

Medicaid Handbook Coversheet

Change Summary for Medicaid Eligibility Handbook Release 26-03

Release Date:08/12/2026

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
Patient's Representative	A patient's representative can enroll an incapacitated individual in Medicaid and authorize expenditures related to health care to the same extent as a guardian of the estate.	• 2.5.1.1 Signatures from Representatives • 20.3.7 Power of Attorney, Guardianship, or Conservator • 22.5 Legal Guardians, Conservators, Power of Attorney, and Other Representatives	2025 Wisconsin Act 115 Ops Memo 26-16 Change to Who Can Sign Health Care Applications and Long-Term Care Forms on Behalf of Incapacitated Adults
Citizenship for Foster Care Recipients	FSTMA Compliance Project introduced a data exchange between CWW and eWiSACWIS. Citizenship verification must be accepted from that new exchange for individuals that previously received Title IV-E Foster Care Medicaid.	• 7.2.1.2 Exempt Populations	OM 26-17 Foster Care Medicaid (FSTMA) Enhancements
Postpartum Coverage for BadgerCare Plus	Changes the postpartum coverage period from 60-days to 12-months.	• 7.3.2.3 Reverification of Immigration Status • 7.3.3.1.5 Additional Criteria for Certain Qualifying Immigrants • 8.1.3 Referral to Child Support Agencies	2025 Wisconsin Act 102 OM 26-24 12-Month Postpartum Coverage for BadgerCare Plus

		8.2.2 Exemptions from Cooperation 9.1.3 Third Party Liability Cooperation Requirements	
Exempt Retirement funds of an Ineligible Spouse	IRAs owned by an ineligible spouse are exempt retirement fund assets for Medicaid purposes. Inherited IRAs are not considered retirement funds for this asset exemption.	16.11.1 Types of Retirement Funds 16.11.2 Retirement Funds as Assets 18.4.1 Spousal Impoverishment Assets Introduction	Amended OM 25-11 Changes to Treatment of Annuities for Medicaid
Spousal Impoverishment Federal Poverty Level Adjustments	Updated values.	39.4.4 LTC Spousal Impoverishment Post-Eligibility Allowances and Community Spouse Asset Share	OM 26-19 Spousal Impoverishment Income Allowance Federal Poverty Level Adjustment
SSI State Supplementary Payment increase	Updated values.	39.4.1 Elderly, Blind, or Disabled Assets and Income Table 39.4.3 LTC Post-Eligibility Allowances 39.4.7 SSI Reference Values	Amended OM 25-21 2026 Cost-of-Living Adjustment (COLA) for Medicaid OM 26-12 Increase to Supplemental Security Income (SSI) State Supplementary Payments
Common Law Marriage	Change to the glossary definition of a spouse to align policy across programs and with federal law.	Glossary	OM 26-14 Common Law Marriage Clarification

Clarifications and Corrections

TOPIC	SUMMARY	SECTIONS
Signatures	Wis. Stat. Chapter 244 Clarification regarding what is required to confirm that an individual is authorized to sign an application as a durable power of attorney for finances.	2.5.1.1 Signatures from Representatives
Late Renewal	Clarification on when a new application is required.	3.1.2 Late Renewals

Changes in Circumstances	Example removed.	3.3.1 Changes in Circumstances
Residency	Adding clarification about when to use the subsections.	6.3 Determining State Residency
Verification of Citizenship	Clarification on populations exempt from the U.S. citizenship verification requirement.	7.2.1.2 Exempt Populations
H.R.1 Noncitizen Eligibility	Aligning numbers and descriptions of registration status codes in preparation for the H.R.1 Noncitizen Eligibility Project.	7.3 Immigrants
Change Reporting	Chapter alignments between BadgerCare Plus Handbook and Medicaid Eligibility Handbook.	Chapter 12 Change Reporting
Medical/Remedial Expenses	• Moved text from LTC subprogram sections to the income deduction section • Removed outdated references • Updated cross-references • Updated examples	• 15.7.3 Medical/Remedial Expenses • 20.3.6 Medical or Remedial Expenses • 27.7.7 Medical or Remedial Expenses and Payments for Noncovered Services • 28.6.3.5 Medical/Remedial Expenses
Divestment	• Corrected cross reference and spacing • Corrected number of months used in calculations • Clarification on calculating penalty period for a specific divestment type	• 17.2.6.1.1 Sufficient Resources to Cover Five Years of Long-Term Care • 17.2.6.1.2 Sufficient Resources to Cover Long-Term Care for Remaining Life Expectancy • 17.2.6.1.4 Pattern of Gifting
Verification	Adding policy clarification about the extension of the verification due date.	20.1.4 General Rules
Verification	Updated for clarity.	• 20.3.1 Mandatory Verification Items Introduction • 20.3.5 Assets • 20.3.5.1 Divestment
IMD	Added an IMD.	Institutions for Mental Disease (IMDs)
Good Faith Claims	Removing obsolete section.	21.10 Good Faith Claims
Liens	Removed links to form that is now system generated.	22.1.4.1 Notice of Intent to File a Lien
SeniorCare	SeniorCare Modernization Project.	Chapter 33

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Glossary

spouse

A person recognized under federal law as another person's legal partner through marriage. This includes a marriage (including common law marriage) that was valid in the state where it was entered into. For marriages entered into outside the United States, this includes a marriage that was valid in the place where it was entered into and could have been entered into in the United States.
~~An individual who is legally married to another individual. This includes individuals who are legally married to an opposite-sex spouse or a same-sex spouse. This does not include domestic partners.~~

2.5 Valid Signature

2.5.1 Valid Signature Introduction

2.5.1.1 Signatures from Representatives

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

1. **Guardian**

When an application is submitted with a signature of someone claiming to be the applicant's guardian, 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.

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 ~~does~~must do 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~~to confirm that the ~~durable~~ power of attorney for finances authority ~~continues notwithstanding any subsequent disability or incapacity of the applicant~~does not end if the applicant becomes incapacitated (i.e., the power of attorney is durable).

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 by the document used to designate the agent ~~on the Durable Power of Attorney for Finances form (F-00036)~~.

The ~~Durable Power of Attorney for Finances form~~document used to designate the agent with durable power of attorney for finances 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. 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.

8. Patient's Representative (Wis. Stat. § 50.06)

A patient's representative is an individual under Wis. Stat. § 50.06 who may consent to an incapacitated individual's admission to a nursing home or community-based residential facility from a hospital. A patient's representative can

make health care decisions to the same extent as a guardian of the person and enroll an incapacitated individual in Medicaid and authorize expenditures related to health care to the same extent as a guardian of the estate.

The authority of a patient's representative ends if any of the following occurs:

- A court appoints a guardian to make decisions for the incapacitated individual
- The incapacitated individual is discharged to a setting that is not a facility
- A health care power of attorney that was not identified earlier is identified
- The individual is determined to be no longer incapacitated

When an application is signed by someone claiming to be a patient's representative, the IM agency does both of the following:

- Obtains a copy of the patient's representative's Patient's Representative Declaration F-03436 indicating that they have the authority to act on behalf of the incapacitated individual
- Reviews the document to confirm the authority has not ended due to a change in circumstances

The application is not properly signed unless both conditions are met.

A patient's representative may not authorize expenditures related to health care if the incapacitated individual has an agent under a durable power of attorney for finances who may authorize expenditures related to health care. See #4, above.

3.1 Renewals

3.1.2 Late Renewals

Health care renewals received within three months of the renewal month can be processed as a late renewal instead of requiring a new application. There is no requirement for prior health care benefits to be maintained for a late renewal. The three-month period that allows for late renewals and renewal-related verifications starts the month after enrollment ended. It does not restart when a late renewal or when late verification has been submitted.

Exceptions: Late renewal policies do not apply to SeniorCare.

This policy applies to members receiving health care benefits based on a met deductible but not to members with an unmet deductible.

Late renewals are only permitted for people whose eligibility has ended due to lack of renewal and not for other reasons.

Late renewals and renewal-related verifications must be accepted for up to three calendar months after the renewal month. Members whose health care benefits are closed more than three months due to lack of renewal ~~must~~ may need to reapply, or re-request if unless there is another individual with open health care benefits on the same case.

A late submission of an online or paper renewal form or a late renewal request by phone or in person is a valid request for health care. If verification is required to complete the renewal, the member has 20 days to provide it, even if this extends renewal processing into the fourth month after benefits closed.

Example 1	Jenny's renewal is due in January. No renewal is received by January adverse action, so a notice is sent to Jenny explaining her coverage will end effective January 31. Her renewal is later received on March 10, and Jenny requested backdated coverage for February. Jenny's income verification is due on March 30. She provides verification of February and March income by the due date and meets all other eligibility criteria for Medicaid. Her new certification period starts on March 1 with a backdate to February 1. Her next renewal will be due in February of the following year.
Example 2	Joni's renewal is due in January. Joni did not submit a renewal by January adverse action, so a notice is sent to Joni explaining her coverage will end effective January 31. She submits a renewal on April 25, with a backdate request to February. The renewal is processed the same day, and she is asked to provide verification of her income by May 15. If Joni provides verification of her February, March and April income on or before May 15 and meets all other eligibility criteria for Medicaid, she will be enrolled in a new certification period starting on April 1 with a backdate to February 1. Her next renewal will be due in March of the following year.

	If Joni submits verification after the May 15 due date, a new application is required. She can request up to three months of backdated coverage when she reapplies.
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For QMB renewals, benefits reopen from the first of the month following when current coverage ends, whether the renewal is completed timely in the renewal month or completed late in the month following the renewal month.

See [Section 32.10.1 QMB Renewals](#).

Example 3	Shelly has Medicaid and QMB renewals due in February. She submits her Medicaid and QMB renewal late with the necessary verifications on March 20. On March 30, the worker processes the renewal and verifications which completes the Medicaid and QMB renewal. The member is enrolled in Medicaid and QMB with a new certification period starting March 1. There is no gap in her QMB eligibility because benefits are confirmed in the month following the renewal month.
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Example 4	Cindy has Medicaid and QMB renewals due in February. She submits her Medicaid and QMB renewal late with the necessary verifications on April 20, requesting a backdate for March. On April 22, the renewal and verifications for March and April are processed, which completes the Medicaid and QMB renewal. The member is enrolled in Medicaid with a new certification period starting April 1 with a backdate to March 1, and QMB with a new certification period starting May 1. There is a gap in her QMB eligibility because the redetermination was not confirmed during the renewal month or the month following the renewal month.
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3.3 Redeterminations for Changes

3.3.1 Changes in Circumstance

Health care eligibility must be promptly redetermined between regular renewals whenever information is received about a change in a member's circumstances that may affect their eligibility. Requests for information or verification must be limited to information related to the change. During redeterminations of eligibility due to a change in circumstances, the member must remain enrolled in their prior health care assistance group without disruption until enough information is available to determine all health care eligibility.

When an individual is enrolled in a new health care certification period on a case, new 12-month certification periods will be established for all eligible health care members in the household, with some exceptions.

New certification periods will be established for existing eligible members when an individual is enrolled in health care following a change in circumstances, person-add, new program request, or renewal. For example, new certification periods can be established when a person joins the household and is enrolled in health care, changes health care categories, or a previously ineligible person becomes eligible due to a change (for example, a reduction in income puts them under the program limit).

New certification periods will not be established for an existing member when:

- A newly added person is found ineligible.
- A new assistance group is pending.
- The member is open for time-limited benefits.
- The member is a child who is in their 12-month continuous coverage period and the change would result in a negative action or would move the child from Medicaid to CHIP.
- The existing member is ineligible based on the change in circumstances.

Example 3

Margaret and Phillip are enrolled in BadgerCare Plus as childless adults with a certification period of January 1, through December 31. On July 2, 11-year-old William joins the household and requests health care. William does not have continuous coverage from another case. William is enrolled in BadgerCare Plus with continuous coverage from July 1 through July 31 of the following year. Margaret and Phillip are now eligible for BadgerCare Plus as caretakers and will also start a new certification period from August 1 through July 31 of the following year.

Example 4

Diego and Sofia are enrolled in BadgerCare Plus and their 4-year-old daughter Gabriella is enrolled in Medicaid from February 1, through January 31. On August 8, Diego's 12-year-old daughter Isabella joins the household and requests health care. Isabella has had BadgerCare Plus on another case since January. Her BadgerCare Plus enrollment ends on the other case, and she is determined eligible on Diego's case.

	Isabella is enrolled in BadgerCare Plus with a new continuous coverage period from September 1, through August 31. Diego and Sofia, remain eligible for BadgerCare Plus and start a new certification period from September 1, through August 31. Gabriella remains eligible in Medicaid and starts a new certification period from September 1, through August 31.
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Example 5	~~Bill and Carrie are enrolled in BadgerCare Plus as parents and their 12-year-old daughter Kiley is disabled and enrolled in SSI-Related Medicaid. Their certification period is January 1, through December 31. Kiley is determined to no longer be disabled on June 5. There was no other change. Kiley transitions from SSI-Related Medicaid to BadgerCare Plus with a new certification period of July 1, through June 30. A new 12-month certification period is established for Bill and Carrie from July 1, through June 30.~~
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Example 65	Edith is enrolled in SSI-Related Medicaid from January 1, through December 31. In July, Edith gets married and requests health care for her husband, Chester. Chester is eligible and enrolled in SSI-Related Medicaid. Edith continues to be eligible. Because someone is newly opening for a health care certification period, a new 12-month certification period is established for Edith and Chester.
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Example 76	Dimitri is enrolled in SSI-Related Medicaid from July 1 through June 30. In October, Dimitri gets married and requests health care for his wife, Polina. Polina is neither a US citizen nor a qualifying immigrant and is found ineligible. Dimitri's SSI-Related Medicaid certification period does not change.
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6.3 Determining 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](#).

For all other applicants and members, use the following subsections to determine state residency.

7.2 Verifying U.S. Citizenship

7.2.1 Citizenship Verification Introduction

7.2.1.2 Exempt Populations

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

- Anyone who receives or previously received Social Security Disability Insurance SSDI, Disabled Adult Child (SSDC), or Disabled Widow(er)'s benefits
- Anyone who receives or previously received Supplemental Security Income (SSI) benefits
- Anyone entitled to or enrolled in Medicare
- Anyone who receives ~~or previously received Title IV-E~~ Foster Care Medicaid (FSTMA), which ~~(includes~~ing Adoption Assistance, ~~or previously received Title IV-E FSTMA)~~
- 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)
- 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](#)).

Data exchanges must be used to verify current or previous receipt of SSI, SSDI, SSDC, FSTMA, and Medicare prior to requesting verification from the recipient.

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 – Non-Citizen Lawfully Present in the U.S. ~~Lawfully Residing~~. Even if an immigrant loses health care eligibility for a period, 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 – Non-Citizen Lawfully Present in the U.S. ~~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~~ 12-month 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 19.3.9 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 (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 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 a minimum of five days be allotted for applicants to receive notices. For this reason, 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	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. A year later, the case is up for renewal. Since Vladimir has a Registration Status Code of 20 – <u>Non-Citizen Lawfully Present in the U.S. Lawfully Residing</u>, 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.
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Example 2	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. One year later, Sasha again applies for health care benefits. Once more, the FDSH returns the same results.
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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.

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~~ them ineligible for Medicaid ~~or BadgerCare Plus~~-benefits.

