012,448.80	$12,224 768.00	$14,134 763.00	$14,592 .4015,241.80	$15,280 960.00	$15,356 .4016,039.80	$18,336 19,152.00	$19,100 950.00	$22,920 23,940.00	$23,378 .4024,418.80	
17	$96,820 101,140.00	$8,068 428.33	$9,682 10,114.00	$10,730 .8811,209.68	$10,892 11,378.25	$12,102 642.50	$12,586 .5913,148.19	$12,909 13,485.33	$14,926 15,592.41	$15,410 .5116,098.11	$16,136 856.66	$16,217 .34940.94	$19,363 20,227.99	$20,170 21,070.83	$24,204 25,284.99	$24,689 .0925,790.69	
18	$101,960 106,520.00	$8,496 876.67	$10,196 652.00	$11,300 .57805.97	$11,470 983.50	$12,745 13,315.01	$13,254 .81847.61	$13,594 14,202.67	$15,716 16,421.84	$16,228 .64954.44	$16,993 17,753.34	$17,078 .31842.11	$20,392 21,304.01	$21,241 22,191.68	$25,490 26,630.01	$25,999 .8127,162.61	
19	$107,100 111,900.00	$8,925 9,325.00	$10,710 11,190.00	$11,870 12,402.25	$12,048 588.75	$13,387 987.50	$13,923 14,547.00	$14,280 920.00	$16,511 17,251.25	$17,046 810.75	$17,850 18,650.00	$17,939 18,743.25	$21,420 22,380.00	$2223, 312.50	$26,775 27,975.00	$27,310 28,534.50	
20	$112,240 117,280.00	$9,353 773.33	$11,224 728.00	$12,439 .93998.53	$12,627 13,194.00	$14,030 660.00	$14,591 .1915,246.39	$14,965 15,637.33	$17,303 18,080.66	$17,864 .8618,667.06	$18,706 19,546.66	$18,800 .19,644.39	$22,447 23,455.99	$23,383 24,433.33	$28,059 29,319.99	$28,621 .1929,906.39	
21	$117,380 122,660.00	$9,781 10,221.67	$11,738 12,266.00	$13,009 .62594.82	$13,205 799.25	$14,672 15,332.51	$15,259 .41945.81	$15,650 16,354.67	$18,096 910.09	$18,682 .9919,523.39	$19,563 20,443.34	$19,661 .1620,545.56	$23,476 24,532.01	$24,454 25,554.18	$29,345 30,665.01	$29,931 .9131,278.31	

22	$122,520128,040.00	$10,210670.00	$12,252804.00	$13,579.3014,191.10	$13,7833 14,404.50	$15,3155 16,005.00	$15,927.6016,645.20	$16,3336 17,072.00	$18,8888 19,739.50	$19,501.10 20,379.70	$20,4220 21,340.00	$20,522.10 21,446.70	$24,5044 25,608.00	$25,5225 26,675.00	$30,6330 32,010.00	$31,242.60 32,650.20	
23	$127,66060 133,420.00	$10,6388 11,118.33	$12,7666 13,342.00	$14,148.98 787.38	$14,3611 15,009.75	$15,9577 16,677.50	$16,595.79 17,344.59	$17,021 789.33	$19,6880 20,568.91	$20,319.21,236.01	$21,2766 22,236.66	$21,383.04 22,347.84	$25,5321 26,683.99	$26,5995 27,795.83	$31,9144 33,354.99	$32,553.29 34,022.09	
24	$1321388,800.00	$11,066566.67	$13,280880.00	$14,71815,383.67	$14,9400 15,615.00	$16,6000 17,350.01	$17,26418,044.01	$17,7006 18,506.67	$20,4733 21,398.34	$21,13722,092.34	$2223, 133.34	$22,24423,249.01	$26,5600 27,760.01	$27,6606 28,916.68	$33,2000 34,700.01	$33,86435,394.01	
each additional person	$5,140380.00	$428448.33	$514538.00	$569.68596.28	$578605.25	$642672.50	$668.19699.39	$685717.33	$792829.41	$818.11856.31	$856896.66	$860.94901.14	$1,027075.99	$1,070120.83	$1,284344.99	$1,310.69371.89	
		QMB BC+ Extensions trigger limit BC+ Adults limit MAPP premi	SLMB	BC+ adult premium limit	QI-1 (SLMB+)		MAGI/BC+ Limit for kids 6-18 subject to access / backdate / EE	Senior Care tier one limit	BC+ EE for kids ages 1-5	MAGI/BC+ limit for kids 1-5 subject to access / backdate / EE	QDWI & lower SI Inc Alloc BC+ kids premiums BC+ adults limit	MAGI/BC+ kids premiums	Senior Care tier three limit	MAPP	BC+ pregnant women kids limit	MAGI/BC+ pregnant women kids limit	excess shelter allowance

