

Medicaid Handbook Coversheet

Change Summary for Medicaid Eligibility Handbook Release 26-02

Release Date: 04/15/2026

This coversheet contains a summary of the changes included in this release and the redline edit changes that were made in the handbook.

Policy Changes

TOPIC	SUMMARY	SECTIONS	SOURCE
Health Care Members with Immigration Status Changes	<p>Children’s 12-month continuous coverage periods can end if the child experiences a change in status mid-certification period and they are no longer in an eligible immigration status or designation. Medicaid kids move to ES for the remainder of their 12-month period.</p> <p>Clarification on ROP and alignment of ROP policy with the BadgerCare Plus Handbook (BCPH).</p> <p>Removal of language about maintaining individuals in a previous status.</p> <p>Similar changes in the BCPH.</p>	<ul style="list-style-type: none">• 1.2.3 Termination of Coverage• 1.2.5 Emergency Services• 7.3 Immigrants	OM 26-06
Updating Member Addresses	<p>A checkbox was added to CWW to indicate when a member has had returned mail with no forwarding address. Members who have this box checked will not go through the admin renewal process. Similar changes in BCPHB 26.2.2.</p>	<ul style="list-style-type: none">• 3.2.2 Administrative Renewal Selection Criteria• 21.6.4 HMO Disenrollment	OM 26-03

SeniorCare Spouse Add	Spouse add clarification resulting from Medicaid Redetermination Compliance.	<ul style="list-style-type: none"> 33.9 SeniorCare Addition of a Spouse 	OM 25-17
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Clarifications and Corrections

TOPIC	SUMMARY	SECTIONS
Health Care Applications	<p>Updates in both MEH and BCPH to align the application chapters.</p> <p>Move affirmative action, civil rights, and intercounty placement information from chapter 2 to chapter 22.</p>	<ul style="list-style-type: none"> 2.1 Applications Introduction 2.2 Application Methods 2.3 Where to Apply 2.4 Valid Application 2.5 Valid Signature 2.6 Filing Date 2.7 Application Processing Period 2.8 Begin Dates 2.9 Denials and Terminations 22.3 Interagency Coordination 22.7 Affirmative Action and Civil Rights
Medicaid Begin Dates for LTC	Updates to better clarify that HCBW start dates set by ADRCs and ICAs do not allow backdates.	<ul style="list-style-type: none"> 2.8.1 Begin Dates Introduction 2.8.2 Backdated Eligibility 28.5 Home and Community-Based Waivers Long-Term Care Medicaid Effective Date
State Residency	Updates in both MEH and BCPH to align wording between the residency chapters.	<ul style="list-style-type: none"> 6.1 Residency Eligibility 6.2 Intent to Reside 6.3 Determining Residence 6.4 Special Situations 6.5 Absence 6.8 Interstate Placements
Verification of Citizenship	Clarification on populations exempt from the U.S. citizenship verification requirement and alignment of wording with BCPH.	<ul style="list-style-type: none"> 7.2 Verifying U.S. Citizenship
Inmates	Correction of dates in example.	<ul style="list-style-type: none"> 13.8.1 Children Whose Parent/Caretaker is an Inmate
Unearned Income	Updates from DWD to align with current terminology used in the Workforce Innovation and Opportunity Act (WIOA) which replaced the Workforce Investment Act (WIA).	<ul style="list-style-type: none"> 15.4.13.3 Workforce Investment Act

Unearned Income	Addition of an income type.	<ul style="list-style-type: none"> • 15.4.19 Payments to Native Americans
Earned Income	Clarification about income imputed by employers.	<ul style="list-style-type: none"> • 15.5.20 Imputed Income
Spousal Impoverishment Assets	Clarification on prenuptial and postnuptial agreements. Correction to internal cross-reference.	<ul style="list-style-type: none"> • 18.4.1 Spousal Impoverishment Assets Introduction
Verification	Updates in both MEH and BCPH to align wording between the verification chapters.	<ul style="list-style-type: none"> • 20.1 Verification
Deductibles	<p>Removing example #16 and replacing with a note. If a third party pays medical expenses on someone's behalf but in turn charges the expense amount to the member, the member remains liable.</p> <p>Updated example numbering in remainder of subsections.</p> <p>Removal of outdated information about Medicaid cards. Removal of information about which months to include in a deductible period, as section 24.12.4 is specific to changes <i>after</i> a deductible has been met.</p>	<ul style="list-style-type: none"> • 24.7 Meeting the Deductible • 24.12 Changes After Meeting a Deductible
MAPP Financial Requirements	Clarification on interest accruals for MAPP Independence accounts.	<ul style="list-style-type: none"> • 26.4.1.1 Independence Accounts
IMD	Addition of new IMD providers.	<ul style="list-style-type: none"> • 27.11 Institutions for Mental Diseases (IMDs)
Medicaid Start Dates for LTC	Updates to better clarify that HCBW start dates set by ADRCs and ICAs do not allow for backdates.	<ul style="list-style-type: none"> • 2.8.1 Begin Dates Introduction • 2.8.2 Backdated Eligibility • 28.5 Home and Community-Based Waivers Long-Term Care Medicaid Effective Date
SeniorCare	Updates to form title so that the form title is consistent throughout the application section.	<ul style="list-style-type: none"> • 33.2.4 Authorized Representative • 33.2.5 Guardian and Power of Attorney • 33.3.1 SeniorCare Nonfinancial Requirements Introduction

	<p>Correcting text that is out of order in the residency section.</p> <p>Wording corrections.</p>	<ul style="list-style-type: none"> • 33.9.3.2 FTG Changes at Level 3 • 33.10.2.2 Applicant or Member Error
Wisconsin Well Woman Medicaid	EM CAPO is able to view a WWWMA applicant's WWWP enrollment in iC, so there is no longer a need for WWWP coordinating agencies to always send the F-44818 to EM CAPO.	<ul style="list-style-type: none"> • 36.2.2.1 WWWP Process for Assisting with WWWMA Application
Children's Waiver Medicaid and CLTS	Terminology updates.	<ul style="list-style-type: none"> • 37.1 Children's Long-Term Support (CLTS) Waiver Program Introduction • 37.2 Agency Roles and Responsibilities • 37.3 HCBW Medicaid CARES Processing for the CLTS Waiver Program
COLA Disregards	Adding cross references.	<ul style="list-style-type: none"> • 39.6 COLA Disregard

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1.2 Continuous Coverage for Qualifying Children

1.2.3 Termination of Coverage

Qualifying children under 19 will only lose health care coverage during their 12-month period for the following reasons:

- The child turns 19.
- The child is no longer a resident of Wisconsin.
- The child passes away.
- The child's citizenship or immigration status is not verified within the reasonable opportunity period.
- The child's immigration status changes and they are no longer in an eligible immigration status or designation (see [Section 1.2.5 Emergency Services](#) for more information).
- ~~The child was eligible as a pregnant minor, turns 19, and their postpartum period ends.~~
- ~~The child's eligibility was based on incorrect information or agency error.~~
- ~~There is a voluntary request for disenrollment from BadgerCare Plus or Medicaid.~~

Example 4	Carlos is 17 and enrolls in Medicaid on February 1, 2024 . On May 12, the household reports moving to Florida. Carlos' Medicaid ends May 31, 2024 .
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Example 5	Carolina applies for Medicaid for her son Javier. Javier is eligible, but verification of his citizenship is still needed. Javier is enrolled in Medicaid as of February 1, 2024 , and is given a reasonable opportunity period to verify his citizenship. Javier's citizenship is not verified by the due date of May 10, 2024 , so his Medicaid ends May 31, 2024 .
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1.2.5 Emergency Services

An immigrant child enrolled in Emergency Services qualifies for a 12-month period of continuous coverage. Their enrollment is not limited to the period their provider indicates they require treatment of an emergency medical condition.

Children in Medicaid enrolled in 12-month continuous coverage periods who are no longer in an eligible immigration status or designation must be transitioned to Emergency Services for the remainder of their certification period. These members are not required to have experienced or be experiencing a life-threatening condition to be certified for Emergency Services for the remainder of their 12-month continuous coverage period. Once the child is enrolled in Emergency Services, Medicaid will only cover claims related to medical emergencies.

Example 9	<u>Tania is 12 years old and enrolls in Medicaid on February 1. She is verified as a non-citizen who is lawfully present in the United States with Temporary Protected Status (TPS). Her household income is 125% of the FPL. Tania's continuous coverage period is February 1 through January 31 of the following year.</u> <u>On June 10, information from CMS requires the agency to verify Tania's status. The information available on the case is submitted to SAVE. SAVE does not verify Tania's immigration status or designation. Tania is sent a notice requesting verification of her immigration status and is placed in a Reasonable Opportunity Period (ROP). Requested information is not returned. Tania's Medicaid full benefit coverage ends in accordance with ROP requirements and with timely notice. Tania is certified for Medicaid Emergency Services through January 31.</u>
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2.1 Applications Introduction

Anyone has the right to apply for Medicaid. ~~However;~~ however, people younger than 18 years old must have a parent, caretaker relative, or legal guardian apply for Medicaid on their behalf unless they are living independently. In situations where a legal guardian, parent, or caretaker is absent, an adult acting responsibly may apply on behalf of a person who is younger than 18 years old.

The applicant may be assisted by any person they choose in completing an application.

Anyone who expresses interest in applying should be encouraged to file an application as soon as possible (see [Section 2.2 Application Methods](#)).

The income maintenance (IM) agency must provide the following documents at application or a new request for health care on an existing case:

- Notice of Assignment: Child Support, Family Support, Maintenance, and Medical Support ([DWSP 2477](#)) must be provided to all applicants.
- Child Support Cooperation & Good Cause notice ([DCF-P-5600](#)) must be provided to applicants with children applying for health care who have an absent parent. The IM agency must also provide this notice to the member in situations where a parent leaves the home resulting in a child on the case now having an absent parent.

Exception: The IM agency does not need to provide these documents to applicants who apply via ACCESS since this information is included in the ACCESS application.

The IM agency must also provide these documents to anyone who requests them.

2.1.1 Health Requests for People Open for Other Programs

People open for non-health care program(s) who want to enroll in a health care program must sign an application or program request for health care. If they or someone else in the household is already open for a health care program, they can request another health care program without a new application or new signature.

Example 1	Tim and Carrie are married. When Tim applies for health care, he indicates that he is requesting health care for himself, but Carrie is not requesting health care. Tim is determined eligible for Medicaid. Four months later, Carrie decides that she would also like to apply for health care. Carrie does not need to submit a new application or new signature. She can contact the IM agency to request health care.
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Note:	An application can be filed on behalf of a deceased person. If the application is filed within the same calendar month as the date of death or within the three months after the date of death, the application should be processed as if the applicant were alive. If the application is filed more than four months after the date of death, the application must be denied.
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2.1.1 Affirmative Action and Civil Rights

~~The Rehabilitation Act of 1973 requires a person with impaired sensory, manual, or speaking skills have an opportunity to participate in programs equivalent to those afforded non-disabled persons.~~

~~Notify members during intake that assistance is available to assure effective communication. This includes certified interpreters for deaf persons and translators for non-English speaking persons. See the Forward Health Enrollment and Benefits Handbook (-).~~

~~The Civil Rights Act of 1964 requires that applicants for public assistance have an equal opportunity to participate regardless of race, color, or national origin.~~

2.2 Application Methods

Medicaid applicants have the choice of ~~one of~~ the following application methods:

- ACCESS online application: access.wisconsin.gov
- Mail-in or fax ~~using~~ the Wisconsin Medicaid for the Elderly, Blind, or Disabled Application Packet ([F-10101](#))
- Mail-in or fax the Wisconsin Medicaid, BadgerCare Plus, and Family Planning Only Services Registration Application (F-10129)
- ~~Telephone interview~~
- ~~Face-to-face interview~~
- Use of the paper or online application
- In person application at an income maintenance agency
- Application available through the Federally-Facilitated Marketplace (FFM)
- ~~Telephone application with the FFM~~

Note	<u>When a signed F-10129 is submitted, the primary person is required to provide a second signature. The primary person can choose to call the IM agency to provide a telephonic signature or mail a signed Application Summary.</u>
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2.3 Where ~~To~~ Apply

2.3.1 Where to Apply Introduction

The agency (county/tribe or consortium) of the applicant's county of residence should process the individual's application.

An individual who resides in a nursing home/hospital for 30 days or more is considered a resident of the county in which the nursing home/hospital is located.

The applicant's county of residence at the time of admission must receive and process applications for persons living in these state institutions:

- Northern, Central, and Southern Centers.
- Winnebago and Mendota Mental Health Institutes.
- The University of Wisconsin Hospital.

When an applicant contacts the wrong consortium or tribal agency, ~~redirect him or her~~ they must be redirected to the consortium or tribal agency responsible for processing the application immediately.

Anytime an application is received in the wrong consortium or tribal agency, it must be redirected to the ~~agency responsible for processing that application no later than the next business day. A paper application must be date stamped before it is redirected.~~ correct agency as soon as it is discovered. The filing date remains the date originally received by the wrong consortium or tribal agency.