7.3.3 Immigrants Eligible for Medicaid

Immigrants may be eligible for Medicaid if they meet all other eligibility requirements and are either Qualifying Immigrants (see [SECTION 7.3.3.1 QUALIFYING IMMIGRANTS](#)) or are Lawfully Present (see [SECTION 7.3.3.2 LAWFULLY PRESENT IMMIGRANT CHILDREN, YOUNG ADULTS, AND PREGNANT PEOPLE](#)).

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 including Special	An immigrant who qualifies for benefits to the same extent	See SECTION 7.3.3.1.1 "REFUGEE-LIKE" IMMIGRANTS WHO HAVE	N/A	04

Immigrant Visa Holders	as a refugee due to an act of Congress.	BENEFITS ELIGIBILITY AS REFUGEES BECAUSE OF AN ACT OF CONGRESS for more information.		
Asylee	An asylee admitted under INA Section 208. 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
Person Granted Withholding of Removal ~~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 withheld under INA Section 241(b)(3) on or after April 1, 1997.	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
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

<u>Foreign-Born Member of a Tribal Nation</u> ~~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.	An immigrant admitted under this status may be eligible for Medicaid, without a five-year waiting period, even if their immigration status later changes.	18
COFA <u>Migrant Citizen</u>	A person who is a citizen of a country in the Compacts of Free Association (COFA)	No additional criteria. See <u>SECTION 7.3.3.1.3 CITIZENS OF THE COMPACTS OF FREE ASSOCIATION COUNTRIES</u> 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.	22
<u>Trafficking Victim or their Family</u> ~~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 <u>7.3.3.1.4 VICTIMS OF TRAFFICKING</u> 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: 1. Have been in a qualifying	Be certified by the Department of Health and Human Services (HHS) as victim of trafficking (applies to	19 - Meets one additional criterion or is certified by HHS as a

		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 for Mental Diseases. 4. Be pregnant.	T1 visa holders and others).	victim of trafficking. Or 21- ~~Five~~-year waiting period applies.
Lawful Permanent Resident	An immigrant lawfully admitted for permanent residence under INA 8 USC 1101 et seq.	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 <u>SECTION 7.3.3.1.5 ADDITIONAL CRITERIA FOR CERTAIN QUALIFYING IMMIGRANTS</u> for more information.	N/A	<u>01- Five-year waiting period ~~ve~~ applies</u> Or <u>23- Five-year waiting period does not apply</u>
<u>Person Paroled for at Least One Year</u> ~~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 (<u>SEE SECTION 7.3.3.1.1 "REFUGEE-LIKE" IMMIGRANTS WHO HAVE BENEFITS ELIGIBILITY AS REFUGEES BECAUSE OF AN ACT OF CONGRESS</u>). Parolees who are nationals of Cuba or Haiti may be Cuban/Haitian Entrants for benefits eligibility purposes (see <u>SECTION 7.3.3.1.2 CUBAN/HAITIAN ENTRANTS</u>).	06

Conditional Entrant	An immigrant granted conditional entry under immigration law in effect before April 1, 1980 [INA Section 203(a)(7)].	N/A	03
<u>VAWA Self-Petitioner</u> ~~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 the U.S. and meets certain other requirements.	N/A	16

7.3.3.1.2 Cuban/-Haitian Entrants

The term "Cuban/-Haitian Entrant" (CHE) relates to benefit eligibility rather than an immigration status. 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). CHEs are qualified immigrants with no waiting period.

The following individuals meet the definition of Cuban/-Haitian Entrant:

- An individual granted parole as a Cuban/-Haitian Entrant (Status Pending) or any other special status subsequently established under the immigration laws for nationals of Cuba or Haiti, regardless of the status of the individual at the time assistance or services are provided; or
- A national of Cuba or Haiti who is not subject to a final, non-appealable and legally enforceable removal order, and:
 - Was paroled into the United States and has not acquired any other status under the Immigration and Nationality Act; or
 - Is in removal proceedings under the Immigration and Nationality Act; or
 - Has an application for asylum pending with USCIS (U.S. Citizenship and Immigration Services).

Cuban/-Haitian Entrants who later have a change in status and become Lawful Permanent Residents are not subject to the five-year waiting period as Lawful Permanent Residents.

7.3.3.1.3 Citizens of the Compacts of Free Association Countries

Citizens of Compacts of Free Association countries are not considered U.S. citizens or nationals. The Compacts of Free Association (COFA) countries include the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau. COFA ~~citizens~~-migrants have a special status with the U.S. that allows them to enter the country, work here, and acquire an SSN without obtaining an immigration status.

As of December 27, 2020, COFA ~~citizens~~-migrants may be eligible for health care if they meet all other eligibility requirements. In addition, COFA ~~citizens~~-migrants are not subject to the five-year waiting period. COFA ~~citizens~~-migrants who have a change in their status and become Lawful Permanent Residents are not subject to the five-year waiting period.

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 a few days after HHS is notified by 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](#) or were certified by HHS as a 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 who are paroled into the U.S. under INA Section 212(d)(5) for at least one year.
- People considered to be [VAWA self-petitioners](#) ~~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.
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 have the five-year waiting period lifted when their pregnancy is reported to the agency. The waiting period is lifted until [12 months](#) ~~60 days~~ after the last day of pregnancy and through the end of the month in which the ~~60th day~~ [12th month](#) 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 (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 immigration 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 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 Medicaid.

8. Also be considered a Cuban/Haitian Entrant.
9. Lawful permanent residents who were previously a refugee, asylee, COFA ~~citizen~~migrant, Foreign-Born Member of a Tribal Nation ~~American Indian~~ or had their ~~deportation~~removal 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](#) for specific policy regarding Victims of Trafficking.

7.3.3.2 Non-Citizen Lawfully Present ~~Immigrant~~ Children, Young Adults, and Pregnant People

Children younger than 19 years old, young adults younger than 21 years old who are residing in an IMD, and pregnant people may qualify for ~~BadgerCare Plus or~~ Medicaid if they are lawfully present in the U.S. under many of the immigrant and non-immigrant statuses. For those who are not in a qualifying Immigrant category, but are lawfully present, use the Registration Status Code of 20. Please see [Process Help Section 24.27 SAVE Responses Mapping to CARES Immigration Status Codes Chart](#) for a list of SAVE Responses and the appropriate Registration Status Code in CWW to apply.

7.3.3.3 Immigrants Eligible for Other Health Care Programs

Immigrants who are not a qualifying immigrant nor lawfully present (for example, someone who is undocumented) and who apply for Medicaid and meet all eligibility requirements, except for citizenship and immigration status, are entitled to receive Medicaid Emergency Services only (see [CHAPTER 34 EMERGENCY SERVICES](#)).

Pregnant immigrants who are not a qualifying immigrant nor lawfully present and who apply for the BadgerCare Plus Prenatal Program and meet the eligibility requirements except for citizenship and immigration status, are entitled to receive BadgerCare Plus Prenatal Program benefits (see BadgerCare Plus Handbook, [Chapter 41 BadgerCare Plus Prenatal Program](#)) Emergency Services (see BadgerCare Plus Handbook, [Chapter 39 Emergency Services](#)), or both.

7.3.3.4 Impact of Immigrant Status on Household

Immigration status is an individual eligibility requirement. An individual's immigration status does not affect the eligibility of the Medicaid Group. The citizen spouse or child of an ineligible immigrant may still be eligible even though the immigrant is not.

7.3.7 Immigration Status Chart

See Process Help, Section 24.27 SAVE Responses Mapping to CARES Immigration Status Codes Chart for a list of Systematic Alien Verification for Entitlement (SAVE) Responses and the appropriate Registration Status Code in CWW to apply.

~~Please see [Process Help Section 24.27 SAVE Responses Mapping to CARES Immigration Status Codes Chart](#) for a list of SAVE Responses and the appropriate Registration Status Code in CWW to apply.~~

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

			August 22, 1996	August 22, 1996	August 22, 1996	on or after August 22, 1996
01	~~Lawfully admitted for permanent residence~~ <u>Lawful Permanent Resident – 5Five- year wait</u>	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009, Eligible
02	Permanent resident under color of law (~~PRUCOL~~)	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
03	~~Lawfully present under Section 203(a)(7)~~ <u>Conditional Entrant</u>	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009, Eligible
04	~~Lawfully present under Section 207(c)~~ <u>Refugee or Special Immigrant Visa Holder</u>	Eligible	Eligible	Eligible	Eligible	Eligible
05	~~Lawfully present under Section 208~~ <u>Asylee</u>	Eligible	Eligible	Eligible	Eligible	Eligible
06	~~Lawfully present under Section 212(d)(5) and paroled for at least one year~~ <u>Person Paroled for at Least One Year</u>	Eligible	Eligible	Ineligible for ~~5~~ five years	Eligible	Effective October 1, 2009, Eligible

07	~~IRCA (No longer valid)~~ Worker Authorized Through IRCA	N/A	N/A	N/A	N/A	N/A
08	~~Lawfully admitted – temporary~~ Temporarily Lawfully Admitted Person	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
09	Undocumented Immigrant	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
10	~~Illegal Immigrant~~ Undocumented Individual	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
11	Cuban/Haitian Entrant	Eligible	Eligible	Eligible	Eligible	Eligible
12	~~Considered a Permanent Resident by USCIS~~ Conditional Permanent Resident	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
13	~~Special agricultural worker under Section 210(A)~~ Special Agricultural Worker	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
14	~~Additional special agricultural worker under Section 210(A)~~ Additional	Ineligible	Ineligible	Ineligible	Ineligible	Eligible

15	<u>Special Agricultural Worker</u> ~~Withheld deportation--~~ <u>Section 243(h) Person Granted Withholding of Removal</u>	Eligible	Eligible	Eligible	Eligible	Eligible
16	~~Battered Immigrant~~ <u>VAWA Self-Petitioner</u>	Eligible	Eligible	Ineligible for ~~5~~ -five years	Eligible	Effective October 1, 2009, Eligible
17	Amerasian	Eligible	Eligible	Eligible	Eligible	Eligible
18	~~Foreign-Born Native American~~ <u>Foreign-Born Member of a Tribal Nation</u>	Eligible	Eligible	Eligible	Eligible	Eligible
19	~~Victims of Trafficking~~ <u>Trafficking Victim or their Family **</u>	Eligible	Eligible	Eligible	Eligible	Eligible
20	~~Lawfully Residing~~ <u>Non-Citizen Lawfully Present in the U.S.</u>	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
21	~~Victims of Trafficking Subject to 5-Year Waiting Period~~ <u>Trafficking Victim with T-1 Visa</u>	Eligible	Eligible	Ineligible for ~~5~~ -five years	Eligible	Eligible

22	~~Citizens of~~ ~~Compacts of Free~~ ~~Assoc (COFA)~~ <u>Compact of Free</u> <u>Association</u> <u>Migrant</u>	Eligible	Eligible	Eligible	Eligible	Eligible
23	<u>Lawful Permanent</u> <u>Resident</u>	<u>Eligible</u>	<u>Eligible</u>	<u>Eligible</u>	<u>Eligible</u>	<u>Eligible</u>

* "Veteran" includes certain veterans and ~~active-duty~~active-duty service ~~members~~men and women, their spouses, dependent children, or certain surviving spouses.

**Some victims of trafficking may need to provide certain verification to be exempt from the five-year waiting period.
~~S~~(see SECTION 7.3.3.1.4 VICTIMS OF TRAFFICKING)~~for more information.~~

8.1 Medical Support

8.1.3 Referral to Child Support Agencies

The income maintenance (IM) agency provides the CSA with information vital to opening medical support cases. The IM agency also supplies continuing information, which assists the CSA in providing medical support services.

For health care applications, new health care requests on existing cases, and person add requests that include minor children who have an absent parent, a referral is systematically sent to the CSA at the time health care eligibility is confirmed, with the exception of the situations listed in [Section 8.2.2 Exemptions from Cooperation](#). Detailed questions about absent parents (such as, name, Social Security number, date of birth, or contact information) cannot be asked during the application process for health care-only applications. The referral will still be sent to the CSA, even if the absent parent's name is unknown (see [Process Help Section 10.2.1 Enter Absent Parent Information](#)).

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

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

While IM agencies refer individuals receiving Medicaid or BadgerCare Plus to the CSA, the CSA determines which cases receive child support services. Not all Medicaid or BadgerCare Plus members qualify for free child support services and not all members are required to cooperate with the CSA.

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

1. A pregnant member who is unmarried or married and not living with their husband. However, pregnant members are not required to cooperate with the CSA during the pregnancy or the 12-month postpartum period (see BadgerCare Plus Handbook, Section 8.1 Pregnant Members) and for an additional 60 days after the last day of the pregnancy and through the end of the month in which the 60th day occurs. The member's eligibility for BadgerCare Plus Medicaid will continue during this period, regardless of the member's cooperation.
 - a) Exception: Pregnant members receiving the BadgerCare Plus Prenatal Benefit should not be referred to a CSA.
2. A child receiving SSI only, if the parents or caretaker relatives ~~requests child support services for the child. Do are~~ not sanctioned this parent or caretaker relative if they do not cooperate with the CSA.
3. Non-marital co-parents when paternity has not been legally established, ~~This includes a non-marital co-parent even when both parents are in the same home.~~
 - a) ~~Exception: Do not r~~ Referrals are not made parents to the CSA when both parents are in the home and the father is on the child's birth certificate or the father's paternity has been legally established in another state by a court order or by a Voluntary Paternity Acknowledgement Form filed with a state agency.
 - b) ~~—~~
4. Biological or adoptive parent(s) not living in the household.

- a) **Exception:** ~~Do not refer~~ Referrals are not made to the CSA when the only reason a parent or stepparent is not in the home is because they are in the military.

~~4.5.~~ Married biological parents in the home, but:

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

Referrals for the following individuals are not made to the local CSA:

~~Do not refer people~~

- Former Foster Care Youth, unless the youth is also a parent of an eligible child in the household.
- People residing in domestic abuse shelters, ~~to the CSA. Once~~ The referral is sent to the CSA after the a person moves out of ~~a the~~ domestic abuse shelter, ~~complete the Absent Parent page in CWW so that the referral is sent to the CSA.~~

8.2 Medical Support/Child Support Agency Cooperation

8.2.2 Exemptions from Cooperation

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

1. The child under their care is eligible for benefits funded under any source other than Title 19, such as Title 21 (Separate CHIP) or General Purpose Revenue (that is, state funds). Information on children's categories funded by Separate CHIP or state funds is available in BadgerCare Plus, [Section 51.1 BadgerCare Plus Categories](#). The CSA will monitor the child's [BadgerCare Plus or](#) Medicaid ~~Eligibility~~ funding source.
2. The child under their care ~~is on~~[receives](#) SSI.
3. The parent or caretaker relative is one of the following:
 - a. Eligible for the BadgerCare Plus Eligibility Extension.,
 - b. A pregnant person, until the end of the ~~month in which the 60th day after the termination of pregnancy occurs~~[12-month postpartum period](#).
 - c. Under 18 years old.
 - d. Age 18 and receiving CHIP coverage under BadgerCare Plus (income is over 156% FPL).
4. Both absent parents are now living in the home with the child.
5. The absent parent is deceased.
6. Paternity has been established and the father is living in the home with the mother and child.
7. The only parent absent from the home is absent because of military service.