		um limit															

		Annual figures for SeniorCare		$~~23,328~~24,096.00 $~~31,552~~32,704.00			$~~29,160~~30,120.00 $~~39,440~~40,880.00			$~~34,992~~36,144.00 $~~47,328~~49,056.00							

39.11 SeniorCare Income Limits

39.11.1 SeniorCare Income Limits Introduction

For applicants determined eligible, SeniorCare pays for a portion of covered prescription drugs, depending on the person's participation level.

Effective with benefit periods starting September 1, 2003, there are four participation levels. The level of benefits an applicant receives depends on their annual income and, for some, on the amount they spend on covered prescription drugs during their 12-month benefit period.

The participation levels are:

- Level 1: Co-Payment (Annual income is at or below 160% of the Federal Poverty Level (FPL).)
- Level 2a: Deductible $500 (Annual income is greater than 160% of the FPL and less than or equal to 200% of the FPL.)
- Level 2b: Deductible $850 (Annual income is greater than 200% of the FPL and less than or equal to 240% of the FPL.)
- Level 3: Spenddown (Annual income is above 240% of the FPL.)

Note	The FPL may be adjusted annually (see Section 39.5 FPL Table for current FPLs). If the FPL changes during the eligibility determination process or before a redetermination can be completed, the new levels will be used.

SeniorCare Levels of Participation	
Income Limits*	**Annual Out-of-Pocket Expense Requirements and Benefits**
Level 1 **Income at or below 160% of FPL** At or below $~~23,328~~24,096 per individual or $~~31,552~~32,704 per couple annually.*	• No deductible or spenddown. • $5 co-pay for each covered generic prescription drug. • $15 co-pay for each covered brand name prescription drug.
Level 2a **Income above 160% and at or below 200% FPL** $~~23,329~~24,097 to $~~29,160~~30,120 per individual and $~~31,553~~32,705 to $~~39,440~~40,880 per couple annually.*	• $500 deductible per person. • Pay the SeniorCare rate for drugs until the $500 deductible is met. • After $500 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.
Level 2b **Income above 200% and at or below 240% of FPL** $~~29,161~~ 30,121 to $~~34,992~~36,144 per individual and $~~39,441~~40,881 to $~~47,328~~49,056 per couple annually.	• $850 deductible per person. • Pay the SeniorCare rate for most covered drugs until the $850 deductible is met. • After $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.
Level 3 **Annual income is above 240% of the FPL** $~~34,993~~36,145 or higher per individual and $~~47,329~~ 49,057 or higher per couple annually.*	• Pay retail price for drugs equal to the difference between the member's income and $~~32,616~~36,144 per individual or $~~43,944~~49,056 per couple. This is called “spenddown.” • Covered drug costs for spenddown will be tracked automatically. During the spenddown, there is no discount on drug costs. • After spenddown is met, meet an $850 deductible per person. • Pay SeniorCare rate for most covered drugs until the $850 deductible is met. • After the $850 deductible is met, pay a $5 co-pay for each covered generic prescription drug and a $15 co-pay for each covered brand name prescription drug.

* These income amounts are based on the ~~2023~~2024 federal poverty guidelines, which typically increase by a small amount each year.

39.11.5 Level 3: Spenddown

39.11.5.1 Level 3: Fiscal Test Group of One

A SeniorCare participant considered as a FTG of one with gross annual income above 240% FPL pays retail prices for covered prescription drugs until those payments equal the spenddown amount.

After the spenddown has been met by purchasing drugs at regular prices the participant has an annual deductible of $850. During the deductible period the participant will get a discount off the retail price for most covered prescription drugs during the deductible period.

After this deductible is met, they are required to pay a $5 copayment for each covered generic prescription drug, and a $15 copayment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name copay.