2.3.2 Intercounty Placements

~~When a county 51.42 board, 51.437 board, human services department, or social services department places a person in a congregate care facility that is located in another county, the placing county remains responsible for determining and reviewing the applicant's Medicaid eligibility. This does not include situations where a guardian or the member elects to move the member to another county.~~

~~A congregate care facility is a:~~

- ~~• Child care institution~~
- ~~• Group home~~
- ~~• Foster home.~~
- ~~• Nursing home~~
- ~~• AFH~~
- ~~• CBRF~~
- ~~• Any other like facility~~

~~The placing county may request the assistance of the receiving county in completing applications for persons who are not enrolled in Medicaid and reviews for Medicaid members. The receiving county must then forward the information to the placing county. The placing county remains responsible for determining the applicant's eligibility.~~

~~If the placing county requests assistance from the receiving county, the placing county must provide the other agency with:~~

- ~~• The applicant's name, age, and SSN.~~
- ~~• The date of placement.~~
- ~~• The applicant's current Medicaid status.~~
- ~~• The name and address of the congregate care facility in which the applicant has been placed.~~
- ~~• The name of the county and agency making the placement.~~

~~When there is a dispute~~ When there is a dispute between the placing county and the receiving county about responsibility, the social or human services department of the receiving county may initiate referral to the Department of Health Services' Area Administration office for resolution. Pending a

decision, the county where the person is physically present must process the application, any changes, and reviews.

2.3.3 Applications Outside Wisconsin

Generally, an application should not be taken for a resident of Wisconsin when he or she is living outside of Wisconsin. An exception is when a Wisconsin resident becomes ill or injured outside of the state or is taken out of the state for medical treatment. In this case, the application may be taken, using Wisconsin's application forms (see [Section 2.2 Application Types/Methods](#)), ~~by the public assistance agency in the other state. The forms should be forwarded to the IM agency in the other state. The Wisconsin IM agency determines eligibility when the forms are returned.~~

2.3.4 Applications Received from the Federal Marketplace

The FFM sends applications to CARES through an account transfer process for individuals the FFM assesses as potentially eligible for BadgerCare Plus or Medicaid. Such applications are considered full applications for all "insurance affordability programs" including Medicaid and should be appropriately processed. The 30-day processing requirement begins on the day that the application is received by the local agency or the next business day if received after normal operating hours or on weekends or holidays. If eligible, the individual's benefits will begin on the first day of the month the application was filed at the Marketplace, not the date that the application was received by the agency. If the individual requests backdating, their eligibility will be backdated for up to three months from the first day of the month the application was filed at the FFM.

If a paper application from the Marketplace is mailed to a consortium or tribal agency, the IM agency must consider that application as an application for BadgerCare Plus and/or Medicaid and process it.

2.4 Valid Application

A valid application for Medicaid must include ~~the applicant's~~ all of the following information from the applicant:

1. Name,
2. Address, ~~and~~
3. Signature (see 2.5.1 Valid Signature Introduction:-)
 - a) ~~In the Signature Section of the Medicaid application (-);~~
 - b) ~~On the Medicaid, BadgerCare Plus, and Family Planning Only Services Registration Application (-;~~
 - c) ~~In the Signature Section of the BadgerCare Plus Application Packet (-;~~
 - d) ~~An electronic signature in ACCESS, or~~
 - e) ~~Telephonically.~~

2.5 Valid Signature

2.5.1 Valid Signature Introduction

The applicant, their representative (see below), or the applicant's caretaker relative must sign one of the following (using their own signature):

- The paper application form [Wisconsin Medicaid for the Elderly, Blind, or Disabled Application Packet \(F-10101\)](#) or [BadgerCare Plus Application Packet \(F-10182\)](#)
- [The Wisconsin Medicaid, BadgerCare Plus and Family Planning Services Registration Application \(F-10129\)](#)
- The signature page of the Application Summary (by telephone, electronically, or with a handwritten signature)
- The ACCESS application with an electronic signature
- The online or paper [Application for Health Coverage & Help Paying Costs](#) from the Federally Facilitated Marketplace (FFM)

Note	When an applicant calls to complete a Request for Assistance (RFA) but does not complete a full application on the same day, a telephonic signature must be collected for the RFA. Another telephonic signature will be required when the full application is completed. However, if the RFA and full application are completed on the same day, a telephonic signature only has to be collected once, and it is valid for both the RFA and the application.
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2.5.1.1 Signatures ~~From~~from Representatives

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

1. Guardian

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

When someone has been designated as one of the following, only the guardian, not the applicant, may sign the application or appoint an authorized representative:

- Guardian of the estate
- Guardian of the person and the estate
- Guardian of the person and the court document appointing the legal guardian of the person specifically grants the guardian the authority to enroll their ward in BadgerCare Plus, Medicaid, or public assistance programs.

If the applicant only has a guardian of the person who has not been granted the authority to enroll their ward in BadgerCare Plus, Medicaid, or public assistance programs, the guardian of the person cannot sign the application unless the applicant appoints them as their authorized representative.

Note	The guardian of the person may ask the court to update their letters of guardianship to grant them the authority to enroll their ward in public assistance programs.
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The applicant may appoint their guardian of the person to be their authorized representative. If the applicant has appointed their guardian of the person to be their authorized representative, the guardian may sign the application as the authorized representative.

2. Conservator (Wis. Stat. 54.76(2))

A conservator is a person who is appointed by a court at an individual's request under Wis. Stat. 54.76(2) to manage the estate of the individual. When an application is submitted with a signature of someone claiming to be the applicant's conservator, a copy of the document that designates the signer of the application as the conservator is required.

The conservator is not required to sign the application, though they are able to sign on behalf of the applicant. If an applicant has a conservator, the applicant can still sign the application on their own behalf.

3. Authorized Representative

The applicant may authorize someone to represent them. An authorized representative can be an individual or an organization (see Section 22.5 Representatives). If the applicant needs to appoint an authorized representative when applying by telephone or in person, the applicant must complete the Appoint, Change, or Remove an Authorized Representative form ([Person F-10126A](#) or [Organization F-10126B](#)). When appointing an authorized representative, someone other than the authorized representative must witness the applicant's signature. If the applicant signs with a mark, two witness signatures are required.

The authorized representative is not required to sign the application, though they are able to sign on behalf of the applicant. If an applicant has an authorized representative, the applicant can still sign the application on their own behalf.

4. Agent with Durable Power of Attorney for Finances (Wis. Stat. ch. 244)

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 have power of attorney for the purpose of providing a valid signature on the application. An agent with power of attorney for health care is not considered 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 IM agency ~~must do~~does both of the following:

- Obtain a copy of the document the applicant used to designate the signer of the application as 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~~The application is not 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 ([F-00036](#)).

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

5. A superintendent of a state mental health institute or center for the developmentally disabled
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.
7. The superintendent of a county psychiatric institution
The superintendent of a county 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**[The IM agency must retain](#) copy of this written authorization. The social or human services director may end the delegation when there is reason to believe that the delegated authority is not being carried out properly.

2.5.2 Witnessing the Signature

The signatures of two witnesses are required when the application is signed with a mark. An agency staff person is not required to witness the signature of a paper, online, or telephonic application.

Note	This does not affect the state of Wisconsin's ability to prosecute for fraud nor does it prevent the Medicaid program from recovering benefits provided incorrectly due to an applicant's or member's misstatement or omission of fact.
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2.5.3 Spousal Impoverishment Medicaid Signatures

All spousal impoverishment Medicaid applications, renewals, or changes in marital status that cause someone to be subject to spousal impoverishment rules, require the signatures of both the institutionalized person and the community spouse or of a person authorized to sign for them as described in [Section 2.5.1.1 Signatures From Representatives](#).

If the benefits are denied or terminated because the community spouse refuses to sign, disclose the value of assets, or provide required information on income or resources, the applicant or member must be sent information on the Undue Hardship Waiver process. For more information on this policy, see Section 22.4 Undue Hardship and [Process Help Section 11.7](#).

2.5.4 Telephone Signature Requirements

Telephonic signatures are valid forms of signatures for Medicaid. ~~To collect a valid telephonic signature:~~

- ~~1. Create an audio recording of the following:

 - ~~a) Key information provided by the household during the telephone interview~~
 - ~~b) Signature statement that includes:

 - ~~i. Rights and responsibilities~~
 - ~~ii. Attestation to the accuracy and completeness of information provided~~
 - ~~iii. Attestation to the identity of individual signing the application~~
 - ~~iv. Release of information~~~~~~
- ~~2. Store the audio recording in the ECF.~~
- ~~3. Send the applicant or member a written summary of the information provided during the interview. Include a cover letter that outlines the applicant or member's responsibility to review the information provided and notify the agency within 10 calendar days if any errors are noted.~~
- ~~4. Store a copy of the written summary and cover letter in the ECF.~~

Note	Applications that are submitted through ACCESS or transferred from the Federally-Facilitated Marketplace are signed electronically, so an additional signature (telephone or physical) is not needed.
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When an applicant calls to complete a Request for Assistance (RFA) but does not complete a full application on the same day, a telephonic signature must be collected for the RFA. Another telephonic signature will be required when the full application is completed. However, if the RFA and full application are completed on the same day, a telephonic signature only has to be collected once, and it is valid for both the RFA and the application.

2.5.5 Valid Signature on the Federally-Facilitated Marketplace Application

~~Agencies should accept the~~ The signature on the FFM application is accepted for all individuals on that application ~~and. There may be a need to~~ create companion cases for adult children listed on a FFM application, without obtaining a separate signature or application. ~~Workers should reference the original FFM-ACCESS application in case comments on the companion case.~~ This policy is for FFM applications only. Current policies for non-FFM applications requiring an adult child to apply separately are still valid. Because the ~~Medicaid health care~~ specific rights and responsibilities information is not provided when a person applies for health care through the FFM, a case summary must be sent to the applicant once the application is processed. No additional signature is required.

Applications that are submitted through ACCESS or transferred from the Federally-Facilitated Marketplace are signed electronically, so an additional signature (telephone or physical) is not needed.

Note	Referrals from the FFM may include households with individuals whose eligibility may not be able to be determined on one case.
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Example <u>1</u>	<p><u>Victoria and Timothy are married and filing taxes jointly. They are claiming Casey, their 24-year-old son, as a tax dependent. Victoria signs and submits an application to the FFM for health care for herself, Timothy, and Casey. The FFM assesses that they are potentially eligible for Medicaid and transfers the application to the agency.</u></p> <p><u>Although Casey is included in the health care request, his Medicaid eligibility cannot be determined on his parents' CARES case. A separate case is established for Casey. No additional signature or application is required for Casey's health care request.</u></p>
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Example <u>2</u>	<p><u>Darrell is filing taxes and claiming Carmen, his 22-year-old niece, as a tax dependent. Darrell signs and submits an application to the FFM for health care for Carmen. The FFM assesses that she is potentially eligible for Medicaid and transfers the application to the agency.</u></p> <p><u>A separate case is established for Carmen. No additional signature or application is required for Carmen's health care request.</u></p>
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Tax dependents living outside the home will not be included in the health care request for their tax filer's household. A separate application is required to determine eligibility for a tax dependent living outside the home.

2.5.6 Electronic Signatures

In general, electronic signatures are valid signatures for documents requiring applicant or member signatures. Electronic signatures may appear typed or printed and may vary depending on the software used to collect the signature. ~~Accept the electronic signature as a valid signature and process the document accordingly.~~

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](#)).

Paper applications are date stamped on the business day they are received.

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.

2.7 Application Processing Period

All applications received by an agency must be processed and eligibility approved or denied as soon as possible. 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 the 30th calendar day after the date on which the application is received ~~by the agency~~ (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 ensure the applicant has at least 20 days from the mailing date of a verification request to provide verification.

Note	<p>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 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., <u>business hours</u>, on a weekend, or on a holiday.</p> <p>For MSP applications originating from LIS data sent by SSA, the date received is the contact date of the request for assistance (RFA).</p>
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Example 1	<p>A signed application is received on March 15. The worker <u>agency</u> processes the application on April 7 and requests verification. Verification is due on April 27 but is to allow the applicant at least 20 days to provide verification. The applicant does not <u>received</u> provide the requested verification by that date <u>April 27</u>. 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 at least 20 days to provide verification.</p>
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Example 2	<p>A signed application was submitted to the FFM on February 28. The Marketplace assessed the person as potentially eligible for Medicaid and transferred the person’s account to the agency on March 5. The first day of the 30-day period for processing requirements was March 6. The end of the 30-day period would have been April 4. The application was approved on March 31, and the applicant is determined eligible beginning February 1.</p>
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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 3	<p>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.</p>
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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	<p>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.</p>
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2.8 Begin Dates

2.8.1 Begin Dates Introduction

Medicaid eligibility begins the first day of the month in which the valid application is submitted and all program requirements are met with the following exceptions. For these exceptions, begin dates are the date a valid application is submitted, all program requirements are met, and:

1. Deductible – The date the deductible was met.
1. ~~Person Adds Foster Care Medicaid~~ – The date the person ~~moved~~entered into ~~the household~~.
2. ~~Recent Moves – The date the member moved to Wisconsin.~~
~~Exception: The begin date for an SSI recipient who moves to Wisconsin is the 1st of the month of the move~~foster care. These dates are established by child welfare agencies.
3. Home and Community-Based ~~Waivers~~Waiver Medicaid – The program start date provided by the ~~Managed Care Organization (MCO),~~Aging and Disability Resource Center (ADRC) or IRIS Consultant Agency (ICA),~~or County Waiver Agency (CWA).~~
4. ~~Institutionalized~~Institutional Medicaid – The date the person entered into the nursing home or hospital.
5. QMB – ~~The~~For applications, the first of the month following the eligibility confirmation. (For renewals, see MEH 32.10.1 QMB Renewals).
6. SeniorCare – The first of the month following the month in which all program requirements have been met.
7. Inmates – The restriction on covered services will end the date the member is no longer an inmate of a public institution. See Section 13.4 Suspension End Date.