9.1 Third Party Liability

9.1.3 Third Party Liability Cooperation Requirements

The Medicaid member must cooperate in providing TPL information unless ~~he or she is~~they are exempt or there is good cause for refusing to cooperate. TPL information could include the name and address of an insurance company, insurance policy number, and the name and address of the policy owner.

If an adult refuses, without good cause, to provide health insurance information for themselves, or anyone for whom they are legally responsible and is receiving Medicaid, the adult is ineligible until ~~he or she~~they cooperates.

~~Do not sanction~~ The following individuals are not sanctioned for non-cooperation:

1. Minors, including minor caretakers.
2. A parent or caretaker relative requesting child support services for a child receiving SSI .
3. Pregnant BadgerCare Plus ~~woman — She May~~members are not ~~be~~ sanctioned during the pregnancy, ~~or for two months after the pregnancy has ended, and~~ or the 12-month postpartum period if the TPL source is from the absent parent ~~of her child(ren)~~.

12.1 Change Reporting Introduction

Medicaid members are required to report to the agency about changes in circumstance that may impact their eligibility.

Any change that is reported or becomes known to the agency (for example, through data exchange or another source) must be acted upon.

~~Members must report to the IM agency, within 10 days of the occurrence, a change in address, income, assets, need, medical expenses or living arrangements which may affect eligibility.~~

~~Some changes may be reported through ACCESS.~~

12.2 Nonfinancial Change Reporting

Medicaid members must report the following non-financial changes within 10 days after occurrence:

- Address
- Household composition, including pregnancy
- Living arrangement (for example, institutionalization, incarceration)
- Change in marital status
- Change in insurance coverage, including Medicare starting or ending
- Changes in disability status

Note If a member reports their release from prison or jail untimely, suspended Medicaid must be lifted effective for the first of the month when the person was released from prison or jail (see Section 13.4 Suspension End Date).

12.3 Financial Change Reporting

Medicaid members must report the following financial changes within 10 days of the occurrence-:

- Changes in income
- Changes in assets
- Changes in medical expenses, including medical insurance premiums and Medicare premiums
- Changes in housing or utility bills

Example 1	Sally's countable income has been \$950 each month since she applied in January. In June her income increased to \$1050 each month. She must report the change by July 10.
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12.4 Change Reporting Methods

Members can report changes using one of the following methods:

- ACCESS
- Mail or fax the Wisconsin Medicaid Change Report (F-10137)
- Call their agency
- Go to their agency

15.7 Income Deductions

15.7.3 Medical/Remedial Expenses

Medical/remedial expenses are used in all the following:

- ~~HCBW programs~~ Institutional monthly need calculations (see Section 27.6 Monthly Need)
- Patient liability calculations for ~~residents of a medical institution~~ Institutional Medicaid
- Cost share and calculations for Home and Community-Based Waiver Medicaid
- ~~MAPP premium calculations~~
- Meeting a Medicaid deductible (see Section 24.7 Meeting the Deductible)
- MAPP eligibility calculation ~~determination~~ if expenses are over \$500 monthly (see Section 26.4.2.1 Deduction for Medical and Remedial Expenses over \$500 ~~for more information on this MAPP-specific deduction~~)
- MAPP premium calculations

Medical Expenses

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

The following are examples of medical expenses:

- Deductibles ~~and copayments~~ for ~~Medicaid~~, Medicare, ~~and or~~ private health insurance.~~s~~
- Health insurance premiums and copayments for Medicaid, Medicare, and private health insurance.

Note

ForwardHealth interChange (iC) data may be used to determine Medicaid co-payment expenses.

- Bills for medical services that are not covered by Wisconsin Medicaid or by any other source such as private insurance or Medicare.
- For purposes of meeting a Medicaid deductible, medical services received before the person became eligible for Medicaid (Past medical bills cannot be used for MAPP premium calculations.)

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

Remedial expenses

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

Some examples of remedial expenses are:

1. Case management

~~2. Day care~~

~~3.2.~~ Housing modifications for accessibility

~~4.3.~~ Respite care or day care

~~5.4.~~ Supportive home care

Supportive Home Care is necessary assistance to help people meet their daily living needs, ensure adequate functioning in their home, and safely access their community. Services may include:

- a. Assistance with activities of daily living
- b. Attendant care
- c. Supervision
- d. Reporting changes in the participant's condition
- e. Assistance with medication and medical procedures which are normally self-administered
- f. The extension of therapy services, ambulation and exercise
- g. Tasks associated with routine household upkeep, including general housekeeping chores, lawn mowing, snow removal, changing storm or screen windows and other household services that are essential to the participant's safety, well-being and care at home

~~6.5.~~ Transportation to obtain medical care. This includes but is not limited to taxi, rideshare services, bus fares, or a person's own vehicle, if approved.

~~7. Services recognized under Wis. Stat. § 46.27~~

6. For billed expenses from a CBRF, AFH, RCAC or other community substitute care setting, only the program costs are allowable remedial expenses. Room and board costs are not allowable as remedial expenses.

- a. Community Based Residential Facility (CBRF), Adult Family/Foster Home (AFH), Residential Care Apartment Complex (RCAC), and all other community substitute care setting program costs, ~~not including room and board expenses, can be counted as a~~ are remedial expenses only as they are incurred. CBRF, AFH, RCAC and all other community substitute care setting program ~~These costs will be considered incurred as of the billing date, that the member is billed for these expenses by the CBRF, AFH, RCAC or other community substitute care setting. The billing procedure used by the CBRF, AFH, RCAC or other community substitute care setting (one month in advance, bimonthly, etc.) for Medicaid residents should be the same as that which is used for its non-Medicaid residents.~~

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

Disallowed expenses

If any of the following is true, the expense is not an allowable medical or remedial expense:

- The same expense was previously used to meet a Medicaid deductible
- The same expense was previously used to reduce a premium, cost-share, or patient liability.
- The expense was incurred because of imposition of a divestment penalty period.
- The expense is a prior patient liability or cost-share.
- The expense was paid by a liable third party.
- The expense is unverified.

16.11 Retirement Funds

16.11.1 Types of Retirement Funds

Retirement funds include employer-sponsored retirement plans and individually owned retirement plans.

Employer-Sponsored Retirement Plans

Employer-sponsored retirement plans include:

- 401(k) or SIMPLE 401(k).
- 403(b) Plans: For employees of public schools and certain tax-exempt organizations.
- 457(b) Plans: Deferred compensation plans available to state and local government employees.
- Thrift Savings Plans (TSPs): Similar to a 401(k) plan but only available to federal employees and military members.
- Qualified Pension Plans: Employer-sponsored pension (such as Wisconsin Retirement System's Employee Trust Fund (ETF)).
- Profit-Sharing Plans: Employer-contributed plans.

Individually Owned Retirement Plans

Individually owned retirement plans include:

- Keogh plans: For self-employed individuals.
- Individual retirement arrangements (IRAs): Types include traditional, Roth, SEP, and SIMPLE IRAs.

An IRA can be in the form of an **individual retirement account** or an **individual retirement annuity**. An individual retirement account can hold a variety of asset types, including stocks, bonds, mutual funds, annuities, CDs, and other assets. An individual retirement annuity ~~or (also called "IRA annuity")~~ invests only in fixed or variable annuities and provides a guaranteed income stream at retirement. IRA annuities can be in accumulation or pay out status, but most often IRA annuities are annuitized at the time they are established.

IRAs cannot be jointly owned. ~~IRAs are not transferable~~ and have exclusive benefits for the individual who funded owns them IRA (or that individual's beneficiary after they die). In rare situations IRA ownership may transfer. ~~a spouse can fund an IRA for their partner, but in that situation only the partner has access to the assets.~~

Other Funds Set Aside for Retirement

Funds that are intended for retirement but not held in an employer-sponsored or individually owned retirement plan are not considered retirement funds for purposes of Medicaid eligibility. They are evaluated based on the type of account in which the funds are held. For example, if funds being saved for retirement are held in a regular savings account, the funds are evaluated as a savings account.

16.11.2 Retirement Funds as Assets

Employer-sponsored and individually owned retirement plans must be evaluated for availability as assets.

Retirement Funds of a Medicaid Applicant or Member

In general, individually owned retirement plans (IRAs and Keoghs) are counted as available assets. The available amount is calculated as the principal, less any penalties for withdrawal. Tax withholdings are not deducted from the available asset value. Exception: IRA annuities that are currently paying out are treated as annuities rather than retirement funds when evaluating their availability as assets (see [SECTION 16.12 ANNUITIES](#)).

Note For long-term care cases, annuity disclosure and remainder beneficiary designation requirements apply to IRA annuities regardless of whether the annuity is evaluated as a retirement fund or as an annuity (see [SECTION 16.12.3 LONG-TERM CARE ANNUITY DISCLOSURE AND REMAINDER BENEFICIARY DESIGNATION REQUIREMENTS](#)).

Employer-sponsored retirement plans are not counted as available assets if any of the following are true:

- The individual is currently receiving periodic payments from the plan.
- The individual is still employed and would have to quit their job to obtain the funds.
- The individual does not have access to the account's principal.

If none of the above are true and the individual has the ability to cash out their employer-sponsored retirement plan, the cash value of the plan (after any penalties but before any tax withholding) is counted as an available asset.

Retirement Funds of an Ineligible Spouse

An ineligible spouse is defined as a Medicaid applicant or member's spouse who is not requesting full-benefit health care. ~~In general, both employer-sponsored and individually owned retirement plans of an owned by an ineligible spouse (defined as a Medicaid applicant or member's spouse who is not requesting full-benefit health care) are disregarded as assets for Medicaid eligibility and spousal impoverishment asset assessments.~~

IRA annuities owned by an ineligible spouse are subject to both annuity disclosure and remainder beneficiary designation requirements (see SECTION 16.12.3 LONG-TERM CARE ANNUITY DISCLOSURE AND REMAINDER BENEFICIARY DESIGNATION REQUIREMENTS).

~~However, IRA annuities owned by an ineligible spouse are only considered exempt retirement funds if the annuitant is the person who funded the IRA. Otherwise, the ineligible spouse's IRA annuity must be evaluated as an annuity rather than a retirement fund when determining whether it must be counted as an asset (see SECTION 16.12 ANNUITIES).~~

Note: Inherited IRAs are not considered retirement funds for purposes of this exemption.

~~For long-term care cases, annuity disclosure and remainder beneficiary designation requirements apply regardless of whether the ineligible spouse's IRA annuity is evaluated as a retirement fund or as an annuity (see SECTION 16.12.3 LONG-TERM CARE ANNUITY DISCLOSURE AND REMAINDER BENEFICIARY DESIGNATION REQUIREMENTS).~~

Example 1	<u>Diane has been admitted to a nursing home, and her stay is expected to be over 30 days. Her husband, Tom, is an ineligible community spouse who owns an IRA annuity. Tom's IRA annuity is not counted for the couple's asset assessment or for Diane's eligibility determination for</u>
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	<u>institutional Medicaid. It is an exempt retirement asset because it is owned by Tom, as an ineligible spouse.</u>
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Conversion of Retirement Funds

Retirement funds that are cashed out or rolled over are treated as a conversion from one asset type to another.

Example

~~1~~2

Carol has a 401(k) retirement plan with her employer. When she ends her employment, she cashes out her 401(k) and rolls the funds into a newly created IRA. Once the IRA is established, the funds are assessed for asset and income availability as an individually owned retirement plan.

Example

~~2~~3

Jane has a 401(k) retirement plan with her employer. When she ends her employment, she cashes out her 401(k) and deposits the funds into her checking account. The funds are assessed for asset availability as part of her checking account as soon as they are deposited into the account and are no longer treated as retirement funds.

17.2 Evaluation of Transfers for Divestment

17.2.6 Allowed Divestments

17.2.6.1 Transfers Made for a Purpose Other Than ~~To~~ Qualify for Medicaid

17.2.6.1.1 Sufficient Resources ~~To~~ Cover Five Years of Long-Term Care

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

For the average monthly nursing home cost of care in effect at the time of the transfer, see ~~Section 39.4.3 LTC Post-Eligibility Allowances~~[Section 39.4.6 Institutional Cost of Care Values](#) (view history pages for prior year amounts). This cost per month multiplied by 60 months provides the amount to compare to the income, assets, and insurance held by the individual immediately after the transfer.

Example 1	Lucius had a money market account. Lucius gave his nephew a graduation present worth \$25,000. After the gift, Lucius' money market account still had enough funds to pay for more than five years of long-term care services. Two years later, Lucius suffered a traumatic brain injury and was institutionalized. Because the cost of specialized nursing home care is significantly greater than a regular nursing home, Lucius depletes his money market account and must apply for Institutional Medicaid after only two years. Because Lucius still had enough money to pay for five years of care at a regular nursing home after he gave the gift to his nephew, the gift is an allowed divestment and doesn't result in a penalty period.
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Example 2	Pierce had an investment portfolio with assets that could pay for more than five years of long-term care services. Pierce paid for his granddaughter to take a trip to Europe. Immediately after the transfer, his investment portfolio still contained enough funds to pay for more than five years of long-term care services. Later, his investments plummeted in value due to the stock market. Before the stock market recovered, he entered a nursing home and quickly spent his remaining assets on his care. Pierce then applied for Medicaid to continue receiving his necessary long-term care services. Because Pierce still had enough assets to pay for his long-term care for five years immediately after he made the gift to his granddaughter, the gift is an allowed divestment and doesn't result in a penalty period even though the gift was in Pierce's look back period.
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17.2.6.1.2 Sufficient Resources ~~To~~ Cover Long-Term Care for Remaining Life Expectancy

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

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

For the average monthly nursing home cost of care in effect at the time of the transfer, see [SECTION 39.4.6 INSTITUTIONAL COST OF CARE VALUES](#) (view history pages for prior year amounts). This cost per month, multiplied by ~~60~~ the number of months in their remaining life expectancy, provides the amount to compare to the income, assets, and insurance held by the individual immediately after the transfer.

17.2.6.1.4 Pattern of Gifting

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

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

If it is determined that the total value of yearly gifts given as part of a clearly established pattern of gifting exceeded 15% of the individual or couple's annual gross income for that year, the divested amount is the gifted amount in excess of 15% of their annual gross income.

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

Example 4	Jacques is applying for long-term care. He has five grandchildren. Two of Jacques's grandchildren graduated during his look back period, and he gave them each \$1,000 as graduation gifts. The amounts of those graduation gifts did not exceed 15% of his income in the years they were given. Jacques can also show that, prior to the look back period, he gave similar gifts to two of his other grandchildren when they graduated from high school. He has therefore shown that the gifts given to his grandchildren during the look back period were part of a "pattern of gifting." The gifts are an allowed divestment and don't result in a penalty period.
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Example 5	<u>Brittany is applying for long-term care in June 2026. She reports that, during her lookback period, she made monthly recurring gifts to several charities. Brittany provides documentation showing these gifts began prior to her lookback period and were part of an established pattern of gifting.</u> <u>From June 2022- to May 2023 (the second year of her lookback period), her gifts exceeded 15% of her gross income by \$1,000. From June 2023- to May 2024 (the third year of her lookback period), her gifts exceeded 15% of her gross income by \$500. The total divested amount is \$1,500.</u>
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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*. 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.

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~~ they have 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~~ owned by an ineligible community spouse (see [SECTION 16.11.2 RETIREMENT FUNDS AS ASSETS](#)).