Example 1:	Dorothy's annual income is $~~35,992~~37,144. This is $1,000 more than 240% of the FPL for a FTG of one. Her spenddown amount for the 12-month benefit period is $1,000. Dorothy pays the retail price for her covered prescription drugs until those payments equal the spenddown amount. If Dorothy meets the spenddown during her benefit period, she can begin purchasing covered prescription drugs at the discounted rate. These costs are applied toward the $850 deductible. After this deductible is met, Dorothy purchases covered prescription drugs at the copayment amounts for the remainder of her benefit period.

39.11.5.2 Level 3: Fiscal Test Group of Two

Married persons considered as a FTG of two with annual income greater than 240% FPL and in which both spouses are determined non-financially eligible at the same time pay retail price for covered prescription drugs until the spenddown requirement is met. In this case, the spenddown amount is shared, and covered prescription drugs purchased for either person in the married couple will count toward meeting the spenddown requirement, when both are eligible.

After the spenddown has been met, each spouse must meet a separate $850 deductible requirement. Participants will get a discount off the retail price for most covered prescription drugs during the deductible period. Only the covered prescription drugs purchased for an individual spouse may count toward that spouse's deductible.

After a spouse has met his or her deductible, he or she is required to pay a $5 copayment for each covered generic prescription drug, and a $15 copayment for each covered brand name prescription drug.

When there is no generic equivalent, the participant will still have to pay the $15 brand name copay.

Example 2:	Bob and Alice's annual income is $~~49,328~~51,056, which is $2,000 more than 240% of the FPL for a FTG of two. Both spouses are eligible and, for the 12-month benefit period, their joint spenddown amount is $2,000. Bob and Alice pay for their covered prescription drugs at retail price until the $2,000 spenddown is met. Covered prescription drugs purchased for either Bob or Alice will count toward the spenddown requirement. After Bob and Alice meet the spenddown, each person has a $850 deductible. Only covered prescription drugs purchased for Bob count toward his deductible, and only covered prescription drugs purchased for Alice count toward her deductible. Bob meets his deductible in two months. He then purchases covered prescription drugs at the copayment amounts for the remainder of his benefit period. Alice meets her deductible in three months. She then purchases covered prescription drugs at the copayment amounts for the remainder of her benefit period.

If only one spouse in a married couple is determined eligible, only that spouse's costs count toward the spenddown. They pay retail price for covered prescription drugs until the spenddown requirement is met.

Example 3:	Tracy and Dave's annual income is $~~49,328~~51,056, which is $2,000 more than 240% of the FPL for a FTG of two. Because Tracy is 63 years old, only Dave is eligible for SeniorCare. For the 12-month benefit period Dave's spenddown amount is $2,000. Tracy and Dave pay for their covered prescription drugs at retail price. Only covered prescription drugs purchased for Dave count toward the spenddown requirement. After Dave has met the $2,000 spenddown, he has a $850 deductible. Only covered prescription drugs purchased for Dave count toward his deductible. After Dave meets his deductible, he purchases covered prescription drugs at the copayment amounts for the remainder of his benefit period.

39.12 Five Percent Copay Limit Tiers

~~2020~~2024 **Per-Member Copay Limits**											
Status	Assistance Group Income Tier as Percentage of the Federal Poverty Level										
	0-50%	>50-100%	>100-150%	>150-200%	>200-250%	>250-300%	>300-350%	>350-400%	>400-450%	>450-500%	>500%
Individual	$0	$26	$53	$79	$106	$132	$159	$186	$212	$239	$265
Prorated (split between counted spouses)	$0	$13	$26.50	$39.50	$53	$66	$79.50	$93	$106	$119.50	$132.50

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~~

The following rates are effective December 1, 2023 – November 31, 2024.

BENEFIT TYPE	AID & ATTENDANCE AMOUNT	HOUSEBOUND ALLOWANCE AMOUNT
Veteran's pension	$922	$306
Surviving spouse pension	$553	$205
Veteran's disability compensation	Benefit could include A&A for the spouse. Amount depends on veteran's disability rating.	N/A
Surviving spouse dependency and indemnity compensation (DIC)	$399.54	$187.17
Surviving parent DIC	$434	N/A

Note:	For ~~need~~ VA pensions, which are based ~~VA benefits~~on need, the A&A or housebound allowance amounts given above or the monthly unreimbursed medical expense (UME) amount shown on the award letter could be greater than the ~~total benefit~~monthly VA pension amount. In this situation, disregard the entire ~~VA benefit amount is disregarded~~pension.