2.8.2 Backdated Eligibility

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

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

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

Home and Community-Based Waiver (HCBW) Medicaid cannot be backdated, as the start date is provided by the ADRC or ICA.

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

Note	<u>Applicants are not eligible for backdated health care benefits while pending for citizenship and/or identity. Applicants who are otherwise eligible must be certified for health care benefits for the 95-day good-faith period within the normal application processing timeframe. Once verification is provided, the applicant's eligibility must then be determined for backdated health care benefits if they have been requested. See Section 7.2 Verifying U.S. Citizenship for more information.</u>
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2.8.2.1 Backdated Eligibility Timeframe

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

~~A backdate request can be made at any time except when the member is already enrolled~~ **2.8.2.2**

Determining Backdated Eligibility

~~Actual nonfinancial information (for example, household composition) and backdating the member's actual income is used to determine eligibility would result in a deductible for in the backdated period months.~~

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

Example 1	Mary who is 66 years old, applied for Medicaid on April 6, and was found eligible. At the time of application, Mary did not request a backdate. In September Mary is billed for a doctor's appointment she had at the end of February. Mary can ask to have her eligibility backdated through February. She meets all non-financial and financial eligibility criteria in the months of February and March. Her worker certifies her for Medicaid for both months.
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~~A person's asset eligibility in a backdate month is determined by whether they had excess assets on the last day of the month. If they had excess assets on the last day of the month, they are ineligible for the entire month. If they were asset eligible on the last day of the month, they are eligible for the whole month.~~

~~The reasonable compatibility test is used when determining backdated eligibility (see Section 20.3.5.2 Reasonable Compatibility for Assets and 20.3.8.1 Reasonable Compatibility for Income for Health Care). If the reasonable compatibility test is passed, further verification of income or assets may not be requested or required. If the reasonable compatibility test is not passed, further verification of income or assets is required.~~

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

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

Assets

~~A person's asset eligibility in a backdate month is determined by whether or not he or she had excess assets on the last day of the month. If he or she had excess assets on the last day of the month, he or she is ineligible for the entire month. If he or she was asset eligible on the last day of the month, he or she is eligible for the whole month.~~

2.8.2.3 Medical Bills During Backdated Eligibility Period

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

Example 1	Mary who is 66 years old, applied for Medicaid on April 6, and was found eligible. At the time of application, Mary did not request a backdate. In September Mary is billed for a doctor's appointment she had at the end of February. Mary can ask to have her eligibility backdated through February. She meets all non-financial and financial eligibility criteria in the months of February and March. She is enrolled in Medicaid for both months.
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2.9 Denials and Terminations

2.9.1 Termination

During the calendar month after a member's enrollment has been terminated for a reason other than not completing a renewal, Medicaid can be reopened without requiring a new application or a new signature. The certification period for the health care assistance group (AG) prior to termination will be reinstated. The person may need to provide verification if required to complete the eligibility determination.

If more than a calendar month has passed since a member's enrollment ended, the applicant person must file a new application or make a new request (if another health care AG is open on the case) to reopen their Medicaid.

Example 1	Leroy is enrolled in MAPP with a renewal date of December 31. On September 3, he reports to his IM agency that he received a raise at work, which requires verification to be provided. MAPP coverage for Leroy is maintained while eligibility is pended. Leroy does not submit the required verification by the due date of September 23, so his eligibility for MAPP ends as of October 31. On November 7, Leroy contacts his IM agency to request that his health care be re-opened, and he provides the required verification of his income on November 20. Since this is within the calendar month after his MAPP ended, Leroy does not need to submit a new application or new signature. Leroy is re-enrolled in MAPP as of November 1.
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Example 2	Linda is enrolled in BadgerCare Plus and her husband Leo is enrolled in MAPP with a renewal date of January 31. On September 2, she reports to her IM agency that Leo received a gift from his aunt, which . <u>The gift</u> increased his assets to \$16,000. Leo's MAPP ends September 30 because his assets are over the MAPP program asset limit, and he is not eligible for any other form of Medicaid. On December 10, Linda contacts her IM agency to request that Leo's MAPP be reopened, as he purchased a vehicle (which is their only vehicle) and is no longer over the MAPP asset limit. It has been more than a calendar month since his MAPP ended, but because Linda is open for BadgerCare Plus, they do not need to submit a new application or new signature. Asset verification is received on December 15, and Leo's eligibility for MAPP is reinstated starting December 1.
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If health care coverage ended due to failure to submit the renewal timely or provide required verification for the renewal, the person can submit the renewal and any necessary verification within three months of the renewal month to have eligibility redetermined from the eligibility end date without completing a new application (see Section 3.1.2 Late Renewals).

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

Note	If someone a person 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).
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3.2 Administrative Renewals

3.2.2 Administrative Renewal Selection Criteria

To be considered for an administrative renewal, a member must be due for renewal in the following month and have eligibility in one or more qualifying BadgerCare Plus, Family Planning Only Services (FPOS), or Elderly, Blind, or Disabled (EBD) Medicaid assistance groups (AGs) open, including members open with a suspended status.

Some members in a household may have their eligibility administratively renewed while other members in the household must complete a regular renewal to continue their eligibility.

A member's health care eligibility can be administratively renewed if all of the information necessary to determine the member's eligibility is on file and their income and assets can be verified through a data exchange (for example, income with a SWICA match or Equifax match through FDSH, Social Security income, Unemployment income).

A member's health care eligibility cannot be administratively renewed if they meet any of the following criteria:

- Have income on file that cannot be verified through a data exchange, such as self-employment income, in-kind income, income from trusts, and other types of countable income for Medicaid.
- Are age 14 or older and have a missing or unverified SSN.
- Are pregnant and the due date is on or before the renewal month.
- Are enrolled in Medicaid after having met a deductible.
- Are enrolled in Institutional Medicaid.
- Are enrolled in Group A Community Waiver based on 1619(b) or EBD Medicaid Eligibility.
- Are enrolled in Group B/B+ Community Waivers.
- Are already in the process of completing a regular renewal.
- Mail was returned for the member's household with no forwarding address, and an up-to-date address has not been received.

6.1 Residency Eligibility

6.1.1 Residency Eligibility Introduction

A person must be a Wisconsin resident to be eligible for Medicaid. ~~He or she must~~ and must meet both of the following conditions:

1. Be physically present in Wisconsin. There is no minimum requirement for the length of time the person has been physically present in Wisconsin. Wisconsin residents who are temporarily out of state, (see [Section 6.5 Absence from Wisconsin](#)), including students going to school in another state, do not have to be physically present to apply. However, individuals who are not Wisconsin residents and intend to move to Wisconsin must be physically present in Wisconsin to apply.

~~and~~

2. Express intent to reside here in Wisconsin (see [Section 6.2 Intent to Reside](#)). ~~Effective January 1, 2014, an~~ An individual can ~~also~~ be considered a resident of Wisconsin if they are physically present in the State and have entered Wisconsin with a job commitment or seeking employment, regardless of whether ~~or not~~ they are employed at the time of application.

Example 1:	This is George's first day in John, a student from Wisconsin. He states that he intends to reside in Wisconsin. For who is attending college in Minnesota, <u>can apply for Medicaid purposes, George is</u> a Wisconsin resident.
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Example 2:	Margie lives in Florida. She is planning to move to Wisconsin in the next few months. Margie would <u>is</u> not be considered a resident of Wisconsin until she is physically present in Wisconsin.
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Example 3:	<u>This is George's first day in Wisconsin. He states that he intends to reside in Wisconsin. For Medicaid purposes, George is</u> a Wisconsin resident.
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6.1.2 Migrant Workers

A person who meets the definition of a migrant worker (see Section 31.1 Migrant Workers) meets the residency requirement if they are currently present in Wisconsin. They do not have to "intend to reside" in Wisconsin. Certain migrant workers qualify for a simplified application procedure. ~~For policies related to migrant workers,~~ (see BadgerCare Plus Handbook, [Chapter 12 Migrant Workers](#)).

6.2 Intent to Reside

Intent to reside means a person intends that Wisconsin is and will remain their state of residence. The intent to reside requirement applies to any adult age 18 or older who is capable of indicating intent. ~~An adult is incapable of, and thus exempt from, indicating intent when:~~
~~His or her~~An adult is incapable of, and thus exempt from, indicating intent when any of the following is true:

1. They are judged legally incompetent by a court of record.
- ~~1-2.~~ Their I.Q. is 49 or less or ~~he or she has~~ they have a mental age of ~~7~~ seven or less, based on tests acceptable to Wisconsin's Department of Health Services (DHS); ~~or~~.
- ~~1. He or she is judged legally incompetent by a court of record; or~~
- ~~2-3. Medical~~ They are incapable of indicating intent based on medical documentation obtained from a physician, psychologist, or other person licensed by Wisconsin in the field of developmental disability ~~supports a finding that he or she is incapable of indicating intent.~~

If the applicant/member is incapable of indicating intent, the guardian or person acting on behalf of the applicant/member can indicate the applicant's/member's intent to reside.

“Intent to reside” does not mean an intent to stay permanently or indefinitely in ~~the state~~ Wisconsin, nor does it require an intent to reside at a fixed address.

6.3 Determining ~~Residence~~ State Residency

For individuals receiving Medicaid based on receipt of Title IV-E assistance, see [BadgerCare Plus Handbook 3.4 Special Situations](#).

For individuals receiving Medicaid based on receiving State SSI, see [SECTION 6.4.1 State Supplementary Payment](#).

For individuals living in Wisconsin as a migrant worker or living with a family member who is a migrant farm worker, see [SECTION 6.1.2 Migrant Workers](#).

For individuals placed in Wisconsin by another state that has legal custody see [SECTION 6.8 Interstate Placements](#).

6.3.1 Under Age 21

~~6.3.1.1~~ Not in an Institution

A person under age 21 and not residing in an institution is a Wisconsin resident if they are any of the following:

- A person under age 18, not emancipated from their parents, not married, are living in Wisconsin, and any of the following is true:
 - They are living in another state when Wisconsin or one of its county agencies has legal custody of them.
 - They are living in Wisconsin and are eligible based on blindness or disability.
 - They are living in another state when their parent is a resident of Wisconsin, has legal custody of them, and they intend to reside with this parent.

Example <u>1</u>	<u>Alicia is a Wisconsin resident and intends to remain living in Wisconsin. She gives birth to her son, Max, at a hospital in Minnesota. Due to medical complications, Max is a patient in the hospital for three weeks immediately after his birth. Even though Max has not physically been in Wisconsin after his birth, he is a resident of Wisconsin. He is a resident because his parent, Alicia, has legal custody of Max, and Max will reside with her in Wisconsin once he is discharged from the hospital.</u>
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- A person age 18 through 20 or under age 18, emancipated from his or her parents or married, and either of the following is true:
 - They are living in Wisconsin with the intent to remain living in Wisconsin.
 - They are living in Wisconsin and entered Wisconsin with a job commitment or to seek employment.

In an Institution

The residence of an institutionalized person under age 21 ~~when his or her parents or legal guardian lives outside of Wisconsin~~ is the state in which ~~the~~ a parent or legal guardian ~~states~~ indicates the institutionalized person is present, ~~and intends to stay.~~ This is true whether their parent or legal guardian lives in Wisconsin or not.

If the parents have abandoned ~~him or her~~ them and no legal guardian has been appointed, ~~his or her~~ their residence is the state in which the institution is, ~~if located,~~ as long as the person ~~making the Medicaid application lives~~ requesting health care on their behalf resides in ~~that~~ the same state.

If ~~he or she is~~ they are married, ~~his or her~~ their residence is the institution's state.