20.1 Verification Introduction

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 may be submitted in person, by mail, fax, e-mail, or electronically through 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

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 preferred language has no impact on the verification policy for U.S. citizenship. Verification of U.S. citizenship is attempted using the same methods used for all applicants that report U.S. citizenship, which is explained in [SECTION 7.2 VERIFYING U.S. CITIZENSHIP](#).

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 cannot be required.
8. During verification, the applicant or member can't be harassed or have their privacy, personal dignity, or constitutional rights violated.
9. A one-time 10-day extension to the verification due date can be provided for the following reasons:
 - a. The applicant or member requests additional time to provide the requested verification.
 - b. The verification submitted by the applicant or member is incomplete or unreadable.

Note

When it is later determined a verification request was incorrect or incomplete, or when it is determined a verification request was not sent due

	<u>to error, the applicant or member must be given a minimum of 20 calendar days to provide the verification.</u> ~~For information required to make an eligibility determination that the member cannot provide, such as disability determinations, extensions are not limited to 10 days.~~
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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 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 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 are redetermined based on the new information.

20.3 Mandatory Verification Items

20.3.1 Mandatory Verification Items Introduction

Verification is mandatory for certain items to determine eligibility. Unless determined questionable, self-declaration is acceptable for all other items.

The following items are mandatory, and must be verified for Medicaid:

- SSN (see [Section 10.1 SSN Requirements](#))
- U.S. citizenship (see [Section 7.2 Verifying U.S. Citizenship](#))
- Immigrant status (see [Section 7.3.2 Verification](#))
- Disability (see [Section 5.2 Determination of Disability](#))
- Income (see [Section 15.1 Income Introduction](#))
- Countable and available aAssets (see [Section 16.1 Assets Introduction](#))
- Divestment details, if a divestment has occurred, for Medicaid long-term care programs (see [Chapter 17 Divestment](#))
- Medical expenses used to meet a deductible (see [Section 24.2 Medicaid Deductible Introduction](#))
- Out-of-pocket medical/remedial expenses for MAPP and Institutional Medicaid patient liability and Waiver Medicaid cost share deductions (see [SECTION 15.7.3 Medical/Remedial Expenses](#))
- Documentation for power of attorney and guardianship (see [Section 22.5 Legal Guardians, Conservators, Power of Attorney, and Other Representatives](#))
- Migrant worker's eligibility in another state (see [Section 31.1 Migrant Workers](#))
- Institutional Medicaid patient liability home maintenance deduction (see [Section 15.7.1 Maintaining Home or Apartment](#))
- Temporary hardship for MAPP premium waiver (see [Section 26.5.8 Temporary MAPP Premium Waivers Due to Hardship](#))
- Huber Law participation, for incarcerated individuals qualifying for the Huber Law exemption (see [Section 13.8.3 Huber Law](#))
- Tribal membership or Native American descent (see [Section 20.3.11 Tribal Membership, Descent, or Eligible to Receive Indian Health Services](#))

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

20.3.5 Assets

Verification of *countable assets* is mandatory.

Verification of exempt assets (such as burial spaces or a household's only vehicle) may only be requested if there is missing or conflicting information about the asset and more information is needed to determine if it is counted or exempt.

Note The value of exempt assets, such as an EBD Medicaid member's burial plot, may not be verified unless the worker has information that deems the member reported amount to be questionable.

If reported assets exceed the asset limit, do not pursue verification.

Do not verify cash on hand.

Verify AVS liquid assets using the Asset Verification System (AVS) integrated within CARES Worker Web. If current asset information is not available through AVS, the applicant/member ~~is~~ has 20-days to ~~required to~~ verify their assets through other sources (for example, bank statements). Assist the applicant/member in obtaining verification if ~~he or she has~~ they have difficulty in obtaining it.

20.3.5.1 Divestment

Verify divestment details, if an applicant or member or their spouse has divested assets when determining eligibility for institutional Medicaid, HCBW Medicaid, or ~~and~~ for other Medicaid types if the applicant or member is requesting LTC services, such as Family Care or IRIS community waivers (see Section 17.1 Divestment Defined).

20.3.6 Medical or Remedial Expenses

Medical or remedial expenses used to meet a deductible or to calculate a patient liability, cost share, or premium amounts must be verified. The expense amount, any ~~third-party~~third-party liability amount, and date of service must all be verified. If verification is not provided, ~~do not include~~ the expense ~~to determine when~~is not allowed to be used to meet a deductible, ~~has been met or in the~~for patient liability, cost share, or premium calculations. ~~Do not deny or terminate eligibility~~Eligibility cannot be denied or terminated for failure to provide ~~the requested~~expense verification.

For HCBW ~~Medicaid, Family Care, Family Care Partnership, PACE, and IRIS~~ members, ~~Care~~MCO care Managersmanagers, ADRC staff, and IRIS Consultant Agencies (ICAs) calculate medical and remedial expenses. Because care managers, ADRC staff, and ICAs ~~already~~ verify all medical and remedial expenses before reporting the ~~ose~~ expenses to IM, additional verification is not needed. Refer to Section 15.7.3 ~~28.6.4.5~~ Medical/Remedial Expenses.

20.3.7 Power of Attorney, Guardianship, ~~or~~ Conservator, or Patient's Representative

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

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

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

If the applicant or member has a patient's representative, documentation of the patient's representative appointment is required.

If verification is not provided, ~~do not grant~~ the claimed agent with power of attorney, guardian, ~~or~~ conservator, or patient's representative cannot be granted access to case information or notices or ~~follow any direction provided by that person~~act on behalf of the applicant or member unless they are an authorized representative. ~~Do not deny or terminate eligibility for failure to provide the requested verification.~~

21.10 ~~Good Faith Claims~~Reserved

21.10.1 ~~Definition of Good Faith Claims~~

A good faith claim is a claim that has been denied by Medicaid with an eligibility-related EOB code. This occurs even though the provider verified eligibility for the dates of service billed and submitted a correct and complete claim. Providers can resubmit the claim to the fiscal agent to be processed as a good faith claim. If the eligibility file has been updated by the time the claim is resubmitted, it will be paid automatically. If the file still does not reflect eligibility for the period covered by the claim, the fiscal agent will try to resolve the eligibility discrepancy. If they are unable to resolve it from the information available, they will contact you to verify eligibility. The Good Faith Medicaid/BadgerCare Plus Certification form (F-10111) is used for this purpose. A good faith claim cannot be reimbursed until the fiscal agent member file is updated.

21.10.2 ~~Denials~~

If a provider receives a claim denial for one of the following reasons on the Remittance Advice, the provider can resubmit it as a good faith claim.

~~R/A Report Denial Code~~	~~Reason~~
~~029~~	~~Medicaid number doesn't match recipient's last name.~~
~~172~~	~~Recipient Medicaid ID number not eligible for dates of service.~~
~~281~~	~~Recipient Medicaid ID number is incorrect. Verify and correct the Medicaid number and resubmit claim.~~
~~614~~	~~Medicaid number doesn't match recipient's first name.~~

21.10.3 ~~Causes and Resolutions~~

Causes and a good faith claim can occur when:

- 1.—A member presents an ID card that is invalid because:
 - a.—You issued a temporary ID card for a prior period or manually determined case and did not update GARES or send the fiscal agent an F-10110 (formerly DES-3070) to update the member's eligibility file. The fiscal agent will apply the dates of eligibility indicated on the card with med-stat 71. A letter will be sent to you to confirm that the member is eligible for the dates on the card. The letter will include instructions on how to complete a F-10111 and the information that is needed.
 - b.—The provider suspects the member of misusing or abusing a Medicaid ID card (i.e., using an altered card or a card that belongs to someone else). If the provider submits a copy of the card and the fiscal agent can tell that it was altered, the fiscal agent will contact you to verify the member was eligible or forward it to the DMS for review.

- 2.—The member's name has changed since the card was issued. The fiscal agent can usually resolve claims that are denied with code "029" and "614." If necessary, the fiscal agent will contact you to confirm the information.

With the implementation of the ForwardHealth ID cards, providers are less likely to receive one of the eligibility-related denials used for good faith claim submissions. Providers are told to verify eligibility using the variety of methods available to them through the Eligibility Verification System (EVS). When the provider verifies the member's eligibility, they are getting the most current information available on the MMIS. Therefore, it is unlikely that they will be told the member is eligible when he or she is not.

The most likely reason a good faith situation arises is when a provider sees a temporary paper ID card issued by the agency. The provider may bill Medicaid before the eligibility is updated on MMIS, or perhaps the eligibility was never sent to MMIS. In either case, if the member presents a valid temporary Medicaid ID card for the dates of service, and the provider sends a copy of the card with the good faith claim, the fiscal agent will update the member's eligibility file with a good faith segment and pay the claim immediately.

The fiscal agent will then attempt to resolve the discrepancy from information on file or contact you to confirm eligibility and correct the eligibility segment. If the provider does not send a copy of the ID card with the claim, the fiscal agent must confirm eligibility with you before the claim can be paid.

The definition of a valid card is either a:

- 1.—ForwardHealth card that indicates eligibility for the dates of service through the EVS.
- 2.—A temporary paper card showing dates of eligibility.

21.10.4 Process

The fiscal agent initiates the good faith claim process by sending you a Good Faith Medicaid/BadgerCare Plus Certification form (F-10111) that they have partially completed and one or two letters, depending on what documentation of eligibility the provider included with the claim. Complete F-10111 for new members (cert. 1) or F-10110 (formerly DES 3070) for amended certifications (cert. 3). Send completed F-10111 forms to:

ForwardHealth
Good Faith Unit
P.O. Box 6215
Madison, WI 53784

Send completed F-10110 forms by fax to 608-221-8815 or by mail to:

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

21.10.5 Instructions

Agency Denial

If the member identified on this Good Faith form was neither eligible nor possessed a valid ID card for the dates of service indicated in field six, place an "X" in this box. If you check "Yes" here, you must also check the reason in the field below:

Member Did Not Have ID Card After Date of Service

Place an "X" in this box if you are certain that the member did not possess a valid Medicaid ID card for the date of service. In the blank provided, enter the closing date of eligibility.

Recipient Not Eligible

Place an "X" in this box if the member was not eligible for any of the dates of service shown. If the member was eligible for some of the dates of service, follow the instructions for completing the Partial Deny box.

Record Not Found

Place an "X" in this box if the member has never been eligible for Medicaid in your agency.

Dates of Services

The fiscal agent enters the dates of service for the claim.

Partial Deny

Use this field only if the member had eligibility for some of the dates of service. Enter the "from" and "to" dates which cover the portion of the dates of service for which the member did not have eligibility.

Type of Certification

The fiscal agent will check one of these boxes:

1.—Initial Certification

The fiscal agent will place an "X" in this box when the member and Medicaid number submitted on the claim cannot be found on the eligibility master file.

2.—Amended Certification

The fiscal agent will place an "X" in this box when the member is on MMIS, but no eligibility exists for the claimed dates of service.

Agency Number

The fiscal agent will enter the three-digit code of the agency they believe may have certified the member during the dates in question.

Casehead ID Number

The fiscal agent will enter the known or suspected MMIS case number (primary person's SSN + tie-breaker) of the member listed on the provider's claim.

Action Date

The fiscal agent enters the date they completed the Good Faith form.

Medical Status Code

When the fiscal agent receives the provider's claim along with a photocopy of an ID card, a hard copy response received through EVS, or a transaction log number from the Automated Voice Response (AVR), the fiscal agent compares the dates of service with the dates on the card. If the dates of service fall within the dates of eligibility for the ID number on the card, the fiscal agent enters a "71" medical status code and pays the claim immediately. The fiscal agent then enters the eligibility dates for the entire month in which services were provided.

If the member was eligible for the entire period of certification shown on the Good Faith form (F-10111), remove the "71" medical status code and write in the correct code. Attach a F-10110 (formerly DES 3070) to add the certification period and appropriate medical status code for the time when the member was eligible for Medicaid.

Period of Certification

If the fiscal agent has entered the suspected period of certification to be added to the member master file, check it for accuracy. Then complete a F-10110 (formerly DES 3070) and enter the period of certification if the member file does not show eligibility for the time when the member was eligible or for the time covered by an ID card issued to the member.

Control Name Year of Birth

The fiscal agent will enter the suspected control name and year of birth (YOB) for the member. This control name must be the first four letters of the member's last name. The YOB is the last two digits in the member's year of birth. Both of these items must match the information currently in the member's fiscal agent file.

Current ID Number

The fiscal agent will enter the member's current Medicaid ID number.

Date of Birth

The fiscal agent completes this field only for initial certifications. Change this birth date if the date entered is incorrect. Indicate birthdate as MM/DD/CCYY.

Signature of Agency Director

Good Faith forms must have an authorized signature for initial certifications.

Worker ID

On initial certifications, enter the six-digit worker code of the certifying IM worker.

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

22.5.6 Patient's Representative

Certain family members and "next of kin" may consent to an incapacitated individual's admission to a nursing home or community-based residential facility directly from a hospital without requiring a petition for guardianship or protective placement, if all of the following apply:

- The incapacitated individual does not have a valid power of attorney (POA) for health care.
- The incapacitated individual has not been adjudicated incompetent in this state, i.e., a court has not appointed a guardian.
- No person who is listed in the same order of priority, or higher priority, disagrees with the proposed admission.
- No person in any level of priority who lives with the incapacitated individual disagrees with the proposed admission, unless the person consenting also resides with, or is the spouse or domestic partner of, the incapacitated individual.
- The incapacitated individual is not diagnosed as developmentally disabled or as having a mental illness at the time of the proposed admission.
- The incapacitated individual does not verbally object to or otherwise actively protest the admission. (If the individual makes an objection or protest, they may be admitted to the facility, but the facility must notify Adult Protective Services for the appropriate county.)

A patient's representative could be, in order of priority, one of the following individuals:

1. A spouse or domestic partner
2. Adult child
3. Parent
4. Adult sibling
5. Grandparent
6. Adult grandchild
7. Adult close friend

A physician and one advanced practice clinician must complete a Medical Certification of Capacity for Determining a Patient's Representative Authority to Act (F-03435). The patient's representative must sign a Patient's Representative Declaration (F-03436). The incapacitated individual must be admitted to the facility directly from a hospital inpatient unit. A patient's representative can make health care decisions to the same extent as a guardian of a person and enroll in Medicaid and authorize expenditures related to health care to the same extent as a guardian of the estate. The authority of a patient's representative ends if any of the following occurs:

- A court appoints a guardian to make decisions for the incapacitated individual
- The incapacitated individual is discharged to a setting that is not a facility
- A health care power of attorney that was not identified earlier is identified
- The individual is determined to be no longer incapacitated

See Section 20.3.7 Power of Attorney, Guardian, Conservator, or Patient's Representative for information on verification requirements. See Section 2.5.1.1 Signatures from Representatives for information on a valid signature by a patient's representative.

27.7 Cost of Care Calculation

27.7.7 Medical or Remedial Expenses ~~and Payments for Noncovered Services~~

27.7.7.1 Introduction

~~Medicaid members in nursing homes are allowed to pay for some medically necessary noncovered services out of their patient liability. They are not required to use their personal needs allowance for these services.~~

~~Effective January 4, 2008, medical~~ Medical or remedial expenses an institutionalized applicant or member has incurred, ~~is actually paying,~~ and is legally obligated to pay ~~are allowable expenses and~~ are used as a monthly need item expense when determining ~~his or her~~ eligibility for Medicaid. See Section 27.6 Monthly Need. ~~These actual payments~~

Medical or remedial expenses an institutionalized applicant or member has incurred and is legally obligated to pay are also allowed as an income deduction to reduce the cost share or patient liability amount. This is sometimes referred to as a “deviation” request when the expense is owed to a nursing home.

~~This includes payments for medical or remedial expenses that the institutionalized applicant or member is currently incurring as well as payments for certain previously incurred medical or remedial expenses. See Section 15.7.3~~

Medical/Remedial Expenses for additional details on countable expenses.

Note ~~This does not include any medical or remedial expenses that another person has incurred.~~

~~In order to use the medical or remedial expense as a need item and as an income deduction in the cost share calculation, the expense must meet both the following criteria:~~

~~The institutionalized person must be legally liable for payment of the incurred medical or remedial expense. Any portion that will be paid by a legally liable third party, such as private health insurance, Medicare, or Medicaid, cannot be allowed as a deduction.~~

~~The institutionalized person must provide verification of the allowable expense (see SECTION 27.7.7.2 DISALLOWED EXPENSES).~~

Example 1	In February, Al had a root canal performed by a dentist who is not a Medicaid provider. ~~He~~ <u>Al</u> is responsible for paying \$600 for the procedure. Al began making payments of \$100 per month on this medical bill in March. On April 1, Al became institutionalized and eligible for Medicaid. The \$100 payment that Al is making on a previously incurred medical expense ~~should be used as~~ <u>is</u> a need item when determining Al’s institutional Medicaid eligibility. ~~The expense should also be used as in, and an~~ <u>income deduction when calculating Al’s cost share obligation patient liability.</u> ~~The \$100 payment can be used as an income deduction in the cost share calculation until it is fully paid in~~ <u>through August. For September, there is no balance remaining on his bill and the expense is removed. Since Al will no longer be making payments in September, the expense should be decreased to zero prior to adverse action in August.</u>
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Example 2	In April, Edna applied for institutional Medicaid and requested a ~~one-two-month~~ <u>backdate to February, when she first became institutionalized.</u> Her <u>backdated</u> request ~~for eligibility~~
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~~in March was~~ is denied because her assets ~~exceeded~~ exceed program limits, but institutional Medicaid was is approved effective April 1, with a \$1200/month patient liability. Edna ~~used her excess assets to make a partial payment to the nursing home for March costs, but still~~ has an outstanding balance of ~~\$1,800~~ \$6,000 at the nursing home for February and March dates, which is a countable medical expense for both her monthly need and patient liability calculations. The expense can be applied for April to August (\$1,200 x 5 months = \$6,000).

Edna's expense decreases her patient liability to \$0, but she pays the nursing home the calculated patient liability of \$1,200/month, which is applied to the outstanding balance through August. For September, there is no balance remaining on her bill and the expense is removed. She continues to pay the \$1,200/month patient liability. ~~agrees to make payments to the nursing home of \$500 per month until the expense is paid in full. The \$500 payment to the nursing home should be used as an income deduction when calculating her cost share for the months of April through June. In July, she will only owe \$300 to the nursing home so the deduction for July should be decreased to \$300 prior to adverse action in June. Edna will no longer be making payments in August, so the expense should be decreased to zero prior to adverse action in July.~~

**Example
3**

Jack has been an institutionalized Medicaid member since January. In March, he had a tooth extracted. The procedure was performed by a dentist who is not an Medicaid provider, so it was a noncovered service. Jack contacts the agency in April to request a deduction from his cost share so that he can pay the expense. The cost of the extraction was \$209. Since this was a one time expense and his patient liability exceeds this amount, the agency enters the expense in CWW to reduce the May cost share by \$209.

27.7.7.2 Disallowed Expenses

Do not allow payments that an institutionalized person is making, or requests to make, as a need item or as a cost share adjustment if the medical or remedial expense meets any of the following exception reasons:

- ~~Remains unpaid but was previously used to meet a Medicaid deductible.~~
- ~~Was incurred as the result of imposition of a divestment penalty period.~~
- ~~A patient liability or cost share from a previous budget period, whether paid or unpaid, cannot be used as an incurred medical or remedial care expense in a subsequent budget period.~~
- ~~Incurred medical and remedial care expenses deducted from income to determine patient liability or cost share in a month cannot be used to determine patient liability or cost share in a subsequent month. The expense is unverified.~~

**Example
4**

On September 17, Alice was hospitalized for injuries she sustained in a fall. Alice was uninsured at the time and incurred a \$2,000 hospital bill. Before leaving the hospital, she set up a payment agreement to pay \$100 per month until the debt was paid. Alice used the outstanding expense to satisfy a deductible in the amount of \$1,800 and was determined Medicaid eligible from September through February.

	In May, Alice was determined to be functionally eligible for HCBWs and was determined eligible for Medicaid under Group B waiver rules. Without a medical or remedial expense, Alice's cost share would be \$100. Alice's care manager verified that Alice still owes \$1,200, but only \$200 of the expense is allowable because \$1,800 was already used to satisfy a deductible. Her care manager will include the \$100 payment in the medical or remedial expense amount submitted to the IM worker for determining her cost share, but will reevaluate Alice's medical or remedial expense amount in two months.
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Example 5	On August 1, Alice moved to a nursing home. Her eligibility for HCBWs ended and she was determined eligible for Nursing Home Medicaid beginning August 1. She is still making the \$100 payments to the hospital, and has an outstanding balance of \$900. However, Alice used \$1,800 to meet a deductible and already received a deduction of \$200 from her community waiver cost share. The payment cannot be used as a medical expense deduction from her income when calculating the monthly patient liability.
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Example 6	In January, Lyle was institutionalized and applied for Medicaid. Due to a previous divestment, Lyle has a three-month divestment penalty period, beginning in December. During this three-month period, Medicaid will not cover the cost of Lyle's institutional care, but will only cover his card services. In March, the divestment penalty period expired, and Lyle is eligible for Medicaid payment of his institutional cost share. He would like to use \$2,000 of his monthly income to pay for the nursing home bills that he incurred in January and February and deduct this amount from his cost share. The request to allow an adjustment in Lyle's cost share must be denied because the medical expense that he wants deducted from his income is to pay for the cost of institutional care incurred during a prior Medicaid divestment penalty period.
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●—The expense is unverified.

CARES Process

Enter allowable expenses on the Medical Expense Page for Institutional and Group B Waivers cases. See [Process Help Section 11.11 Medical Expenses](#).

27.10 ILTC Liability Effective Dates

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

- Eligibility redetermined **before** adverse action: Effective the first of the following month.
- Eligibility redetermined **after** adverse action: Effective the first of the month after the following month.

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

Decreases in patient liability or cost share are always effective the first of the month in which the decrease ~~in income~~ occurs or the decrease is reported, whichever is later.

Liability changes must be reviewed when coverage was maintained following a reported change or a timely renewal. Once eligibility is able to be redetermined, liability amounts for months with coverage maintained may need to be reduced. See [Process Help Section 12.18.10.1.2 Restoration of Benefits for Institutional Medicaid](#).

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

27.11 Institutions for Mental Disease (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.

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

[Shorewood Behavioral Health](#)

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.

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)

28.6 HCBWLTC Eligibility Groups and Cost Sharing

28.6.3 Cost Share Amount

28.6.3.5 Medical/Remedial Expenses

The dollar amount of the applicant's medical and remedial expenses, as reported by the MCO care manager, ICA, or ADRC, must be deducted from income when calculating cost share. See [Section 15.7.3 Medical/Remedial Expenses](#) and [Section 20.3.6 Medical or Remedial Expenses](#).

Note ~~Care managers should refer to the limitations associated with allowable medical or remedial expenses that are described in Section 27.7.7 Medical or Remedial Expenses and Payments for Non-Covered Services.~~

Example In February, Alice became eligible for Group B HCBW Medicaid with a cost share of \$1100. In March, her MCO care manager verifies and reports a recurring medical expense of \$500 each month. Starting in March her cost share is reduced to \$600/month. In early September, Alice's care manager reports her medical expense for October will be \$0. Her cost share is recalculated for October and returns to \$1100/month.

33 SeniorCare

33.2 Application

33.2.1 SeniorCare Application Introduction

An individual interested in participating in SeniorCare must complete a SeniorCare Application form ([F-10076](#)). Applications may be printed from the Department of Health Services' SeniorCare web site at: <https://www.dhs.wisconsin.gov/seniorcare/apply.htm>. Local Aging and Disability Resource Centers may also have copies of the SeniorCare application. If the applicant is unsure where to obtain an application or wants to have one mailed, ~~he or she~~they should call 1-800- 657-2038 (TTY and translation services are available).

A \$30 enrollment fee per person is required as a condition of eligibility. If the enrollment fee is not sent with the application, the eligibility begin date could be delayed (See [Section 33.3.2 Enrollment Fee](#)).

SeniorCare applications should be mailed to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

Note: For benefit renewal requirements, see [Section 33.15 Annual Eligibility Renewal](#).

33.2.2 Application Processing

A valid application for SeniorCare is a SeniorCare Application form ([F-10076](#)) with the applicant's:

1. Name, **and**
2. Address, **and**
3. Signature (see [33.2.3 Signing the Application](#)) in Section ~~V~~4. Applications that are not signed in Section ~~V~~4 of [F-10076](#) ~~will be returned to the applicant.~~not be processed until after the department requests and receives a signature.

However, non-financial (see [Section 33.3 Nonfinancial Requirements](#)) and income ([33.6 Financial Requirements](#)) information is needed to determine eligibility.

"General Delivery" may be used for a mailing address but cannot be used as a residence address.

The presence of a signature on a SeniorCare application indicates intent to apply. When a signed application is received without an enrollment fee, the department will send an enrollment fee request notice to the applicant(s). An application will not be approved until an enrollment fee is received.

When an application is received with an enrollment fee(s) where the applicant(s) has answered "No" to the question "Are you Requesting SeniorCare?", the department will assume that there is a request for at least one person. When an

application is received without the enrollment fee where the applicant's answer to the question is "No", the department will follow up with the applicant(s) to determine his or her intent.

The date a valid application is received by the SeniorCare program is the application filing date. Eligibility for SeniorCare will be determined as soon as possible, but not later than 30 days from the date a valid application is received.

A delay in processing the application may occur if there is a delay in obtaining information or in receipt of the enrollment fee necessary for determining eligibility. If a delay occurs, the applicant will be notified in writing that there is a delay in processing the application. The notice will specify the reason for the delay and inform the applicant of his or her right to appeal the delay.

If the initial application is denied and the applicant wishes to reapply, ~~he or she~~ they should check the "New Application" box on the application form. "Reapplication" refers to current members who are requesting establishment of a new benefit period due to a change in circumstances.

33.2.3 Signing the Application

The applicant must sign the application form in Section ~~4V~~ of F-10076 (~~Section VI of the 07/02 version of F-10076~~) with ~~his or her~~ their signature, a mark or an "X", unless one of the following signs for ~~him or her~~ them:

1. A guardian of the estate, a guardian of the person and the estate, or a guardian in general.
2. An authorized representative.
3. A power of attorney/durable power of attorney. (Health Care Power of Attorney is not accepted as proof of authority.)
- ~~3-4.~~ A conservator that has been appointed by a court to manage the estate of the individual. (Copy of the document designating the signer of the application as the conservator is required).

33.2.3.1 Witnessing the Signature

If a SeniorCare applicant signs the application form in Section ~~4V~~ of F-10076 with a mark or an "X", the signature must be witnessed by two individuals. (~~Section VI of the 07/02 version of F-10076~~).

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 Authorization of Representative form (F-10080)~~. Appoint, Change or Remove an Authorized Representative: Person form (F-10126A) or Appoint, Change, or Remove an Authorized Representative: Organization form (F-10126B).

There can be only one authorized representative at a time ~~for a SeniorCare applicant or member~~ on a case. 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.~~ Once appointed, the authorized representative has the ability to act for all open programs on the case.

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~~ Appoint, Change or Remove an Authorized 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 and IM agency on any benefit-related matters
- File grievances or appeals regarding the applicant or member's ~~SeniorCare~~ eligibility

To change or remove an authorized representative, the member must complete and submit the ~~SeniorCare Authorization of Representative~~ Appoint, Change or Remove an Authorized Representative (Person F-10126A or Organization F-10126B) 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 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 ~~p~~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~~ Appoint, Change, or Remove an Authorized Representative (Person F-10126A or Organization F-10126B) 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.

3. Be a U.S. citizen or have qualifying immigrant status. (see [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~~ their 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](#)).

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~~ them 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.

Verify the SSN only once.

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
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 ~~their~~^{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.

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.

33.3.2.1 Refunds

No Application Received

If *EM CAPO* receives an enrollment fee without an application, a manual notice and application will be sent, if possible, to the individual from whom the enrollment fee was received. If a SeniorCare application is not received by EM CAPO within 45 days of the receipt of the enrollment fee, a refund will be processed at the request of the person who submitted the enrollment fee.

Application Denied

Anytime an application for SeniorCare is denied, a refund of the paid enrollment fee is automatically issued. A refund may be requested prior to eligibility being confirmed or within specified timelines outlined below.

Opt Out

In all opt-out cases, a refund will be issued only if the request to withdraw from the SeniorCare program is received by the later of:

- ~~Ten~~ 10 days following issuance of the eligibility notice, or
- 30 days from the application filing date.

The date by which a request for refund must be received will be printed on the initial eligibility determination notice. Filing of a hearing request will not delay these deadlines for refunds.

Refunds are based on individual participation. A SeniorCare member may receive an enrollment fee refund if ~~he or she~~ they received an initial eligibility notification, but have not received any SeniorCare prescription drug benefits or services and requests to withdraw from the program (see [Section 33.12.2 Withdrawal](#)).

SeniorCare prescription drug benefits include use of the SeniorCare card to receive discounted drug prices in levels 1, 2a, and 2b. A refund may be issued if such charges are reversed by the pharmacy.

Use of the SeniorCare card at Level 3 where a spenddown has not been met constitutes receipt of SeniorCare prescription drug services. A refund of the enrollment fee may be issued if such claims are reversed by the pharmacy.

Example 1:	Julie is a SeniorCare member at Level 2b. Julie's SeniorCare application filing date was October 26th, and her benefit period began November 1st. On November 15th, Julie calls the SeniorCare Customer Service hotline to withdraw from the SeniorCare program and request a refund of her \$30 enrollment fee. Julie used her SeniorCare card on November 10th, when she purchased a prescription. Although Julie requested a refund within 30 days of her application filing date, she is not entitled to a refund, because she received her prescription at a discounted cost by using her SeniorCare card.
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Example 2:	Mike is a Level 3 SeniorCare member. Mike's SeniorCare application filing date was October 28th and his benefit period began November 1st. On November 20th, Mike requests to withdraw from the SeniorCare program and that his \$30 enrollment fee be refunded to him. Mike used his SeniorCare card on November 18th, when he purchased a prescription; however, he had not met his Level 3 spenddown, so he did not receive a discounted price for his prescription. Mike is entitled to a refund of his enrollment fee if the pharmacy reverses this
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	prescription claim. He made the refund request within 30 days of his application filing date and he has not received any SeniorCare prescription drug benefits or services. If the claims are not reversed, Mike is not entitled to a refund.
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33.3.2.2 Refunds to Deceased Members

A refund may also be requested by the family member of a deceased member when all the following criteria are met:

1. ~~They~~ ~~He or she~~ received an eligibility notification, and
2. Death occurs prior to the start of or within 30 days of the beginning of the SeniorCare benefit period, and
3. The request is made within 45 days of the date of death; and
4. ~~He or she~~ ~~They~~ had not received any SeniorCare prescription drug benefits or services.