~~6.3.1.2~~ Not in Institution

~~A person under age 21 and not residing in an institution is a Wisconsin resident if he or she is:~~

- ~~Age 18 or under age 18 and emancipated from his or her parents, or married, and is:~~

- ~~Living in Wisconsin with the intent to remain living in Wisconsin, or~~
- ~~Living in Wisconsin and entered Wisconsin with a job commitment or to seek employment.~~
- ~~Under age 18 and not emancipated from his or her parents and not married, and is:

 1. ~~Living here temporarily, not receiving Medicaid from another state, and is a migrant farm worker or living with a family member who is a migrant farm worker.~~
 2. ~~Living in another state when Wisconsin or one of its county agencies has legal custody of him or her.~~
 3. ~~Living here and is an EBD Medicaid case (the person's eligibility is based on blindness or disability)~~~~

6.3.2 Age 21 and Over

6.3.2.1 Not in an Institution

An individual age 21 or over who is not in an institution is a Wisconsin resident if either of the following is true:

- They are living in Wisconsin with the intent to remain living in Wisconsin.
- They are living in Wisconsin and entered Wisconsin with a job commitment or to seek employment.

If they are incapable of expressing intent, an individual is a resident if they are living in Wisconsin.

In an Institution

The residence of an institutionalized ~~person~~individual aged 21 or over capable of indicating intent is the state in which ~~he or she is~~they are residing with the intent to remain.

If ~~he or she is~~they became incapable of indicating intent, ~~his or her residence is~~ before age 21, their residency is determined in the same way as ~~the residence of~~ an institutionalized person under age 21.

If they became incapable of indicating intent at age 21 or older, their residence is Wisconsin.

For all others, the person is a Wisconsin resident if they intend to reside in Wisconsin.

6.4 Special Situations

6.4.1 State Supplementary Payment

The State Supplementary Payment (SSP) is the portion of an SSI payment paid by a state, not by the federal government. ~~An~~ A person receiving SSP payments is a resident of the state making the SSP payment. ~~recipient's residence~~

6.4.2 Foster Care Medicaid

For Foster Care recipient residency, see [BadgerCare Plus Handbook 3.4.2 Foster Care Medicaid](#).

6.4.3 Homeless Persons

A homeless person living in Wisconsin meets the residency requirement ~~of~~ by being physically present in Wisconsin. ~~The agency must, by using its own address or some other fixed address, make Medicaid cards available to eligible applicants who have no fixed dwelling place or~~ See Section 21.7.2 Homeless for information about mailing addresses for ForwardHealth cards. ~~address~~

6.5 Absence from Wisconsin

6.5.1 Absence Introduction

Once established, Wisconsin residence is retained until ~~one~~any of the following occurs:

- The person notifies the ~~income maintenance~~IM agency that ~~he or she~~they no longer ~~intends~~intend to reside in Wisconsin.
- Another state determines the person is a resident in that state for Medicaid/Medical Assistance.
- Other information is provided that indicates the person is no longer a resident.

6.5.2 Temporary Absence

Temporary absence ends when another state determines the person is a resident there for Medicaid/Medical Assistance purposes.

6.8 Interstate Placements

6.8.1 Interstate Placements Introduction

An interstate placement occurs when a state or state contracted agency arranges for an individual to be admitted to an institution in another state.

"Arranges for" means any action by a state or state-contracted agency beyond providing information to the person or the person's family (or both). Do not consider the following to indicate interstate placement:

1. Giving information to individuals about another state's Medicaid program.
2. Giving information to ~~persons~~individuals about the availability of health care services and facilities in another state.
3. Helping ~~a person~~individuals locate an institution in another state when that person is capable of indicating intent and independently decides to move.

When a state or state-contracted agency makes the placement, the state making the placement is the person's Medicaid residence. The person's intent makes no difference. If Wisconsin places a person into an institution in Tennessee, Wisconsin remains the state of residence for Medicaid even if the person expresses an intent to reside in Tennessee.

If Tennessee places a person in Wisconsin, Tennessee is the Medicaid residence despite an indicated intent by the person to make his or her home in Wisconsin.

Follow this rule even when placement is made by a state because that state lacks a sufficient number of appropriate facilities to provide services to its residents.

Use the general rule of residency when a competent person leaves an institution in which he or she was placed by another state. If the person is not able to indicate intent, Medicaid residence continues to be that of the state that made the placement.

6.8.2 Reciprocal Agreement

Wisconsin has a reciprocal agreement with some other states (see the list below) in which ~~persons~~individuals that are placed in out-of-state institutions (not placed there as a result of an interstate placement) are the residents of the state where the institution is. For example, a person institutionalized in Wisconsin who would otherwise be considered a resident of Minnesota is a Wisconsin resident for Medicaid purposes.

These are the states with which ~~we have~~Wisconsin has this agreement:

- Alabama
- Arkansas
- California
- Georgia
- Idaho
- Kansas
- Kentucky
- Maryland
- Minnesota
- Mississippi
- New Mexico
- ~~N.~~North Dakota
- Ohio
- Pennsylvania

- ~~S.~~South Carolina
- ~~S.~~South Dakota
- Texas
- Virginia
- ~~W.~~West Virginia

6.8.3 Disputes

The state in which the person is physically present is the Medicaid residence when two or more states disagree about the person's residence.

~~If you determine that a state other than Wisconsin is the person's legal residence, contact the other state about providing Medicaid coverage.~~

7.2 Verifying U.S. Citizenship

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~~[exchanges](#) with the Social Security Administration, [birth record query](#), and [Systematic Alien Verification for Entitlements \(SAVE\)](#) before requesting documentation of citizenship from applicants. (See [Section 7.2.3 U.S. Citizenship Verification Through the Social Security \(SSA\) 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 Other Methods of 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.

7.2.1.2 Exempt Populations

The following populations are exempt from the U.S. citizenship verification requirement:

- ~~Anyone currently receiving~~ [Anyone who receives or previously received Social Security Disability Insurance \(SSDI\), or a Disabled Adult Child benefit \(SSDC\), or Disabled Widow\(er\)'s benefits](#)
- Anyone who ~~is currently receiving~~ [receives or previously received Supplemental Security Income \(SSI\) benefits](#)
- Anyone ~~currently receiving~~ [entitled to or enrolled in Medicare](#)
- ~~Anyone currently receiving~~ [who receives or previously received Title IV-E Foster Care \(Title IV-E and Non IV-E\)](#)
- ~~Anyone currently receiving~~ [Medicaid \(including Adoption Assistance\)](#)
- 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 (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~~ [Anyone](#) 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~~ [Data exchanges must be used to verify receipt of SSI, SSDI, SSDC, and Medicare Recipients](#)

~~Medicare, SSDI, and SSI recipients lose their exemption from the citizenship~~ [prior to requesting verification requirement when their enrollment in these programs ends](#) ~~from the recipient.~~

Note:	IM workers must use data exchanges to verify receipt of SSI, SSDI, and Medicare prior to requesting verification from the applicant or member.
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7.2.3 U.S. Citizenship Verification Through [the Social Security Administration \(SSA\) Data Exchange](#)

For ~~persons~~ [individuals](#) who meet the selection criteria below, a request ~~will be~~ [is](#) 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 the SSA's data. If the SSA is able to verify U.S. verifies citizenship, no additional verification of U.S. citizenship is required.

To be selected for this data exchange, a person must:

- Be requesting health care.
- Have declared they are a U.S. citizen or national.
- Have provided an SSN.
- Not belong to an exempt population listed in [Section 7.2.1.2 Exempt Populations](#).
- Not have already had their U.S. citizenship verified through other means.

Non-exempt Medicaid applicants or 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 having their citizenship verified through a birth record query, SAVE, or by providing documentation as defined in [Section 7.2.4 Other Methods of Citizenship Verification Through Documentation](#).

7.2.4 U.S. Other Methods of Citizenship Verification through Documentation

For individuals who are not exempt from the U.S. citizenship verification requirement and have not had their U.S. citizenship verified by the Social Security Administration, agencies must first attempt to verify U.S. citizenship as follows:

- For applicants born in Wisconsin, attempt verification of citizenship through a birth record query.
- For applicants who had legal non-citizen status and subsequently gain U.S. citizenship, attempt verification of citizenship through SAVE.

If verification cannot be obtained through the SSA, birth record query, or SAVE, the individual must provide verification of U.S. citizenship through either stand-alone documentation of citizenship (see [Section 7.2.4.1 Stand-Alone Documentation of Citizenship](#)) or both documentation of citizenship (see [Section 7.2.4.2 Evidence of Citizenship](#)) and identity (see [Section 7.2.4.3 Evidence of Identity](#)).

Whether benefits may be granted while waiting for documentation to be provided and for how long are discussed under the Reasonable Opportunity Period for Verification of Citizenship (see [Section 7.2.4.4 Reasonable Opportunity Period for Verification of Citizenship](#)).

If an individual has provided proof of U.S. citizenship in a state other than Wisconsin, the IM worker can either request that the individual resubmit the documentation or request and obtain a copy or electronic copy of the original documentation reviewed by the other state to keep on file in Wisconsin. If an applicant/member contacts the agency for help with verifying citizenship, work with him or her to determine if anything on the document list in Process Help, [Section 68.3 Acceptable Citizenship and Identity Documentation](#) is readily available to the applicant/member. In certain circumstances the agency can authorize payment of documentation for an applicant/member. See [Section 7.2.5 Agencies Paying for Documentation](#).

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

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

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

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

7.3 Immigrants

7.3.2 Verification

7.3.2.3 Reverification of Immigration Status

Immigration status for many members should only be verified once, unless the status for an individual is questionable or they have a Registration Status Code of 20 – Lawfully Residing. Even if an immigrant loses health care eligibility for a period ~~of time~~, their immigration status does not need to be re-verified. When a non-citizen is no longer eligible for Medicaid due to their immigration status, their status may be reverified to ascertain if they have had a change in status through which they may be eligible for benefits.

People with a Registration Status Code of 20 – Lawfully Residing are required to re-verify their immigration status at application or renewal, even if they have previously verified their immigration status.

This reverification requirement is only to be applied at the time of subsequent applications, renewals, or when an agency receives information indicating that the member may no longer be lawfully residing in the U.S. For pregnant people, the reverification is not to occur until the renewal is done to determine the person's eligibility after the end of the 60-day postpartum period.

Individuals who report they have moved from a non-qualifying to a qualifying immigration status must have their new qualifying immigration status verified. Individuals who report they have become naturalized citizens must have their U.S. citizenship verified.

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

7.3.2.4 Reasonable Opportunity Period for Verification of Immigration Status

Applicants who have declared that they are in a satisfactory immigration status, ~~are otherwise eligible and~~ (and are only pending for verification of immigration status), are otherwise eligible and must be certified for health care benefits within the normal application processing timeframe (30 days from the filing date). They are to continue receiving health care benefits for which they are eligible, while the IM agency waits for immigration status verification.

Applicants who are otherwise eligible and are only pending for verification of immigration ~~will~~status have 90 days after receiving a request for immigration status verification to provide the requested documentation. This 90-day period is called the Reasonable Opportunity Period (ROP). The 90-day ROP starts on the date after the member receives the notice informing the member of the need to provide immigration status verification by the end of the reasonable opportunity period. Federal regulations require that ~~we assume~~ a minimum of five-day time frame days be allotted for applicants to receive notices. For this reason, ~~we must set~~ the end of the ROP must be set no less than 95 days after the date on the notice, even when the member receives the notice in less than five days. It also means that if a member shows that a notice was received more than five days after the date on the notice, the deadline must be extended to 90 days after the date the member received the notice.

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

Applicants are eligible for benefits beginning with the first of the month of application or request.

However, they are not eligible for backdated health care benefits while waiting for verification of their immigration status. Once verification of an eligible immigration status is provided, the applicant's eligibility must then be determined for backdated health care benefits if they have been requested.

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

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

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

A person may receive a reasonable opportunity period more than once in a lifetime.

Example 1	<p>Vladimir is a 12-year-old lawfully present in the United States on a visa applying for health care benefits with his parents. When verification is attempted through the FDSH, the response requires a secondary verification request to SAVE. Vladimir is otherwise eligible for Medicaid and is enrolled in Medicaid and the ROP notice is sent to the family while waiting for the SAVE response. A week later, SAVE verifies the child is lawfully present in the U.S. under a Temporary Protected Status and the reasonable opportunity period ends.</p> <p>A year later, the case is up for renewal. Since Vladimir has a Registration Status Code of 20 – Lawfully Residing, his immigration status must be verified again. Once more, the FDSH response requires verification of the child's status through SAVE. If Vladimir is otherwise eligible for Medicaid, they will be enrolled without delay and be sent a new reasonable opportunity period notice to the family. Again, Vladimir may be eligible for up to 90 days after receiving the notice while his immigration status is being verified.</p>
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Example 2	<p>Sasha is a 22-year-old applying for health care benefits. Information received from the FDSH indicates she is a victim of trafficking. Confirmation of her status as a victim of trafficking is needed, and she must submit a letter from the U.S. Department of Health and Human Services Office on Trafficking in Persons (HHS OTIP). She is enrolled in BadgerCare Plus and is sent the ROP notice requesting Sasha submit a letter from HHS OTIP. Sasha never submits a letter from HHS OTIP and her benefits end when the ROP expires.</p> <p>One year later, Sasha again applies for health care benefits. Once more, the FDSH returns the same results. Sasha is otherwise eligible for BadgerCare Plus. She must be enrolled in BadgerCare Plus without delay and sent a new ROP notice to Sasha requesting a letter from HHS OTIP. Again, Sasha is eligible for BadgerCare plus for 90 days after receiving the notice while waiting for Sasha to provide a letter from HHS OTIP.</p>
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Benefits issued during a reasonable opportunity period to a person otherwise eligible for Medicaid or BadgerCare Plus are not subject to recovery, even if the person turns out to have an immigration status that makes him or her ineligible for Medicaid or BadgerCare Plus benefits.