Example 3:	Henry was a SeniorCare member at Level 1 whose benefit period began December 1st. Henry passed away on December 4th. His daughter reported Henry's death to the SeniorCare program on December 10th, and requested a refund of his \$30 enrollment fee. Henry's SeniorCare card had been used on December 1st to purchase a prescription; however, the pharmacy had reversed those charges on December 5th, since Henry's prescription had not been picked up. The \$30 enrollment fee should be refunded in this case since Henry did not receive any SeniorCare prescription drug benefits or services.
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Note: If all of the above conditions are met, a refund will be issued even if the death is reported beyond the refund deadline date.

33.3.2.3 Opt-In

Once the opt-out of eligibility is confirmed, the ~~participant member~~ will have 30-days to contact the EM CAPO if ~~he or she~~ ~~they~~ chooses to "opt in" to the program. ~~He or she~~ ~~They~~ would need to send another enrollment fee if the original enrollment fee has been refunded. A new application is not required to opt in.

A ~~participant member~~ who decides after the 30-day period that ~~he or she~~ ~~they~~ wants to rejoin the program will need to complete a new application and submit the enrollment fee.

33.3.3 Age Limitation

SeniorCare is for people who are 65 years of age or older. The earliest SeniorCare eligibility can begin is the month after an applicant's 65th birthday.

A single applicant should apply for SeniorCare no sooner than the calendar month of ~~his or her~~ ~~their~~ 65th birthday.

When a couple applies where one spouse is 65 or older and the other is under 65 at the time of application, only the spouse that is 65 or older can be determined eligible. If both apply, the younger spouse would be denied SeniorCare unless they are turning 65 within the current or next calendar month. If the younger spouse will turn 65 within the 12-

month enrollment period, they will receive a notice pending their eligibility for the enrollment fee approximately one month prior to their 65th birthday.

33.3.5 Creditable Coverage

Wisconsin's SeniorCare prescription drug assistance program is considered to be creditable prescription drug coverage. This means SeniorCare meets or exceeds the standard Medicare Part D plan. If an individual chooses to enroll in SeniorCare instead of Medicare Part D, they will not have a penalty for Medicare Part D.

If an individual is enrolled in SeniorCare, they can keep SeniorCare and not pay extra if they decide to enroll in Medicare Part D later. However, if their SeniorCare coverage ends and they do not enroll in a Medicare Part D plan right away, they may have to pay more to enroll in Medicare Part D at a later date.

If an individual goes without creditable prescription drug coverage for 63 days or longer, their monthly premium for Medicare Part D will go up at least one percent for each month they did not have creditable coverage. For example, if they go nine months without coverage, their premium will always be at least nine percent higher ~~that~~ than if they had enrolled in Medicare Part D right away.

If individuals enroll in a Medicare Part D plan, their coverage will typically begin about a month after they enroll. If they need help paying for their prescription drugs and they are enrolled in SeniorCare, they may choose to remain enrolled in SeniorCare until their Medicare Part D coverage begins.

If an individual does not enroll in a Medicare Part D plan when they are eligible, they may have to wait until the next enrollment period before they can enroll. The enrollment period is from October 15 through December 7 each year, and coverage begins January 1.

Individuals with limited income and resources may be able to get extra help paying premiums, deductibles, and copayments for Medicare Part D. They can apply or get more information about Extra Help, also called the Low Income Subsidy, by calling the Social Security Administration at 800-722-1213 or visiting www.socialsecurity.gov/extrahelp.

If applicants have questions about SeniorCare and Medicare Part D, or need help choosing which prescription drug plan is best for them, they should be referred to a benefits specialist at their local aging and disability resource center (ADRC) or the Wisconsin Medigap Part D and Prescription Drug Helpline at 1-855-677-2783.

33.4 SeniorCare Fiscal Test Group

The FTG consists solely of an applicant, unless the applicant is married and resides with ~~his or her~~their spouse.

If the applicant is married and resides with ~~his or her~~their spouse, the FTG consists of both the applicant and ~~his or her~~their spouse. An applicant is considered to be residing with ~~his or her~~their spouse if the permanent residence of the spouse is the same as that of the applicant.

Exceptions: The FTG consists only of the applicant if any of the following apply:

1. One spouse is institutionalized and is expected to be out of the home for 30 or more days, ~~or~~
2. The applicant's spouse is a SSI recipient, ~~or~~
3. The applicants are married but are living separately, ~~or~~
4. Both spouses are living in a nursing home.

33.5 SeniorCare Benefit Period

33.5.1 SeniorCare Benefit Period Introduction

The benefit period for SeniorCare is 12 consecutive months. The benefit period and eligibility remain intact unless the member:

1. Moves out of state~~7~~
2. Reapplies ([33.11 Re-Application](#))~~7~~
3. Requests to withdraw from the program ([33.12 Early Termination](#))~~7~~
4. Dies~~7~~~~or~~
5. Becomes an inmate of a public institution~~7~~

Once eligibility has been established, any changes in income will not be considered until the next renewal, unless the individual reapplies for a new benefit period.

33.5.2 ID Cards

When an applicant is found eligible for SeniorCare, ~~he or she is~~they are mailed a plastic SeniorCare ID card and information about how to use it. SeniorCare members who renew their eligibility will continue to use their original card.

SeniorCare members must present their SeniorCare card to their pharmacy provider. The card does not show enrollment dates. The pharmacy provider will verify the member's enrollment at each visit.

If SeniorCare members have questions regarding their eligibility status or need a replacement SeniorCare card, they should call the SeniorCare Customer Service hotline at 1-800-657-2038.



33.5.3 Eligibility Begin Date

SeniorCare eligibility begins on the first day of the month following the month in which all eligibility requirements have been met. This includes receipt of a completed application and enrollment fee.

Exception: SeniorCare eligibility begins the day after Medicaid eligibility ends if a SeniorCare application is submitted prior to the Medicaid termination date and all eligibility requirements are met.

Example 1:	Carol applies for SeniorCare on September 19th and meets all eligibility requirements. Her application is processed on October 10th, and eligibility is confirmed the same day. Carol's benefit period is from October 1st through September 30th.
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Example 2:	William applied for SeniorCare on September 19th but did not submit the enrollment fee with his application. His eligibility pends and a notice is issued. William submits the fee on October 1st and eligibility is confirmed the same day. William's benefit period is from November 1st through October 31st.
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Example 3:	Mary is notified that Medicaid eligibility will end on November 30th because her assets exceed the program limit. She applied for SeniorCare on November 29th and will meet all SeniorCare eligibility requirements on December 1st (when she is no longer a full-benefit Medicaid member). Mary's benefit period is from December 1st through November 30th.
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Note: If a gap in coverage of not more than one month occurs due to an agency error, eligibility for a new 12-month benefit period begins the first of the month the completed application is received and all eligibility requirements are met, including payment of the annual enrollment fee.

Example 4:	Harold's Renewal Application was mailed to him on December 13th to be completed for his new benefit period that would begin February 1st. The Renewal Application was mailed to the last known address in CARES which belonged to Harold's wife Mary who was in a nursing home. Mary passed away on May 2nd of this year and although the IM worker ended her Medicaid eligibility, the case address was not updated in CARES. Harold has not moved, so he was not required to report a change of address to the SeniorCare program. Due to the incorrect address, Harold did not receive the Renewal Application form to complete until late in January. The completed Renewal Application was received by the SeniorCare program on February 10th, along with a letter explaining why it was late. Harold's new SeniorCare benefit period is February 1st through January 31st, since the one-month gap in coverage was due to an agency error.
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33.6 SeniorCare Financial Requirements

33.6.1 Assets

There is no asset test for SeniorCare. In general, cash that is received as a result of converting an asset from one form to another is not income. This includes withdrawals from savings and/or checking accounts, CDs, or money market accounts. However, special provisions apply to retirement benefits (see [Section 33.6.7 Gross Retirement Income](#)) and Cobell buy-out payments (see [Section 16.7.11.2 Lump Sum Payments Under the Settlement of the Cobell v. Salazar Class-Action Trust Case](#)). Income generated from any assets that the SeniorCare ~~participant~~ member may have is considered budgetable income and must be reported on the application or renewal application.

Example 1	Eric has a savings account with \$5,000 in it. Eric's savings account is considered an asset, but the interest that he anticipates earning is countable income. Eric anticipates withdrawing \$1,000 from his savings account during the coming year. This amount does not count as income. It is an asset that has been converted to cash. Only the interest Eric anticipates receiving from the savings account is countable income. Any withdrawals from his savings account are considered the conversion of an asset and are not counted as income.
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33.6.2 Income

Income for SeniorCare is based on what the FTG expects to receive in the next ~~12-month~~ 12-month period, beginning with the month of application. The incomes for the applicant and ~~his or her~~ their spouse are counted together if they live together. Applicants can use the previous year's information from tax returns or other sources as a guide when estimating what to report on their application. Applicants are asked to round income amounts to the nearest whole dollar when entering their good faith estimates on their SeniorCare application or renewal application.

Social Security income will always be verified. For all other income types, if reported amounts seem unreasonable or questionable, further verification may be obtained from the applicant or other available sources, such as a data exchange.

The income of a spouse who is in the SeniorCare FTG is included in the estimate of the annual, budgetable income even if ~~he or she does~~ they do not apply or ~~is~~ are nonfinancially ineligible. However, the spouse's income is not counted if one of the exceptions noted in ~~Section 33.4 Fiscal Test Group applies~~ Section 33.4 Fiscal Test Group applies.

Annual income is determined prospectively from the month of application through the next 12 calendar months. Income exempted for Medicaid eligibility is also exempted for SeniorCare (see [Section 15.3 Exempt and Disregarded Income](#)), including EITC and income tax refunds (see [Section 15.5.7 Income Tax Refunds](#)).

Budgetable income consists of projected gross annual income, except for self-employment income, which uses net income (see [Section 33.6.6 Self-Employment Earnings](#)).

In the following income related sections, policy is defined according to the categories on the SeniorCare Application form, [F-10076](#). All income listed in the following sections should be prospectively budgeted for a 12-month period beginning with the month of application.

33.6.3 Gross Social Security

When calculating anticipated gross annual Social Security income, ~~add~~ any deductions for Medicare Part B or D and court-ordered guardianship fees, alimony, and/or child support must be added to the net payment amount.

Exception: If a SeniorCare applicant is receiving Medicare premium assistance (see [Section 32.1 Medicare Savings Programs](#)), ~~his or her~~their monthly payment already includes the Medicare Part B premium.

The applicant should contact the SSA at 1-800-772-1213 if ~~he or she does~~they do not know ~~his or her~~their Medicare premium amount.

When the applicant is a surviving spouse receiving benefits under ~~his or her~~their spouse's Social Security number, the amount should be considered the applicant's income and reported under the applicant's income column of the application.

Social Security income is verified through the Social Security Administration data exchange.

33.6.5 Interest and Dividends

The SeniorCare applicant must report the estimated gross amount of all interest and dividends that they expect to receive in the next 12 months, beginning with the month of application. Sources of interest and dividends include, but are not limited to, the following:

- Bonds
- CDs
- Checking accounts
- Money market accounts
- Savings accounts
- Stocks
- Capital gains (see [Section 33.6.5.1 Capital Gains](#))
- Trusts (see [Section 33.6.5.2 Trusts](#))
- Annuities
- Land contracts (see [Section 15.4.7 Land Contract](#))
- Loans (see [Section 15.4.8 Loans, Promissory Notes, and Mortgages](#))

Payments do not need to be directly received. If they are rolled back into the asset, they still must be reported.

Irrevocable interest that a SeniorCare applicant receives for an irrevocable burial trust is not budgetable income.

Note Unlike Medicaid, income that is received irregularly and infrequently and is under \$20 per month ~~should~~must be reported as budgetable income for SeniorCare applicants.

33.6.5.1 Capital Gains

Budgetable income consists of all anticipated capital gains that would be reportable as capital gains to the IRS for tax purposes. All anticipated losses ~~should~~must be subtracted from the gross capital gains amount, and the net capital gain amount ~~should~~must be reported if it is greater than zero. Negative amounts should not be reported and will not be used to offset other types of income.

The principal or initial investment in the capital asset that the person receives in cash when ~~he or she~~they sells the asset is not considered income. That portion is considered a conversion of an asset from one form to another.

33.6.5.3 Joint Savings

Each person who is a holder in a joint savings account is assigned an equal share of the interest earned. The applicant or applicant's spouse should report only ~~his or her~~their individual share of the interest.

If the applicant and ~~his or her~~their spouse are not living together and hold a joint savings account, the applicant should only report their own~~his or her~~ share of the interest

33.6.7 Gross Retirement Income

Examples of retirement income that ~~should be~~are counted for SeniorCare include:

- Veterans retirement benefits
- Railroad Retirement Board benefits
- The taxable portion of IRAs, annuities, work-related retirement plans, and pensions

Retirement benefits include work-related plans for providing income when employment ends (e.g., pension, disability, or retirement plans administered by an employer or union). Other examples are funds held in an IRA and plans for self-employed individuals, sometimes referred to as Keogh plans.

The funds in retirement accounts, including IRAs, Keogh plans, etc., are assets and are therefore not counted for SeniorCare. However, periodic payments, withdrawals, and distributions the individual expects to receive from their retirement account or annuity in the next 12 months are counted as income. The only exception is when the individual has never previously made withdrawals from the account and ~~he or she~~they withdraws the full amount at one time. This is not considered a periodic payment and is not countable income.

Note Rolling over an IRA (transferring the funds from one IRA to another) is the conversion of an asset from one form to another. Any potential income from an IRA rollover is countable income for SeniorCare.

Example 2	Mike owns a \$2,000 IRA and plans to withdraw all of it this year. Mike has not withdrawn any money from this IRA in the past. If Mike withdraws the full \$2,000 at one time, the \$2,000 continues to be considered an asset. This is a conversion from one form of an asset to another.
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	If Mike were planning to make a one-time withdrawal of \$1,000 from the \$2,000 IRA in the next 12 months, the \$1,000 would be considered income. He should report this income on his SeniorCare application and it should be budgeted. If Mike were planning to withdraw \$100 monthly from his IRA in the next 12 months, the \$100 he plans to receive monthly from the IRA is counted as income. He should report this income on his SeniorCare application and it should be budgeted.
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33.6.8.1 Allocated Income From a Medicaid Member Spouse

A SeniorCare applicant whose spouse is a Medicaid member living outside the home (e.g., in a nursing home) must report the spousal income allocation amount (see [Section 18.6 Spousal Impoverishment Income Allocation](#)) as income.

Example 3	Betty is a Medicaid member and in a nursing home. She is allowed to allocate up to \$1,000 to her spouse, Carl, according to the notice she receives. Betty only actually has \$650 available, and of that, \$55 is set aside as her personal needs allowance. The \$595 per month that she allocates to Carl would be counted as unearned income for Carl. He would report \$7,140 as “Other Income” on his SeniorCare application.
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A SeniorCare applicant whose spouse is a Medicaid member living in the home (e.g., a community waivers participant) should not report income that is allocated to ~~him or her~~them. The allocated amount must be included in the income estimate for the Medicaid member spouse because ~~he or she is~~they are living in the home.