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. Unless otherwise specified, categories of qualifying immigrants are enumerated in 8 U.S.C. § 1641(b) and (c).

Types of Qualifying Immigrants

Short Name	Qualifying Immigrant Description	Eligible if:	Additional Eligibility Information	CWW Registration Status
Refugee	A refugee admitted under Immigration and Nationality Act (INA) Section 207. A refugee is a person who flees their country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group.	No additional criteria.	An immigrant admitted under this status may be eligible for Medicaid, without a five-year waiting period, even if their immigration status later changes.	04
Refugee-Like	An immigrant who has qualifies for benefits eligibility to the same extent as refugees a refugee due to an act of Congress.	See Section 7.3.3.1.1 “Refugee-Like” Immigrants who have Benefits Eligibility as Refugees Because of an Act of Congress for more information.	N/A	04
Asylee	An asylee admitted under INA Section 208. an An asylee is a person who seeks asylum and is already present in the U.S. when they request permission to stay.	No additional criteria.	An immigrant admitted under this status may be eligible for Medicaid, without a five-year waiting period, even if their immigration status later changes.	05
Deportation Withheld	An immigrant whose deportation is withheld under INA Section 243(h) and such status was granted prior to April 1, 1997, or an immigrant whose removal is	No additional criteria.	An immigrant admitted under this status may be eligible for Medicaid, without a five-year waiting period, even if their immigration status later changes.	15

	withheld under INA Section 241(b)(3) on or after April 1, 1997.			
Cuban-Haitian Entrant	Cuban-Haitian Entrants are defined as certain nationals of Cuba or Haiti who have permission to reside in the U.S. based on humanitarian considerations or under Section 501(e) of the Refugee Education Assistance Act of 1980 (REAA).	No additional criteria. See Section 7.3.3.1.2 Cuban-Haitian Entrants for more information.	The term “Cuban-Haitian Entrant” (CHE) relates to benefit eligibility rather than an immigration status. Individuals who meet the definition of a CHE may be eligible for certain public benefits.	11
Foreign Born American Indian	An American Indian born in Canada who is at least 50% American Indian by blood, as defined by §289 of the Immigration and Nationality Act or An American Indian born outside the U.S. who is a member of a federally recognized Indian tribe, as defined in 25 U.S.C. 450b(e).	No additional criteria.	N/A <u>An immigrant admitted under this status may be eligible for Medicaid, without a five-year waiting period, even if their immigration status later changes.</u>	18
COFA Citizen	A person who is a citizen of a country in the Compacts of Free Association (COFA) See for more information	No additional criteria. See Section 7.3.3.1.3 Citizens of the Compacts of Free Association Countries for more information.	N/A <u>An immigrant admitted under this status may be eligible for Medicaid, without a five-year waiting period, even if their immigration status later changes.</u>	22

Trafficking Victim's child, spouse, or parent	Victims of a severe form of trafficking, and their child, spouse, or parent in accordance with 107(b)(1) of the Trafficking Victims Protection Act of 2000 (P.L. 106-386).- See for more information.	See 7.3.3.1.4 Victims of Trafficking for more information.	An immigrant admitted under this status may be eligible for Medicaid, without a five-year waiting period, even if their immigration status later changes.	19
Trafficking victim		Meet one additional criterion: <ol style="list-style-type: none"> 1. Have been in a qualifying immigration status for at least five years. 2. Be a child younger than 19 years old. 3. Be younger than 21 years old and reside in an institution<u>Institution</u> for Mental Diseases. 4. Be pregnant. 5. Have arrived in the U.S. before August 22, 1996, and have been continuously present. 6. Have a military service/connection. 7. Be an Amerasian immigrant. 8. See Section 7.3.3.1.5 Additional Criteria for Certain Qualifying Immigrants for more information. 	Be certified by the Department of Health and Human Services (HHS) as victim of trafficking (applies to T1 visa holders and others).	19 - Meets one additional criterion or is certified by HHS as a victim of trafficking. Or 21- five-year waiting period applies.
LPR <u>Lawful Permanent Resident</u>	An immigrant lawfully admitted for permanent residence under INA 8 USC 1101 et seq		LPRs who were first refugees, asylees, Cuban or Haitian entrants, certain trafficking victims, or had their deportation withheld maintain that status for benefits eligibility purposes. <u>N/A</u>	01
Parolee	An immigrant paroled into the U.S. under INA Section 212(d)(5) for at least one year		Certain parolees are treated as refugees for benefits eligibility purposes due to acts of Congress (see Section 7.3.3.1.1 "Refugee-Like" Immigrants who have Benefits Eligibility as Refugees Because of an Act of Congress).	06

			Parolees who are nationals of Cuba or Haiti may be Cuban Haitian Entrants for benefits eligibility purposes (see Section 7.3.3.1.2 Cuban- Haitian Entrants).	
Conditional Entrant	An immigrant granted conditional entry under immigration law in effect before April 1, 1980 [INA Section 203(a)(7)].		N/A	03
Battered Immigrants	An immigrant as described at 8 U.S.C. §1641(c)(1) who has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements		N/A	16
	An immigrant as described at 8 U.S.C. §1641(c)(2) whose child has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.	N/A		16
	An immigrant child as described at 8 U.S.C. §1641(c)(3) who resides with a parent who has been battered or subjected to extreme cruelty in	N/A		16

	the U.S. and meets certain other requirements.			
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7.3.3.1.4 Victims of Trafficking

The U.S. Department of Health and Human Services (HHS) Office on Trafficking Persons (HHS OTIP) provides adult victims of trafficking with Certification Letters which allow those whose immigration status would otherwise prevent them from being eligible to receive Medicaid to be eligible to receive benefits. The certification process typically takes ~~only~~ a few days after HHS is notified by ~~DHS~~ [the U.S. Department of Homeland Security](#) that a person has made a bona fide application for a T visa or has been granted a T visa or Continued Presence.

- Applicants with a victim Certification Letter from HHS OTIP qualify for benefits as a Victim of Trafficking regardless of their immigration status.
- Applicants who are victims of trafficking with COA codes: ST6 or T1 and are:
 - Under 18 at the time of application do NOT require a Certification Letter.
 - 18 or older must either have a victim Certification Letter or meet one of the additional qualifying criteria for certain qualifying immigrants (see [Section 7.3.3.1.5 Additional Criteria for Certain Qualifying Immigrants](#))

Children, spouses, and parents of trafficking victims (COA codes: ST0, ST1, ST7, ST8, ST9, T2, T3, T4, T5, or T6) do not need a Certification Letter to be eligible for benefits.

Trafficking victims who meet additional criteria described in [Section 7.3.3.1.5 Additional Criteria for Certain Qualifying Immigrants](#) ~~are confirmed or were certified by HHS~~ as ~~eligible for Medicaid without a five-year waiting period~~ victim of trafficking and who later adjust their status and become Lawful Permanent Residents are not subject to the five-year waiting period as Lawful Permanent Residents.

7.3.3.1.5 Additional Criteria for Certain Qualifying Immigrants

Certain qualifying immigrants must meet one additional criterion to be eligible for full-benefit Medicaid and BadgerCare Plus. These groups include:

- Lawful permanent residents (LPR)
- ~~People whose deportation is withheld under INA Section 243(h) and such status was granted prior to April 1, 1997, or an immigrant whose removal is withheld under INA Section 241(b)(3) on or after April 1, 1997.~~
- People who are paroled into the U.S. under INA Section 212(d)(5) for at least one year.
- People considered to be battered immigrants who suffered domestic abuse.

The groups listed above must meet one of the following additional criteria:

1. Have been in a qualifying immigration status for five years.
 - ~~These immigrants~~ immigrants who arrived in the U.S. on or after August 22, 1996, are subject to a five-year waiting period to receive federal benefits (including BadgerCare Plus and Medicaid), other than emergency services. For these immigrants, the five-year waiting period is calculated beginning when they first receive their qualifying immigration status.
2. Are less than 19 years old.
3. Are less than 21 years old and reside in an Institution for Mental Diseases.
4. Are pregnant.
 - Pregnant applicants are eligible for full-benefit Medicaid and BadgerCare Plus.
 - Pregnant people ~~will~~ have the five-year waiting period lifted when their pregnancy is reported to the agency. The waiting period ~~will be~~ is lifted until 60 days after the last day of pregnancy and through the end of the month in which the 60th day occurs.

5. Arrived in the U.S. before August 22, 1996, and have been continuously present. Applicants who alleged an arrival date in the U.S. before August 22, 1996, and obtained a qualified immigrant status after August 22, 1996, may be eligible to receive Medicaid. The immigrants described below, who apply for Medicaid and meet all eligibility requirements, are entitled to receive Medicaid benefits:

- A non-citizen who:
 - Arrived in the U.S. before August 22, 1996, in a legal, but non-qualified, immigration status and
 - Had a change in their status to (making them a qualified immigrant) on or after August 22, 1996, and
 - Remained continuously present from their date of arrival in the U.S. until the date they gained qualified immigration status.
- A non-citizen who:
 - Arrived in the U.S. before August 22, 1996, in undocumented status, or
 - Overstayed their original visa, and
 - Remained continuously present from their date of arrival in the U.S. until the date they gained qualified immigration status.

For those non-citizens who arrived in the U.S. before August 22, 1996, but whose continuous presence cannot be verified, the five-year waiting period applies from the date the individual obtained a qualified immigrant status.

An individual meets the "continuous presence" test if they:

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

6. Have a military service/connection.

Applicants may be eligible for ~~BadgerCare Plus~~ Medicaid if they meet any of the following criteria related to military service:

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

7. Are an Amerasian immigrant.
 - Amerasian immigrants, defined under §584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988, may be eligible for ~~BadgerCare Plus~~ Medicaid.
8. Also be considered a Cuban/Haitian Entrant.
9. Lawful permanent residents who were previously a refugee, asylee, COFA citizen, Foreign Born American Indian or had their deportation withheld under INA Section 243(h) ~~are not required to have been in a qualifying immigration status for five years.~~
 - ~~See Section 7.3.3.1.4 Victims of Trafficking Immigrants admitted under these statuses continue to be treated as refugees, asylees or immigrants who had their deportation withheld for benefits eligibility.~~
 - ~~See for additional details.~~

for specific policy regarding Victims of Trafficking.

7.3.8 Refugee Assistance Programs

7.3.8.2 Refugee Medical Assistance

If refugees, asylees, and certain other immigrants apply for BadgerCare Plus or Wisconsin Medicaid and do not meet the eligibility requirements, they may be eligible for Refugee Medical Assistance (RMA). However, unlike BadgerCare Plus and Wisconsin Medicaid, Refugee Medical Assistance is a time-limited benefit and people must apply within a certain timeframe of receiving their refugee, asylee or other eligible immigration status.

RMA provides the same level of benefits as BadgerCare Plus but is funded separately.

While W-2 agencies have contractual responsibility for providing Refugee Medical Assistance, they must coordinate with income maintenance agencies to ensure eligibility is determined for all ~~regular other~~ BadgerCare Plus or Medicaid subprograms ~~is tested~~ first.

More information about this program is in the [Bureau of Refugee Programs Policy Manual](#), Section 6 ~~Refugee Medical Assistance~~.

13.8 Special Rules

13.8.1 Children Whose Parent/Caretaker is an Inmate

If the only parent(s) or caretaker(s) in the household are incarcerated, any children on the case open for Medicaid will remain eligible for the remainder of their 12-month continuous coverage period. Eligibility for the children will end at the end of the 12-month period unless they open for health care on another case.

Example 1	Faye and her 10-year-old daughter, Chantelle, are both enrolled in health care as of January 1, 2024 . Faye is enrolled in medically needy Medicaid and Chantelle is enrolled in BadgerCare Plus. On March 9, 2021 , Faye is incarcerated. Faye's suspended Medicaid starts April 1, 2021 . Chantelle will remain open for full-benefit BadgerCare Plus on Faye's case for the remainder of her 12-month continuous coverage period. Chantelle's BadgerCare Plus will end December 31, 2024 . Chantelle could re-enroll in BadgerCare Plus as part of the household she now resides in or through another program such as Foster Care Medicaid depending on her situation.
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15.4 Unearned Income

15.4.13 Money for School

15.4.13.3 Workforce ~~Investment~~ Innovation and Opportunity Act (WIOA)

For both family and elderly/disabled Medicaid cases, disregard all unearned income from ~~WIA~~WIOA to any adult or minor participating in ~~WIA~~WIOA, including:

- "Need-~~based~~related payments" paid to people as allowances to enable them to participate in a training program.
- "Compensation in lieu of wages" paid to people in "~~tryout employment~~work experience" and/or "transitional jobs." This is arranged when private-for-profit opportunities are not available ~~and is generally limited to people younger than 22 years old. Ask any applicant younger than 23 years old or the local WIA staff if he or she is participating in "tryout employment." If he or she is, count this as unearned income.~~
- "Payments for supportive services" ~~paid to people in~~ that enable participation in WIOA career and/or training programs who are not able to pay for training-related expenses services (e.g., transportation, health care, child care, meals).