33.6.8.4 Veterans Benefits

Veterans benefit payments should be reported as income.

~~Don't count as income a~~Any portion of a veterans benefit that is an aid & attendance (A&A) or housebound allowance or is intended to help the beneficiary pay for their unreimbursed medical expenses is not counted (see [Section 15.3.26 VA Allowances](#)).

An applicant should check with the Department of Veterans Affairs (VA) at 1-800-827-1000 to determine what (if any) amount of their veterans benefit is considered an A&A or housebound allowance or is for unreimbursed medical expenses.

Reimbursement from the VA for medical costs does not count as income.

33.8 SeniorCare Countable Costs

33.8.1 SeniorCare Countable Costs Introduction

~~In order for the prescription drug purchase to~~ count towards meeting a spenddown or deductible, ~~it~~the prescription drug purchase must be:

1. Prescribed for the eligible SeniorCare member,
2. Purchased during the benefit period, and
3. Covered by the SeniorCare program (see [Section 33.6 Financial Requirements](#)).

All covered prescription drug costs the member incurs will be tracked, and the SeniorCare Program will coordinate coverage with other insurance companies if the member has other coverage. If the prescription is covered by other insurance, only the portion not paid by other insurance is applied toward the spenddown or deductible.

When a member's out-of-pocket expense requirements are met for a deductible or spenddown, participating pharmacies will be informed.

33.9 SeniorCare Addition of a Spouse

33.9.1 SeniorCare Addition of a Spouse Introduction

The following exceptions apply when one spouse (hereafter referred to as Spouse 2) is determined eligible after the participating spouse's (hereafter referred to as Spouse 1) benefit period has begun.

In all of these situations, Spouse 1's eligibility and benefit period does not change, unless ~~he or she chooses~~ they choose to reapply (see [Section 33.11 Re-Application](#)).

If Spouse 2 becomes eligible after Spouse 1's benefit period has begun, Spouse 2's benefit period ends on the same date that Spouse 1's benefit period ends.

The participation level for Spouse 2 depends on whether:

1. Spouse 2 was married and living with Spouse 1 at the time of Spouse 1's application (see [Section 33.9.2 Adding a Spouse No Change in FTG](#)).
 - a. If Spouse 1's eligibility was determined at level 2a or 2b, then refer to [33.9.2 Adding a Spouse No Change in FTG](#).
 - b. If Spouse 1's eligibility was determined at level 3 then refer to [Section 33.9.2.2 Adding a Spouse, No FTG Change, At level 3](#). Refer to the applicable policy depending on whether or not the spenddown has been met as follows:
 - i. ~~Met~~ Unmet spenddown (see [Section 33.9.2.2.1 Unmet Spenddown](#))
 - ii. ~~Unmet~~ Met spenddown (see [Section 33.9.2.2.2 Met Spenddown](#))

Or

2. Spouse 2 was not included in the FTG (e.g., single or not living with Spouse 1) at the time of Spouse 1's application (see [Section 33.9.3 FTG Changes](#)), but they are now residing together.
 - a. If ~~sp~~ Spouse 1's eligibility was determined at level ~~at level~~ 2a or 2b, refer to [Section 33.9.3.1 FTG Changes at Level 2a and 2b](#)
 - b. If ~~s~~ Spouse 1's eligibility was determined at level 3, refer to [Section 33.9.3.2 FTG Changes At Level 3](#)

See [33.9.4 Addition of a Spouse Summary Table](#)

33.9.2.1 Adding A Spouse, No FTG Change, At Levels 2a and 2b

Spouse 2's deductible is prorated if the couple's gross annual income is between 160% and 240% of the FPL, and Spouse 2 becomes SeniorCare eligible after Spouse 1's benefit period has begun. To prorate the deductible, multiply the required deductible amount (\$500 or \$850) is multiplied by the number of months in Spouse 2's benefit period and divided by 12.

Example 2	-Mary and Jim apply for SeniorCare in January. They have an annual income between 160% and 200% of the FPL for a FTG of two (see Section 39.11 SeniorCare Income Limits and Participation Levels). Their income places them in Level 2a with a \$500 deductible. Jim is determined eligible for SeniorCare, but Mary's eligibility for SeniorCare is denied because she is 64. Mary is refunded her enrollment fee. Jim's 12-month benefit period begins February 1st. Jim has a \$500 deductible. In June, Mary will turn 65. At adverse action in the month of May, CARES will process this case through batch. At that time, the application status is updated if the applicant who is turning 65 <u>is meets both of the following criteria:</u> 1. <u>Is</u> in an open SeniorCare case, ~~and~~ 2. ~~The individual h~~Has requested SeniorCare. A letter is sent to Mary notifying her that if she still wishes to participate in SeniorCare, she must submit her \$30 annual enrollment fee. If Mary's enrollment fee is received before July 1st, she will be determined eligible beginning July 1st. Because Mary paid her enrollment fee on July 5th, Mary's benefit period begins August 1st, and ends January 31st, when Jim's benefit period ends. Mary's deductible is prorated. Since there are six months in her benefit period, \$500 is multiplied by six and the total is divided by 12. $\\$500 \times 6 = \\$3,000 / 12 = \\$250$ Mary's deductible is \$250. Once Mary meets the \$250 deductible by purchasing covered prescription drugs, she is eligible to purchase covered prescription drugs at the co-payment amounts through the remainder of her benefit period. Jim's eligibility and benefit period are not affected. If the couple's income were between 200% and 240% of the FPL, the example would be the same except that the \$500 deductible would be \$850.
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33.9.2.2.1 Unmet Spenddown

When Spouse 2 is added before Spouse 1 has met the spenddown, covered prescription drug purchases of both spouses will count toward the remaining spenddown requirement.

After the spenddown has been met, both spouses begin to participate at Level 2b, and each will have a deductible requirement. The deductible for Spouse 1 is \$850. The deductible for Spouse 2 is prorated ([33.9.3.1 FTG Changes at Level 2a and 2b](#)).

~~Participants~~ Members will get a discount off the retail price for most covered prescription drugs during the deductible period.

After a spouse has met ~~his or her~~ their deductible, ~~he or she purchases~~ they purchase covered prescription drugs at the co-payment amounts for the remainder of the benefit period.

Example 3	Reginald and Elizabeth’s joint income is \$3,000 more than 240% of the FPL for a FTG of two. Elizabeth applies in December and is determined eligible for SeniorCare effective January 1. Only Elizabeth’s covered prescription drug costs are applied toward the spenddown. In March, Reginald turns 65 and is determined eligible for SeniorCare beginning April 1. His benefit period ends December 31, when Elizabeth’s ends. Since Elizabeth has not yet met the spenddown when Reginald’s eligibility begins, both spouses’ covered prescription expenses are applied toward the remaining spenddown amount, beginning April 1. In June, Elizabeth and Reginald meet the spenddown. Elizabeth has a \$850 deductible, but Reginald’s deductible is prorated. Since there are nine months in his benefit period, \$850 is multiplied by nine and the total is divided by 12. $\\$850 \times 9 = \\$7,650 / 12 = \\$638$ Reginald’s deductible is \$638. Once Reginald meets the \$638 deductible, he purchases covered prescription drugs at the copayment amounts through the remainder of his benefit period. Once Elizabeth meets her \$850 deductible, she purchases covered prescription drugs at the copayment amounts through the remainder of the benefit period.
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33.9.2.2.2 Met Spenddown

When a second spouse is added after the spenddown has been met, the eligibility and benefit period for Spouse 1 is not affected.

If Spouse 2’s income was included in Spouse 1’s determination and the spenddown has been met, the deductible for Spouse 2 is prorated ([33.9.2.1](#)). ~~Participants~~ Members will get a discount off the retail price for most covered prescription drugs during the deductible period.

After a spouse has met ~~his or her~~ their deductible, ~~he or she purchases~~ they purchase covered prescription drugs at the co-payment amounts for the remainder of the benefit period.

Example 4	Bob and Bernice’s joint income is \$1,000 more than 240% of the FPL for a FTG of two. Bernice applies in December and is determined eligible for SeniorCare effective January 1. Bob does not apply because he is not yet 65 years old. Only Bernice’s covered prescription drug costs are applied toward the spenddown amount of \$1,000. Bernice meets the spenddown requirement in April. She then begins purchasing covered prescription drugs that count toward her \$850 deductible. In June, she has \$100 left before she will meet her deductible. In May, Bob turns 65 and is determined eligible for SeniorCare. His eligibility begin date is June 1. His benefit period ends December 31, when Bernice’s ends. Since Bernice has already met the spenddown requirement, Bob will begin participating at Level 2b. His deductible will be prorated. Since there are seven months in his benefit period, \$850 is multiplied by seven and the total is divided by 12.
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	$\$850 \times 7 = \$5,950/12 = \$496$ Bob's deductible is \$496. After he meets the \$496 deductible by purchasing covered prescription drugs, he purchases covered prescription drugs at copayment amounts for the remainder of his benefit period. Bernice's eligibility and benefit period are not affected. Once she meets her deductible by purchasing another \$100 in covered prescription drugs, she purchases covered prescription drugs at the copayment amounts for the remainder of her benefit period.
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33.9.3 FTG Changes

When a married SeniorCare participant applies after Spouse 1's benefit period has begun, and Spouse 2 was not included in the FTG when the participation level for Spouse 1 was determined:

1. The gross annual income test for Spouse 2 is based on a FTG of two, **and**
2. Gross annual income for Spouse 2 is determined prospectively beginning with the month Spouse 2's request is received, **and**
3. The eligibility and benefit period for Spouse 1 is not affected, unless ~~he or she chooses~~ they choose to reapply.

Example 5	Jim is a SeniorCare participant from September through August. Because he was not married and living with a spouse when he applied, Jim's benefit level was based on a FTG of one. In January, Jim marries Helen. Helen applies for SeniorCare in February. Jim's eligibility is not redetermined when Helen applies. Helen's participation level is determined based on a FTG of two. Income is estimated for Helen prospectively for the 12-month period beginning in February. Helen's benefit period begins in March, if she met all eligibility requirements in February. Helen's benefit period ends in August, when Jim's benefit period ends.
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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 is multiplied by the number of months of Spouse 2's benefit period and divided 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~~ Members 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~~ they purchase covered prescription drugs at the copayment amounts for the remainder of the benefit period.

Example 7	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. 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. 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. 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. 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. $\\$1,000 \times 6 = \\$6,000 / 12 = \\$500$ 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. $\\$850 \times 6 = \\$5,100 / 12 = \\$425$ 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 the benefit period. Tim's eligibility and benefit period are not affected.
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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. 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.
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~~ <u>they choose</u> 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~~ <u>she</u> <u>they</u> ~~apply~~ <u>ies</u> . 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.

33.10 SeniorCare Changes

33.10.1 SeniorCare Changes Introduction

The following changes must be reported to the SeniorCare program within 10 days:

1. Address (including a change in mailing address or permanent residency outside of Wisconsin).
2. Household Composition (including marriage, divorce, separation, or someone moving to a nursing home or other medical facility).
3. Death.

Changes may be reported by phone to the SeniorCare Customer Service hotline at 1-800-657-2038.

Changes may also be reported by writing to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

Members are asked to include an SSN or case number on any written correspondence.

If an individual reports any changes before the case has been confirmed in CARES, the new information will be used in ~~their~~^{his or her} SeniorCare eligibility determination.

Changes reported after the case has been confirmed in CARES will be applied to the member's SeniorCare benefits as follows:

1. Address change:
 - a. Reports of address changes within Wisconsin will result in SeniorCare notices being sent to the new address. SeniorCare benefit levels will not change for the current benefit period.
 - b. Address changes that result in termination of Wisconsin residency result in discontinuation of SeniorCare benefits. The member will be provided with at least 10 days notice before the effective date of an adverse action

Note: Reporting an out-of-state address does not necessarily signify that an applicant is not a Wisconsin resident (see [Section 33.3 SeniorCare Nonfinancial Requirements](#)).

2. Death

If a member passes away, their SeniorCare eligibility will end as of the notice date.

If a member's spouse dies, the member will remain eligible at the same benefit level through the current SeniorCare benefit period. The member may wish to re-apply to establish a new benefit level if the spouse's death will result in a reduction in income.

3. Change in household composition

If a member experiences a change in household composition, the SeniorCare benefit level will not change

through the remainder of the SeniorCare benefit period. The member may wish to re-apply to establish a new benefit level if the change in household composition will result in a better level of participation.

4. Inmate of a Public Institution (see [Section 33.3.1 SeniorCare Nonfinancial Requirements Introduction, Number 6](#)).

If a member becomes an inmate of a public institution, their SeniorCare eligibility will end as of the notice date.

If a member's spouse is an inmate of a public institution the member ~~benefit level~~ will remain eligible ~~at~~ the same benefit level through the current SeniorCare benefit period. The member may wish to re-apply to establish a new benefit level if the spouse's incarceration will result in a better level of participation.

5. Change in Circumstance

If an applicant needs to correct their application, or has a change in circumstances during the application processing period, they may need to report this information before their eligibility is determined in order to have the change impact their SeniorCare eligibility and participation level.

Depending on the nature of a client-reported error or agency-discovered error, a member's eligibility will be redetermined (see [Section 33.10.2 Correction of Errors](#)). The member will be provided with at least 10 days notice before the effective date of an adverse action.

If the case has already been confirmed in CARES, and the individual reports a change in circumstances since they applied (for example, a job loss), eligibility will not be redetermined. The applicant may opt out and reapply if they so desire.

Example 1	Sally and Fred are husband and wife and applied for SeniorCare in July. Both Sally and Fred were found eligible at Level 2a with a deductible for August. In September, Fred loses his job. He reports the change to the SeniorCare program. This change will not affect Sally or Fred's SeniorCare benefits, because Fred reported the change after his case had been confirmed in CARES. If Fred had reported the change prior to his case being confirmed in CARES, the change would have been applied to Sally and Fred's eligibility determination, and they would have paid the co-payment amounts for prescription drugs. If Fred and Sally wish, they may request to file a reapplication (see Section 33.11 Re-Application) and submit enrollment fees to have their eligibility redetermined and change their benefit level. Without the income from Fred's job, Sally and Fred would be able to purchase prescription drugs at the co-payment level, if a reapplication is filed.
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33.10.2 Correction of Errors

All errors made on the SeniorCare Application ([F -10076](#)) must be reported by the member or ~~his or her~~ their Authorized Representative, POA, or Guardian to the SeniorCare Customer Services hotline at 1-800-657-2038 (TTY and translation services are available) or in writing to:

SeniorCare
P.O. Box 671
Madison, WI 53716-0710

An error may include, but is not limited to:

1. Doubling of income (for example, totaling income on the application incorrectly).
2. Incorrect entries (for example, income amounts are off by a factor of 100 due to the lack of decimal point).
3. Application processing errors.

An applicant who wishes to report a change in circumstances from what was on ~~his or her~~ their submitted application may do so, but to impact eligibility, this change should be reported prior to eligibility being confirmed in CARES (see [Section 33.10.1 #5 Change in Circumstance](#)).

If a member has been found eligible for either an incorrect SeniorCare benefit level or spenddown amount due to an error, action will be taken to correct the mistake. The effective date of the correction is based on whether the error is determined to be due to agency error or ~~A~~applicant/~~M~~member error, as follows.