Earned ~~WIA~~WIOA income is paid in the form of wages from on-the-job training ~~and work experience~~ activities. Disregard all earned ~~WIA~~WIOA income of a minor for up to a total of six months per calendar year. Negotiate with the Medicaid group which six months of income to disregard. The six months do not need to be consecutive. Budget ~~WIA~~WIOA income earned by a minor in other than these six months according to ([Section 15.5.8. Student Income](#)).

Count the earned ~~WIA~~WIOA income of adult participants.

The Job Corps Program is a part of ~~WIA~~WIOA. Consider a minor who is participating in the Job Corps as a student when you calculate the income disregards for full-time students and part-time students who are not employed full-time.

Consider Job Corps payments to adult participants as unearned ~~WIA~~WIOA income.

15.4.19 Payments to Native Americans

Tribal Per Capita Payments

Disregard the first \$500 of the monthly income from Tribal Per Capita payments from gaming revenue. If the payments are received less often than monthly, prorate the gross payment amount over the months it is intended to cover and disregard \$500 from the monthly amount.

This applies to eligibility determinations for all Medicaid subprograms for elderly, blind, or disabled persons except SeniorCare and LTC programs such as Institutional Medicaid, Family Care, and HCBWs, including Partnership and PACE. For these subprograms, count all income from Tribal Per Capita payments from gaming revenue as unearned income.

Tribal General Welfare Assistance Payments

Disregard Tribal General Welfare Assistance payments when determining Medicaid eligibility. See #22 in Section 15.3.14 Payments to Native Americans for details.

Bureau of Indian Affairs (BIA) General Assistance payments

Count BIA General Assistance payments as unearned income.

15.5 Earned Income

15.5.20 Imputed Income

Income imputed for premium costs of life insurance coverage in excess of \$50,000 is countable as part of gross employment income for Medicaid.

Example 3	Olga has life insurance coverage in excess of \$50,000 through her employer. According to Olga's paystub, her employer pays a portion of her life insurance premium. The value of this compensation is imputed income. Imputed income is added to Olga's earnings before taxes are taken out. This imputed income is countable as earned income.
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18.4 Spousal Impoverishment Assets

18.4.1 Spousal Impoverishment Assets Introduction

Count the combined assets of the institutionalized person and his or her community spouse.

(Note: Disregard prenuptial agreements. They have no effect on spousal impoverishment determinations.) Add together all countable, available assets (see Section 16.1 Assets Introduction) the couple owns.

Note	Marital agreements, including prenuptial and postnuptial agreements, have no effect on spousal impoverishment determinations.
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Do not count the following assets:

- Homestead property. If the institutionalized person and the community spouse each own home property and meet the criteria in Section 16.8.1.3 Exempt Home Property, exempt the institutionalized person's home but not the community spouse's home.

Example 1	One spouse is in a nursing home, the other lives in the community. They have lived apart for 10 years. The institutionalized person owns a home and intends to return. The community spouse owns a different home. The home that each spouse owns is the principal residence of that spouse. The institutionalized person's home is an exempt asset. The community spouse's home is not exempt.
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- If they both own homes and the institutionalized person's home is not exempt, count the institutionalized person's home but exempt the spouse's home. Both homes cannot be exempt simultaneously.
- One vehicle, regardless of value or purpose. If the AG has more than one vehicle, completely disregard the vehicle with the highest equity value, regardless of purpose. Then, for the remaining vehicles, follow the EBD rules for vehicles (see Section 16.7.9 Vehicles [Automobiles]).

Example 2	Howard is applying for benefits. Howard is in an institution and Marianne is his community spouse. They own a boat with an equity value of \$10,000 and an automobile with an equity value of \$7,000. Because the boat has a higher equity value, it is disregarded. The automobile does not meet the criteria for exemption and so is a counted asset; count \$7,000 in the asset assessment and the asset determination.
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- All assets designated for burial purposes. This includes burial assets owned by the applicant/member and/or the community spouse for a child(ren).
- Any unreasonable amount should be supported by documentation of the burial-related costs or contract.

Do not allow applicants and members to simply state that they are setting aside an unreasonable amount of cash (e.g., \$1,000,000) as their burial fund for unspecified funeral expenses. If they can document the funeral expense that they expect to incur, it can be totally exempt regardless of its cost.

For example, ask the member to document that he or she has arranged to purchase a \$100,000 casket or that a funeral home will provide them with a \$75,000 funeral along with an itemized listing of the funeral goods and services that will be provided.

This differs from EBD burial policies for non-institutionalized persons and institutionalized persons without a community spouse (see Section 16.5 Burial Assets).

- Household goods and personal items, regardless of their value.
- All assets not counted in determining EBD Medicaid eligibility.
- IRA and work-related retirement benefit plans or individually-owned retirement accounts, such as IRAs or Keoghs of an ineligible community spouse (see Section 16.7.2011.2 Retirement ~~Benefits~~Funds as Assets).

20.1 Verification

Proof of certain information is required to determine eligibility for Medicaid. Mandatory (see Section 20.3 Mandatory Verification Items) and questionable (see Section 20.4 Questionable Items) items must be verified at application, renewal, person addition or deletion, or when there is a change in circumstance that affects eligibility or benefit level. One time only verification items do not need to be re-verified. For changes in circumstance and timely renewals, current benefits are maintained until a redetermination of benefits is completed.

Verification means to establish the accuracy of verbal or written statements made by or about an individual's circumstances. Case files or case comments must include documentation for any information required to be verified to determine eligibility or benefit levels.

20.1.1 Verification Definition

Verification is part of determining eligibility. To verify means to establish the accuracy of verbal or written statements made by or about an individual's or group's circumstances.

If the member is applying for other programs of assistance ~~or if you are looking for sources of verification,~~ see the ~~specific~~ verification chapters ~~for~~ those ~~programs in their respective~~ program handbooks.

20.1.2 Documentation

Documentation ~~is a method by which you accomplish verification. Case~~ includes storing received information in the case record.

Documentation also includes adding case comments ~~in CWW provide documentation, including worker notes regarding. For collateral contacts, viewing documents, home visits, etc. Include enough data to~~ contact or any other information that cannot be stored in the case record, case comments must describe the nature and source of information if follow up is needed. Documentation must explain current eligibility, ineligibility, benefit level, and coverage group changes.

All documentation must be in sufficient detail to permit a reviewer to determine the reasonableness and accuracy of the determination.

20.1.3 Verification Receipt Date

The verification receipt date is the day verification is ~~delivered~~ submitted to the appropriate IM agency or the next business day if verification is ~~delivered~~ submitted after the agency's regularly scheduled business hours.

IM agencies must stamp the receipt date on each piece of verification ~~provided~~ submitted.

20.1.4 General Rules

1. Over-verification, including requiring excessive pieces of evidence for any one item or requesting verification that is not needed to determine eligibility, is prohibited. Once the accuracy of a written or verbal statement has been established, additional verification can't be required. For example, once U.S. citizenship is verified, a member or applicant never has to verify it again (see [Section 7.2 Verifying U.S. Citizenship](#)).
2. If information has already been verified, the applicant or member does not need to verify it again except in the following situations:
 - a) There is reason to believe the information is fraudulent or differs from more recent information. If fraud is suspected, the IM agency will determine if a referral for fraud or for front-end verification should be made (see Section 20.6 Front End Verification).
 - b) The member reported a change to information that is subject to mandatory verification rules or is questionable.

- c) At renewal, if information is subject to mandatory verification rules or is questionable.
3. One particular type of verification can't be exclusively required when various types are adequate and available.
 4. ~~Verification need not be presented in person.~~ Verification may be submitted in person, by mail, fax, ~~email~~, or ~~another electronic device, or electronically~~ through an authorized representative ACCESS or the MyACCESS mobile app. Verification is not required to be presented in person.
 5. Applicants and members must not be subject to different verification requirements solely based on race, color, national origin, age, disability, sex, religion, or migrant status when people in similar circumstances would not otherwise have the same verification requirements.

Example 1	<p>Marie reports on her application that she is a U.S. citizen. She also reports that the primary language spoken in her home is a language other than English, and it is her preferred language. Marie's U.S. citizenship was found questionable because she has a preferred language that is not English. A request was sent to Marie to specifically submit her birth certificate in order to verify her U.S. citizenship. This action is not allowed. <u>has no impact on the verification policy for U.S. citizenship.</u> Verification of U.S. citizenship must first be <u>is attempted through data exchange or other documentation as</u> using the same methods used for all applicants that report U.S. citizenship, which is explained in Section 7.2 Verifying U.S. Citizenship Section 7.2 Verifying U.S. Citizenship.</p>
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6. The applicant or member can't be required to sign a release form (either blanket or specialized) when the member provides required verification.
7. Verification of information that is not used to determine eligibility ~~can't~~ cannot be required.
8. During verification, the applicant or member can't be harassed or have their privacy, personal dignity, or constitutional rights violated.

The applicant or member has primary responsibility for providing verification and resolving questionable information. However, the IM worker must use all available data exchanges to verify information rather than requiring the applicant to provide it, unless the information from the data source is not reasonably compatible with what the applicant or member has reported (see Section 20.3.8.1 Reasonable Compatibility for Income for Health Care and Section 20.3.5.2 Reasonable Compatibility for Assets). IM agencies must assist the applicant or member in obtaining verification if they request help or have difficulty in obtaining it.

The best information available ~~should be~~ is used to process the application or change within the time limit when both of the following conditions exist:

1. The applicant or member does not have the power to produce verification.
2. Information is not obtainable timely even with the IM worker's assistance.

Applicants meeting the health care program eligibility criteria based on ~~this~~ best available information are eligible for benefits. Even after the application or change is processed using best available information, the IM agency is required to continue in their attempts to obtain verification. When the verification is received, benefits ~~may need to be adjusted~~ are redetermined based on the new information. ~~The agency must explain this to the applicant or member when requesting verification.~~

21.6 HMO Enrollment

21.6.4 HMO Disenrollment

21.6.4.1 Automatic Disenrollment

Automatic disenrollment occurs when there are changes to the member’s eligibility or enrollment status that affects their HMO enrollment and typically occurs automatically once eligibility has been updated. The table below includes a list of automatic disenrollments and date on which the disenrollment is effective.

Reason for Disenrollment	Disenrollment Date
Loss of Medicaid eligibility	End of the month in which Medicaid eligibility ends.
Date of Death entered	Date of Death
Moving outside of the HMO’s service area	End of the month in which the move was reported
Incarceration or Institutionalization	End of the month prior to the month incarceration or institutionalization starts and lasts more than 30 calendar days
Enrollment in a Waiver program or Long-Term Care MCO	<p>End of the month prior to the month waiver program or LTC MCO enrollment starts<u>start date or up to the last day of the month a member is enrolled in a Waiver program.</u></p> <p><u>Note: Waiver Medicaid enrollment can run concurrently with HMO enrollment, but LTC MCO enrollment cannot.</u></p>
<u>Mail was returned for the member’s household with no forwarding address, and an up-to-date address has not been received.</u>	<u>End of the month in which it is determined an up-to-date address cannot be received.</u>

22.3 Interagency ~~Case Transfer~~ Coordination

~~A case transfer occurs when the primary person who is currently receiving benefits (or whose benefits have been closed for less than one calendar month) reports that they have moved to a different county or tribal area. The only exception to this is protective placements (see -).~~

A case transfer does not impact the certification period(s) of ~~the~~ case members. A new application or renewal is not required when a case is transferred.

The agency to which the member reports the move must collect information about the changes, including the new residential address. If the agency does not have sufficient information about the changed circumstances, it must request information from the member according to the verification policy in [Chapter 20 Verification](#).

See [Process Help 6.1 Interagency Case / RFA Transfer Process](#).

22.3.1 Intercounty Placements

Some Wisconsin residents, due to serious and persistent medical impairments, may need protective services or protective placement by a county agency. These placement options ensure that anyone with such an impairment is placed in a living arrangement that has the least amount of restriction on their rights and that they are protected from abuse, financial exploitation, neglect, and self-neglect.

When a county 51.42 board, 51.437 board, human services department, or social services department places a person in a care facility that is located in another county, the placing county remains responsible for the applicant. This does not include situations where a guardian or the member elects to voluntarily move the member to another county.

For interstate placements, see [Section 6.8 Interstate Placements](#).

22.7 Affirmative Action and Civil Rights

The Rehabilitation Act of 1973 requires a person with impaired sensory, manual, or speaking skills to have an opportunity to participate in programs equivalent to those afforded non-disabled persons.

Assistance must be provided to all Medicaid applicants and members to ensure effective communication. This includes certified interpreters for deaf persons and translators for non-English speaking persons. See the ForwardHealth Enrollment and Benefits Handbook ([P-00079](#)).

The Civil Rights Act of 1964 requires that applicants for public assistance have an equal opportunity to participate regardless of race, color, or national origin.

24.7 Meeting the Deductible

24.7.2 Noncountable Costs

Do not count the following toward the deductible:

1. Medical bills written off through bankruptcy.
2. Medical services payable or paid for by a third party who is legally liable for the bill. This includes bills that will be paid or have been paid by Medicaid, Medicare, or other Insurance.

Example 16 Note	Medical services provided to an incarcerated person. In this case, the incarcerating authority is the legally liable third party. If the third party in turn charges the applicant or member for the medical expenses, then the applicant or member remains the liable party for those medical expenses.
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3. A bill cannot be used if it has been used to meet a prior deductible. If only a portion of an unpaid bill was used to meet a prior deductible, any remaining balance that was not applied to the prior deductible, may be applied to a subsequent deductible period as long as it is still owed or meets criteria in [24.7.1 Countable Costs](#).

Example 17 <u>16</u>	An applicant incurs a \$300 medical bill. She applies the \$300 toward her deductible even though she has not made any payments on the bill. She meets her deductible and is certified for Medicaid. Three years later she applies for Medicaid again and a deductible is calculated for her. She now pays the \$300 bill. She cannot use it to meet her current deductible because she already used it to meet the prior deductible.
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24.7.3 Prepaying a Deductible

24.7.3.1 Payment of Entire Deductible Amount

If the entire deductible amount is paid at any point during the deductible period, eligibility begins on the first date of the deductible period.

Example 18 <u>17</u>	Laura's deductible period is from March 1st through August 31st. The total deductible amount is \$1,000. Laura submits payment of \$1,000 on August 15th. Laura's Medicaid eligibility begins on March 1st.
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24.7.3.2 Combination of Payment and Incurred Expenses

If the deductible is met through a combination of payment and incurred medical expenses, ~~count~~ the incurred medical expenses are counted first. Eligibility, by paying the remaining deductible amount, can begin no earlier than the last date of incurred medical expense within the deductible period.

Example 19 <u>18</u>	Chad's deductible period is from March 1st through August 31st. The total Medicaid deductible amount is \$1,800. Chad submits a medical bill with a March 8th date of service for \$800. On July 15th, he submits payment of \$1,000. Chad's Medicaid eligibility begins March 8th.
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24.7.3.3 Combination of Payment and Outstanding Expenses

If the deductible is met through a combination of payment and outstanding medical expenses (incurred prior to the beginning of the deductible period), eligibility begins on the first date of the deductible period.

Example 20 <u>19</u>	Roberta's deductible period is from March 1st through August 31st. The total Medicaid deductible amount is \$1,500. She submits an outstanding bill from January 10th for \$500. On August 15th, she submits payment of \$1,000. Roberta's Medicaid eligibility begins March 1st.
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24.12 Changes After Meeting a Deductible

24.12.4 Non-Financial Changes

If there is a change in non-financial eligibility ~~during~~after the deductible ~~period~~is met, discontinue Medicaid eligibility for those persons who have become non-financially ineligible.

~~The deductible period (24.3 Deductible Period) for which excess income is calculated may include a month(s) in which, if a member had applied, he or she would have been ineligible for a non-financial reason.~~

~~If a child enters the Medicaid group, the child's name will appear on the Medicaid card for the remainder of the deductible period.~~

~~If an adult caretaker relative who is EBD or is medically verified as pregnant enters the Medicaid group, his or her name will appear on the Medicaid card for the remainder of the deductible period.~~

If a member loses non-financial eligibility and regains it during the same deductible period, ~~reopen Medicaid for the dates when he or she was non-financially eligible~~the member may choose:

- To continue with the current deductible period.

OR

- To reapply and establish a new deductible period if their income still exceeds the income limit.

26.4 MAPP Financial Requirements

26.4.1 Assets

26.4.1.1 Independence Accounts

MAPP members can establish one or more Independence Accounts. These accounts are an exempt asset. There is no limit to the number of Independence Accounts a MAPP member may have and no restriction on what the money can be used for.

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). Any interest accrued to any type of independence account while enrolled in MAPP is exempt and is not considered a "member deposit" subject to the 50% of earned income limitation.

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	<p>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.</p> <p>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</p>
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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:
 - a) Pension and retirement accounts
 - b) Non-retirement accounts that were registered as Independence Accounts before August 1, 2020

There are different rules for retirement and non-retirement accounts regarding how they may be registered as Independence Accounts and when funds may be deposited.

Retirement Accounts

MAPP members may register their existing retirement or pension accounts as Independence Accounts. The amount that was already accumulated in the retirement or pension account before it was registered as an Independence Account is called the "Pre-Independence Account Balance." The Pre-Independence Account Balance is a countable asset. Funds may be deposited in a retirement or pension account that

has been registered as an Independence Account during periods of MAPP ineligibility. However, with the exception of account interest, 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.
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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 for 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.
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Non-Retirement Accounts

In order for a non-retirement account to be registered as an Independence 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 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.
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Non-retirement accounts registered as Independence Accounts may only have funds deposited during months when the member is eligible for MAPP. If any funds, with the exception of account interest, are deposited in a non-retirement account during a period of MAPP ineligibility, the entire account ~~balance will be considered a countable~~loses its independence account status, and the entire account balance is considered a countable asset. However, any interest accrued to a non-retirement account during a period of MAPP ineligibility does not change the account exemption. As long as the member did not deposit funds into the account themselves while not enrolled in MAPP, the account balance remains an exempt 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 for November to and 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.
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~~For non-retirement 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 accounts that were registered as Independence Accounts prior to August 1, 2020, any existing Pre-Independence Account Balance will continue to count for all Medicaid programs and the Independence Account Balance will be exempt for all Medicaid programs. However, no new funds may be deposited during months when the member is ineligible for MAPP.~~

~~For all non-retirement accounts, if new funds are deposited during months when the member is ineligible, the account loses its independence account status, and the entire asset will be counted.~~

Note	<p><u>For non-retirement 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.</u></p> <p><u>For non-retirement accounts that were registered as Independence Accounts prior to August 1, 2020, any existing Pre-Independence Account Balance will continue to count for all Medicaid programs, and the Independence Account Balance will be exempt for all Medicaid programs.</u></p>
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27.11 Institutions for Mental Diseases (IMDs)

An institution for mental diseases (IMD) is defined as a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases.

Some IMDS provide residential substance use disorder (SUD) treatment. 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). The IMDs that provide residential SUD treatment are specified below.

Note	Because the number of beds and whether a facility provides SUD treatment are subject to change, this list may not always be up-to-date. When in doubt, contact the facility to determine if it is considered an IMD or provides residential SUD treatment.
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Brown

[ATTIC Correctional Services – Marshall House, Green Bay \(provides residential SUD treatment\)](#)

Bellin Psychiatric Center, Green Bay

Willow Creek Behavioral Health, Green Bay

Clark

[Lutheran Social Services - Deep River, Neilsville \(provides residential SUD treatment\)](#)

Dane

5 Door Recovery/Hope Haven/Rebos United, Madison (provides residential SUD treatment)

Acadia Psychiatric Hospital, Madison

[ATTIC Correctional Services – Schwert AODA Treatment Center, Madison \(provides residential SUD treatment\)](#)

[ATTIC Correctional Treatment Center, Madison \(provides residential SUD treatment\)](#)

[Jessie Crawford Recovery Center, Sun Prairie \(provides residential SUD treatment\)](#)

Mendota Mental Health Institute, Madison

Miramont Behavioral Health, Middleton

Dunn

[Arbor Place, Menomonie \(provides residential SUD treatment\)](#)

Eau Claire

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

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

Green

[Iris Health Clinic Brodhead, Brodhead \(provides residential SUD treatment\)](#)

Manitowoc

[Pathways To A Better Life, Kiel \(provides residential SUD treatment\)](#)

Milwaukee

Aurora Psychiatric Hospital, Milwaukee

Genesis Behavioral Services Inc. – Jeanetta Robinson House, Milwaukee (provides residential SUD treatment)

Granite Hills Hospital, West Allis

Matt Talbot Recovery Services, Milwaukee (provides residential SUD treatment)

[Meta House, Milwaukee \(provides residential SUD treatment\)](#)

Rogers Memorial Hospital Inc., Brown Deer

Rogers Memorial Hospital Inc., Milwaukee

[United Community Centers - Latinas Unidas, Milwaukee \(provides residential SUD treatment\)](#)

[United Community Center, Milwaukee \(provides residential SUD treatment\)](#)

[Wisconsin Community Services, Inc - Joshua Glover, Milwaukee \(provides residential SUD treatment\)](#)

Oneida

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

Outagamie

Mooring House, Appleton (provides residential SUD treatment)

Casa Clare, Appleton (provides residential SUD treatment)

ATTIC Correctional Services - Addams House, Appleton (provides residential SUD treatment)

Pierce

Kinnic Falls Alcohol-Drug Abuse Services, River Falls (provides residential SUD treatment)

Sheboygan

Pathways To A Better Life, Waldo (provides residential SUD treatment)

St. Croix

Burkwood Treatment Center, Hudson (provides residential SUD treatment)

Trempealeau

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

Note:	The Trempealeau County Health Care Center is a multi-purpose complex that includes facilities that are not IMDs. To make a correct Medicaid eligibility determination for the residents of this complex, identify the type of facility the Medicaid applicant or member is in.
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Trempealeau County IMD, Whitehall - license # 5001

Vilas

Gookomis Endaad, Lac du Flambeau (provides residential SUD treatment)

Washington

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

Waukesha

Lutheran Social Services – Aspen Center, Waukesha (provides residential SUD treatment)

Lutheran Social Services - Bethany Recovery Center, Oconomowoc (provides residential SUD treatment)

Rogers Memorial Hospital Inc., Oconomowoc

Winnebago

Winnebago Mental Health Institute, Winnebago

Nova Counseling Services, Oshkosh (provides residential SUD treatment)

28.5 Home and Community-Based ~~Waivers~~Waiver Long-Term ~~Care~~Medicaid Effective Date

The begin date of ~~waiver~~Home and Community-Based Waiver Medicaid eligibility is the program start date ~~submitted to the IM agency~~determined by the care manager ADRC or ~~the ADRC~~IRIS Consultant Agency (ICA). Waiver Medicaid cannot be backdated.

33.2 Application

33.2.4 Authorized Representative

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

A SeniorCare applicant or member may appoint an individual or an organization as an authorized representative by completing the SeniorCare ~~Authorized~~ Authorization of Representative form ([F-10080](#)). There can be only one authorized representative at a time for a SeniorCare ~~applicant or member~~. There is no time limit on how long a person or organization can act as authorized representative. The appointment of the authorized representative is valid until the applicant or member notifies the agency of a change or removal in writing. SeniorCare authorized representatives can only act on the individual's behalf for SeniorCare.

Organizations acting as authorized representatives must provide the name and contact information of a person from the organization. Once the organization has been appointed as the authorized representative, anyone from the organization will be able to take action on behalf of the applicant or member (not just the person who signed the form on behalf of the organization). If an organization is only changing the contact person for the organization, the member is not required to complete a new SeniorCare Authorization of Representative form if the organization is going to remain as the authorized representative.

The authorized representative should be familiar with the applicant or member's household situation and is expected to fulfill their responsibilities to the same extent as the individual being represented. An authorized representative is limited to doing any or all of the following on behalf of the applicant or member:

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

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

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

33.2.5 Guardian and Power of Attorney

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~~ applicant or member would like the legal guardian of the

person to act on their behalf. If the applicant or member has 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.

33.3 SeniorCare Nonfinancial Requirements

33.3.1 SeniorCare Nonfinancial Requirements Introduction

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

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

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

- ~~a) Has a permanent residence in Wisconsin~~
- ~~b) Is considered a Wisconsin resident for tax purposes~~
- ~~c) Is a registered voter in Wisconsin~~
- 2.3. Be a U.S. citizen or have qualifying immigrant status. (see Section Section 7.1 US Citizens and Nationals). An applicant who is not a U.S. citizen will need to have a qualifying immigrant status to be eligible for SeniorCare (see [Section 7.3 Immigrants](#)). The applicant will need to provide his or her immigration registration number. Verification of the applicant's immigration status will be made through the U.S. Citizenship and Immigration Services' Systematic Alien Verification for Entitlements (SAVE) program. In some cases, the individual may need to provide an official government document. For example, if the applicant's immigration status cannot be verified through SAVE or there are discrepancies between reported and verified data, supporting legal documentation must be provided by the applicant.

If current SSDI, SSI, Medicare, Foster Care, or Adoption Assistance benefits have been verified, the applicant is exempt from documenting their citizenship (see [Section 7.2 verifying u.s. Citizenship](#)).

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

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

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

SeniorCare applications without the SSN or with an incorrect SSN will not be returned. Applicants will be contacted and given an opportunity to provide a valid SSN or apply for one. The SeniorCare program will honor the original application date for individuals who initially

provide an incorrect SSN or who need assistance in applying.

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

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

If the Social Security Administration finds that the SSN has been used fraudulently it may: Verify the SSN only once.

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

~~4.5.~~ Not be a full-benefit Medicaid member (see Section 21.2 Full-Benefit Medicaid). This includes members who are covered by BadgerCare Plus (see the [BadgerCare Plus Handbook](#)).

Individuals are not considered Medicaid members for SeniorCare if they have an unmet Medicaid deductible (see Section 24.2 Medicaid Deductible Introduction) or receive one of the following:

- a) Medicare Savings Program (see Section 32.1 Medicare Savings Programs).
- b) Tuberculosis (TB) Related Medicaid
- c) Family Planning Only Services

~~5.6.~~ Not be an inmate of a public institution. An inmate is someone who resides in a public institution on an involuntary basis through operation of law enforcement authorities. For example, a prisoner in a jail, prison, or other correctional facility is considered an inmate.

The following individuals are not considered to be inmates for the purposes of SeniorCare:

- a) A staff person voluntarily residing in a public institution is not considered an inmate.
- b) An individual voluntarily residing in an institution while waiting for other living arrangements to be made that are appropriate to the person's needs.
- c) An individual who is legally confined to his or her home by a monitoring device, such as an ankle bracelet.
- d) People who are on parole, probation, or have been released to the community pending trial (including those under pre-trial supervision).

A public institution is an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. This includes correctional facilities operated by or under contract with a governmental unit. A public institution does not include a medical institution (see Section 27.1 Institutions), a publicly operated community residence that serves no more than 16 residents, or a child care institution in which Foster Care maintenance payments are made under Title IV-E. People residing in these situations are not inmates.

Even though the following institutions may accommodate 16 or fewer residents, they are not

considered to be publicly operated community residences. People residing in these institutions may be inmates if they are residing there on an involuntary basis through operation of law enforcement authorities:

- a) Residential facilities located on the grounds of, or immediately adjacent to, any large institution or multiple purpose complex.
- b) Correctional or holding facilities for people who are prisoners, have been arrested or detained pending disposition of charges, or are held under court order as material witnesses or juveniles.

Some inmates may be allowed to leave jail for various reasons under the Huber Law, also known as the Huber Program. Huber Law prisoners who are released from jail to attend to the needs of their families can become eligible for SeniorCare if both the following are true:

- a) They intended to return to the home.
- b) They continue to be involved in the planning for the support and care of their minor children.

Huber Law prisoners who are released for a purpose other than attending to the needs of their families are not eligible for SeniorCare.

~~6.7.~~ Cooperate with providing information and/or verification necessary to determine eligibility (see [Chapter 20 Verification](#)) and for quality assurance purposes.

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

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

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

33.9 SeniorCare Addition of a Spouse

33.9.3 FTG Changes

33.9.3.2 FTG Changes At Level 3

Spouse 2's spenddown is prorated only if:

1. The income for Spouse 2, based on a FTG of two, is determined to be above 240% of the FPL, and
2. Spouse 2 becomes eligible after Spouse 1's benefit period has begun, and
3. Spouse 2 was not included in the FTG when the participation level for Spouse # 1 was determined.

To prorate Spouse 2's spenddown, multiply the amount of income exceeding 240% FPL by the number of months of Spouse 2's benefit period and divide by 12. The result is equal to the prorated spenddown amount of Spouse 2. Only covered prescription drug costs of Spouse 2 count toward the prorated spenddown.

After the spenddown has been met, the deductible for Spouse 2 is prorated ([33.9.3.1 FTG Changes at Level 2a and 2b](#)). Participants will get a discount off the retail price for most covered prescription drugs during the deductible period.

After the deductible is met, he or she purchases covered prescription drugs at the copayment amounts for the remainder of the benefit period.

Example 7:	<p>Tim is married, but his wife Marsha was institutionalized at the time he applied for SeniorCare. Marsha was expected to be out of the home for five months.</p> <p>Tim applies for SeniorCare in May. Tim's benefit level is based on a FTG of one. Tim's gross annual income is less than 160% of the FPL for a FTG of one.</p> <p>Tim is determined to be SeniorCare eligible beginning June 1. His 12-month benefit period ends the following May. Tim does not pay a deductible or spenddown. He purchases covered prescription drugs at the copayment amounts.</p> <p>Tim's wife Marsha returns home in November. She applies for SeniorCare in November and is determined eligible beginning December 1. Marsha's participation level is determined based on a FTG of two. Their joint income is \$1,000 above 240% of the FPL for a FTG of two. Her benefit period ends May 31, when Tim's benefit period ends.</p> <p>Since there are six months in her benefit period, Marsha's spenddown amount is prorated. The spenddown amount of \$1,000 is multiplied by six and then divided by 12.</p> <p>$\\$1,000 \times 6 = \\$6,000 / 12 = \\$500$</p> <p>Marsha's spenddown amount is \$500. After she has met her spenddown, she then has a prorated deductible. Since there are six months in her benefit period, \$850 is multiplied by six and then divided by 12.</p> <p>$\\$850 \times 6 = \\$5,100 / 12 = \\$425$</p>
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	<p>Marsha pays for covered prescription drugs until she has met the \$425 deductible. After Marsha has met the deductible, she purchases covered prescription drugs at the copayment amounts for the remainder of <u>the</u> benefit period.</p> <p>Tim's eligibility and benefit period are not affected.</p>
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33.9.4 Addition of a Spouse Summary Table

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

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

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

Note	If Spouse 1's eligibility is terminated prior to Spouse 2's request, a new application is required for a new 12-month benefit period.
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33.10 SeniorCare Changes

33.10.2 Correction of Errors

33.10.2.2 Applicant or Member Error

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

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

Example 2:	<p>In August, Charlie lost thishis job at the Burger Palace. In September, Charlie applied for SeniorCare. In his application, Charlie erroneously reported income of \$1150 per month from the Burger Palace job. Charlie's notice of decision had a mail date of October 1, and stated that Charlie had a \$1500 spenddown.</p> <p>Depending on when Charlie reports this error, his benefits may be corrected back to the eligibility begin date or the first <u>of the</u> month in which the error was reported (see Section 33.10.2 Correction of Errors).</p> <p>If he reported the error by November 15, within the first 45 days after the notice of decision mail date, his benefits would be corrected back to the original effective date.</p> <p>If he reported the error November 16 or later (more than 45 days after the notice of decision mail date), the benefit level change would be made effective the first of the month in which the error was reported.</p>
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Example 3:	<p>Eric applied for SeniorCare in July and was determined eligible at level 1 effective August 1. Prior to applying for SeniorCare, Eric got a part-time job that had begun in June. When Eric applied for SeniorCare, he neglected to report his anticipated part-time earnings on the SeniorCare application.</p> <p>Eric receives his notice of decision, dated August 8. The notice informs him that he is eligible at level 1. Eric reviews the income used in his eligibility determination that is printed in the notice and realizes that he forgot to report the earnings from his part-time job. He calls the SeniorCare Customer Service hotline on August 21 to report his error.</p> <p>Eric indicates that he is working 10 hours per week and earns \$10 per hour. He plans to keep the job as long as possible. He estimates that his earnings will be \$5,200 for his 12-month benefit period. The only other income that Eric receives is Social Security. His earnings in addition to the annual Social Security income move him from level 1 to level 2b.</p> <p>Since the income correction will result in a negative impact on his eligibility, the effective date of the corrective benefit is October 1, providing Eric with a 10-day notice of the negative action in his case.</p> <p>Prior to reporting this mistake, Eric had purchased several prescriptions at the copayment levels with his SeniorCare card. Since the correction resulted in Eric's eligibility at level 2b, he must now meet an \$850 deductible between October 1 and July 31 (the end of his 12-month benefit period). SeniorCare will have overpaid Eric's benefits and could seek recovery of the overpaid amount.</p>
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36.2 WWWMA Enrollment

36.2.2 WWWMA Enrollment through the Wisconsin Well Woman Program

36.2.2.1 WWWP Process for Assisting with WWWMA Application

1. The WWWP coordinating agency will complete the [F-44818](#) with the assistance of the applicant prior to the applicant's health care screening. The [F-44818](#) enrolls the person in WWWP. Their WWWP eligibility will be in interChange under medical status code "CS."
2. The WWWP client will receive a breast and cervical cancer screening from a WWWP provider.
3. If the WWWP client is diagnosed with breast or cervical cancer or a precancerous condition of the breast or cervix and wants to apply for WWWMA, they will complete Part A - Applicant/Member Information in the Wisconsin Well Woman Medicaid Application and Renewal form ([F-10075](#)). They will sign and date the application,
4. The WWWP provider will complete Part-B Diagnosing or Recertifying Provider in the [F-10075](#) recording the diagnosis and indicating that treatment is required. The provider will sign and date the [F-10075](#). The applicant and provider signature dates do not have to be the same date.
5. **If doing a temporary enrollment determination:** The provider will fill in the begin and end dates of the temporary enrollment for WWWMA in Part C – Temporary Enrollment / Presumptive Eligibility on the [F-10075](#). The begin date is the date of diagnosis. The end date is the last day of the month following the month of diagnosis. See [Section 36.2.2.2 Temporary Enrollment \(TE\) Available Only to Persons Enrolling Through WWWP](#).
6. The provider will forward a copy of the [F-10075](#) to the WWWP coordinating agency.
7. The WWWP coordinating agency will provide the member with a copy of the signed [F-10075](#) and [F-44818](#) forms.
8. **If doing a temporary enrollment determination:** The WWWP coordinating agency will check to be sure correct temporary eligibility dates are entered on the [F-10075](#) and explain that the client's temporary enrollment for WWWMA will end on the last day of the following calendar month. The WWWP coordinating agency will 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 in ForwardHealth.
9. The WWWP coordinating agency or the member will fax, mail, or scan and email the ~~and the~~ [F-10075](#) to EM CAPO. EM CAPO will process the application and determine eligibility for a 12-month certification period for WWWMA. EM CAPO may contact the WWWP coordinating agency for the [F-44818](#) if EM CAPO is otherwise unable to verify the applicant's WWWP enrollment.

37.1 Children's Long-Term Support (CLTS) Waiver Program Introduction

37.1.1 Program Purpose

Children's Long-Term Support (CLTS) is a ~~Medicaid~~ Home and Community-Based Waiver (HCBW) Program that enables children and youth with disabilities to live at home and participate in family and community life rather than reside in an institution or nursing home. The ~~waiver program~~ CLTS Waiver Program allows Medicaid to pay for supports and services that normally are not covered by Medicaid. The CLTS Waiver Program serves eligible children and youth in the following three target groups:

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

37.1.2 Eligibility Requirements

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

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

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

Children in the CLTS Waiver Program qualify for 12 months of continuous Medicaid coverage. If they are disenrolled from CLTS ~~waiver services~~ (for example, because they lose their functional eligibility) during ~~the~~ their continuous coverage period and they do not qualify for any other form of full-benefit health care, they will keep their HCBW Medicaid and can keep getting Medicaid card services for the rest of their continuous coverage period. If they voluntarily disenroll from CLTS, it will be treated as a voluntary disenrollment from Waiver Medicaid.

37.2 Agency Roles and Responsibilities

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

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

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

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

37.3 HCBW Medicaid CARES Processing for the CLTS Waiver Program

When a child who is functionally eligible for the CLTS program is referred to IM, he or she must first ~~be tested for~~ have eligibility determined using HCBW Medicaid rules. To be eligible for HCBW Medicaid, the child must be both Medicaid-eligible and functionally eligible. To determine eligibility for HCBW Medicaid, only the child's income is counted. ~~Effective 10/01/09, assets~~ Assets are ~~no longer~~ not counted for disabled or institutionalized children. Since assets are disregarded, there can be no divestment in a HCBW Medicaid case for a child.

If an applicant or participant is ineligible for HCBW, ~~he or she~~ Medicaid, they must ~~then be tested~~ have eligibility determined for BadgerCare Plus.

If the CLTS applicant is the only household member applying for healthcare, the packet provided by the CWA is all that is required to be submitted. ~~When~~ if the CWA submits ~~the~~ a signed [F-10129](#) to the IM agency, the primary person is required to provide a second signature. The primary person can choose to call the IM agency to provide a telephonic signature or mail a signed Application Summary (see [2.5.1 Valid Signature Introduction](#) [Section 2.2 Application Methods](#)).

Individuals can be eligible for the CLTS Waiver Program and HCBW Medicaid through age 21. When a CLTS Waiver Program applicant or member reaches 18 years old and their source of Medicaid is HCBW, they must apply for HCBW Medicaid as the primary person. Federal and state privacy and confidentiality protections prevent the parents of adults from automatically having access to protected information; therefore, these young adults must apply separately from their parents.

See [Process Help Section 11.4 Home and Community-Based Waiver Medicaid for Children's Long-Term Support](#) for processing instructions.

39.6 COLA Disregard

See Section 25.3.3 Determining the COLA Disregard for 503 Groups.

For more information about annual COLA updates and disregards see [Section 15.3.35 Temporary COLA Disregard for Social Security Recipients](#) and [Process Help FPL, COLA, and Other Annual Updates](#).