33.10.2.1 Agency Error

Agency errors for SeniorCare will be determined on a ~~case-by-case~~ case-by-case basis. If the error resulted in an overpayment, ~~past~~the overpaid benefits ~~are not recoverable~~will not be recovered. If the error resulted in an underpayment, corrected benefits will be restored back to the initial eligibility date of the current benefit period.

33.10.2.2 Applicant or Member Error

If an applicant or member error resulted in an overpayment, ~~benefit recovery will not be pursued~~ the overpaid benefits will not be recovered, ~~and~~ if 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~~ they reported the error within 45 days of the mail date of the notice of decision, corrected benefits ~~should~~ will 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

In August, Charlie lost his 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.

Depending on when Charlie reports this error, his benefits may be corrected back to the eligibility begin date or the first of the month in which the error was reported (see [Section 33.10.2 Correction of Errors](#)).

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.

	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.
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Example 3	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. 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. <u>The earnings from Eric's part-time job</u> ~~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. 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. Prior to reporting this mistake, Eric had purchased several prescriptions at the copayment levels with his SeniorCare card. <u>These overpaid benefits will not be recovered.</u> 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.~~
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33.10.3 Fraud

Fraud is defined as intentionally getting or helping another person get benefits to which ~~he or she is~~they are not entitled. Penalties for fraud include a fine of up to \$10,000, imprisonment up to one year, or both, and suspension from the SeniorCare program.

Fraudulent acts include:

1. Intent to provide misleading, fraudulent, omitted, or incomplete information on the SeniorCare application;
2. Not reporting an event that knowingly affects initial or continued eligibility for SeniorCare;
3. Applying for SeniorCare on behalf of another person and use of any part of the benefit for oneself;
4. Allowing another person to use someone else's card to get prescription drugs.

33.11 SeniorCare Re-Application

SeniorCare ~~participants~~ members may request to establish a new SeniorCare benefit period at any time. However, it is not beneficial for a SeniorCare ~~participant~~ member to reapply unless ~~he or she~~ they will experience a reduction in gross annual income. The reduction in annual income may occur for various reasons, such as ~~varying from~~ loss of income, divorce, marriage, institutionalization or death of a spouse, or any other change that results in a significant decrease in income ~~to household composition changes~~. This could result in SeniorCare eligibility at a lower income level resulting in a reduction/elimination of spenddown or deductible.

~~Such a change may result from divorce, marriage, institutionalization or death of a spouse, or any other change that results in a significant decrease in income.~~

To reapply, ~~participants~~ members must submit a new application form and pay a \$30 enrollment fee per person. Eligibility will be redetermined for a new 12-month period (within 30 days) after a complete application is received.

When eligibility for a new benefit period is determined, the ~~participant's~~ member's previous benefit period is terminated, and ~~he or she is~~ they are not allowed to restart the previous benefit period. Any expenses applied to the previous benefit period will not be applied to the new benefit period.

Eligibility for a new benefit period begins on the first day of the month after a complete application is received and all eligibility requirements are met.

33.12 SeniorCare Early Termination

33.12.1 SeniorCare Early Termination

SeniorCare eligibility is terminated prior to the end of the established benefit period if:

1. A member no longer meets non-financial eligibility requirements, or
2. ~~S/he~~They requests to withdraw from the program, or
3. ~~S/he~~They requests to establish a new benefit period and eligibility for the new benefit period is confirmed (see [Section 33.11 Re-Application](#)).

When SeniorCare eligibility has been terminated prior to the end of the established benefit period and the SeniorCare ~~p~~Program is notified that all eligibility requirements are again satisfied, within one calendar month of SeniorCare eligibility termination, the benefit period is restored.

Exception: SeniorCare members who lose SeniorCare eligibility solely due to receipt of Medicaid benefits do not have their benefit period terminated; however, they are not eligible for SeniorCare benefits or services for the calendar months that they receive Medicaid benefits.

If Medicaid eligibility ends prior to the end of the SeniorCare benefit period, and the member is still SeniorCare eligible, SeniorCare eligibility automatically resumes.

Example 1:	Amy applies for SeniorCare on October 4th and is determined eligible effective November 1st. In December she applies for Medicaid and is determined eligible, effective December 1st. Amy is not eligible for SeniorCare benefits or services while she is receiving Medicaid. In January, Amy inherits \$5,000 and is notified that her Medicaid eligibility ends January 31st, because her assets exceed the limit. Amy still meets SeniorCare eligibility requirements, so SeniorCare eligibility will resume from February 1st through October 31st.
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See [Section 33.15 Annual Eligibility Review](#) for termination as it applies to the need for an annual review.

33.12.2 Withdrawal

Applicants or ~~participants~~members may withdraw from the SeniorCare ~~p~~Program at any time. To withdraw by phone, call the SeniorCare Customer Service Hotline at 1-800-657-2038.

A request to withdraw can be made in writing to:

SeniorCare
P.O. Box 6710
Madison, WI 53716-0710

A SeniorCare ~~participant~~member is eligible for an enrollment fee refund only if ~~he or she meets~~they meet the requirements listed in [33.3.2.1 Refunds](#).

If an applicant chooses to withdraw ~~his or her~~their application prior to eligibility confirmation, ~~he or she~~ they will get a refund. If they ~~he or she~~ later wishes to “opt in”, they ~~he or she will have to~~must re-apply. To re-apply, a new application and enrollment fee are required.

Once eligible, if a ~~participant member~~ chooses to “opt-out” and SeniorCare receives the request to withdraw within the timeframe for obtaining a refund, ~~he or she~~ they will get a refund of the original enrollment fee. If, within thirty calendar days of opting out, the ~~participant member~~ requests to opt in, ~~he or she~~they would need to send in another enrollment fee but would not have to send in another application form. Eligibility will be restored back to the beginning of ~~his or her~~their benefit period, once the fee is received and processed.

The enrollment fee must be received by the deadline identified in the CARES notice to comply with the administrative rule requirement that ~~he or she~~ they meets eligibility requirements. If within thirty calendar days of opting out ~~he or she~~ they does not contact SeniorCare and SeniorCare does not receive the enrollment fee, ~~he or she~~ they will have to submit a new application and another \$30 enrollment fee if ~~he or she~~ they wants to ~~come back into~~ re-enroll in the program.

If the ~~participant member~~ chooses to opt-out and does not do so within the timeframe for obtaining a refund, ~~he or she~~ they will not get a refund. SeniorCare Customer Service ~~should~~ would counsel the ~~participant member~~ that ~~he or she~~ they will not be getting a refund, and ~~he or she~~ they can keep their ~~his or her~~ case open in the event ~~his or her~~ their circumstances change and ~~he or she~~ they wants to use the SeniorCare benefit in the next 12 months.

If the ~~participant member~~ still opts out, but contacts SeniorCare within thirty calendar days of opting out to request to opt in, the original enrollment fee that had not been refunded will be applied. ~~He or she~~ They will not have to send in another application form. The person will be made eligible back to their original eligibility begin date for that benefit period. ~~This requires a manual work-around because the system will require another \$30 enrollment fee to be credited for CARES to process correctly.~~

33.13 SeniorCare Notice of Decision

A written notice is sent to the applicant indicating SeniorCare certification, benefit reduction, denial, or termination.

The initial notice of decision will provide information regarding total income used for determining the participation level. It will also provide the member with information regarding spenddown, deductible and co-payment amounts.

For reductions, denials, or terminations, the notice contains reasons for the action, with any supporting regulations. It also specifies fair hearing rights and the circumstances under which SeniorCare benefits will be continued if a hearing is requested.

SeniorCare members will be notified of an adverse action at least 10 days prior to the effective date of the adverse action, except under certain circumstances.

Timely notice requirements do not apply when:

1. A prescription drug billing must be reversed due to an incorrect billing, and that reversal results in a benefit or service change.
2. A member chooses to withdraw from the program.
3. A member requests to establish a new benefit period and eligibility for the previous benefit period is terminated (see [Section 33.11 Re-Application](#)).
4. A ~~person~~-member is an inmate of a public institution.
5. A member passes away.

33.14 SeniorCare Appeals

33.14.1 SeniorCare Appeals Introduction

SeniorCare applicants, ~~participants~~ members or representatives may file an appeal by writing to the Division of Hearings and Appeals (DHA) when one of the following occurs and the action is not the result of a general program policy change:

1. An application is denied, or the person is denied the right to apply.
2. An application is not acted upon within thirty calendar days.
3. A ~~participant~~ member believes that the benefits they ~~he or she~~ received, or the initial eligibility date of program benefits were not properly determined.
4. Program benefits are reduced, discontinued, suspended, or terminated.

An appeal may result in a hearing.

33.14.2 Requesting a Hearing

The SeniorCare applicant or ~~participant~~ member, or ~~their~~ his or her representative, ~~may~~ request a hearing. The request for a hearing must be made in writing to the DHA within 45 days from the effective date of the adverse action.

Benefits will be continued only if the ~~participant~~ individual requests a hearing prior to the effective date of the adverse action.

Hearings may be requested by writing to:

Wisconsin Department of Administration
Division of Hearings and Appeals
PO Box 7875
Madison, WI 53707-7875

33.15 SeniorCare Annual Eligibility Renewal

An annual eligibility review is required for each ~~participant~~ member by the end of the current 12 month benefit period to prevent a gap in coverage.

Members are mailed a preprinted Renewal Application and instructions approximately six weeks prior to the end of their current benefit period. The Renewal Application is preprinted with the information currently on file for the member. Members are required to review the information for accuracy, make any necessary changes, answer any questions, and return the signed form with their enrollment fee.

Eligibility for a new benefit period begins on the first day of the month immediately following the end of the previous benefit period when:

1. A valid pre-printed Renewal Application or new application form ([F-10076](#)) is received by the end of the current benefit period, and
2. All eligibility requirements are met, including payment of the \$30 annual enrollment fee per person.

Note: For the definition of “valid,” see [Section 3.2.2 Application Processing](#).

33.16 SeniorCare Benefits

33.16.1 SeniorCare Benefits Introduction

For all of the participation levels, SeniorCare allows the following:

1. The generic form of any covered prescription drug, unless the medical practitioner writes on the prescription that the brand name form of the covered prescription drug is medically necessary.
2. Insulins are the only general category of over-the-counter drugs that are covered.
3. For levels 1 and 2a all prescription drugs covered by Medicaid. Some limitations apply to prescription drug coverage for levels 2b and 3 if a rebate agreement has not been signed by the drug manufacturer.
4. Chemotherapy drugs that are FDA approved and the manufacturer has signed a rebate agreement.
5. Certain vaccines. For a list of covered vaccines, see [SeniorCare Vaccines](#).

Most prescriptions are limited to a 34-day supply of medication. There are a few classes of medications that are allowed to be filled as a three-month supply. Members should work with their pharmacist and prescriber to determine whether it is clinically appropriate to dispense a three-month supply. The co-payment amount is not affected by the number of days in the supply.

Note Some drugs require prior approval from the SeniorCare program, called prior authorization.

Note The member should contact ~~his or her~~their provider to verify that SeniorCare covers a specific drug.

SeniorCare does not cover the following:

1. Prescription drugs administered in a physician's office.
2. Prescription drugs that are experimental or are for a cosmetic and not a medical purpose.
3. Over-the-counter drugs such as vitamins and aspirin, even with a prescription.
4. Prescription drugs for which authorization has been denied.
5. Prescription drugs from manufacturers who have not signed the appropriate rebate agreement;
 - a. Prescription drugs for members in levels 1 and 2a are limited to drugs from manufacturers who have signed a federal rebate agreement.
 - b. Prescription drugs for members in levels 2b and 3 are limited to drugs from manufacturers who have signed a SeniorCare rebate agreement with the state of Wisconsin.
6. Drugs that have not been dispensed from a pharmacy.

If a member chooses to purchase a prescription that is not covered under SeniorCare, they are responsible for the cost at the pharmacy's retail price and it will not count towards their spenddown and/or deductible.

SeniorCare provides medication therapy management (MTM) services. The MTM services are provided by the pharmacist to answer the member's questions about the drugs they get. The goal of MTM services is to help the member understand more about the drugs they take, make sure they are taking their drugs properly, and make sure they are only taking drugs they need.

33.16.2 Discount Pricing

The discount for a particular drug during the deductible period will be the same at every pharmacy. During the deductible period, the pharmacy must use the SeniorCare allowed price.

Exception: If a pharmacy's usual and customary charge is less than the SeniorCare allowed amount, then the ~~participant~~ member would be charged the usual and customary charge and this amount will apply to SeniorCare spenddown and/or deductible.

33.16.3 Early Refills

When the ~~participant~~ member is temporarily leaving the state and the supply on ~~his or her~~ their prescriptions is insufficient, ~~he or she~~ they will need to make arrangements with the pharmacist to have any additional refills mailed or have someone else pick-up the refill. Postage costs are not covered by SeniorCare, nor do they count toward the deductible and/or spenddown. Requests for early refills will be denied.

33.16.4 Out-of-State Pharmacies

In an emergency, a ~~participant~~ member can get a prescription filled out of state and have it count toward SeniorCare as long as the ~~participant~~ member is within the US, Canada, or Mexico and the pharmacy completes the necessary forms.

Out-of-state pharmacies should contact 1-800-947-9627 to file a claim for reimbursement. Non-emergency prescriptions will be covered only when prior authorization has been granted.

39.4 Elderly, Blind, or Disabled Assets and Income Tables

39.4.1 Elderly, Blind, or Disabled Assets and Income Table

Category	Limit	Group Size 1	Group Size 2	Effective	Updated Annually?
SSI-Related Categorically Needy	Asset	\$2,000.00	\$3,000.00	1/1/1989	No
	Income	~~\$1,077.78~~ \$1,086.16	~~\$1,623.05~~ \$1,636.26	~~1~~ 5/1/2026	Yes
SSI-Related Medically Needy	Asset	\$2,000.00	\$3,000.00	1/1/1989	No
	Income	\$1,330.00	\$1,803.33	2/1/2026	Yes
MAPP	Asset	\$15,000.00	N/A	3/1/2000	No
	Income	Less than 250% FPL (see SECTION 39.5 FPL TABLE)		2/1/2026	Yes
Institutions Categorically Needy	Income	\$2,982.00	N/A	1/1/2026	Yes
Group B Community Waivers	Income	\$2,982.00	N/A	1/1/2026	Yes
QMB	Asset	\$9,950.00	\$14,910.00	1/1/2026	Yes
	Income	At or below 100% FPL (see SECTION 39.5 FPL TABLE)		2/1/2026	Yes
SLMB	Asset	\$9,950.00	\$14,910.00	1/1/2026	Yes
	Income	At least 100% FPL but less than 120% FPL (see SECTION 39.5 FPL TABLE)		2/1/2026	Yes
SLMB+	Asset	\$9,950.00	\$14,910.00	1/1/2026	Yes
	Income	At least 120% FPL but less than 135% FPL (see SECTION 39.5 FPL TABLE)		2/1/2026	Yes
QDWI	Asset	\$4,000.00	\$6,000.00	7/1/1990	No
	Income	\$2,660.00	\$3,606.66	2/1/2026	Yes

39.4.3 LTC Post-Eligibility Allowances

Item	Amount	Effective	Updated Annually?
Institutions Personal Needs Allowance	\$55.00	7/1/2024	No
Institutions Home Maintenance Allowance Maximum	~~\$1,173.77~~ \$1,191.75	~~1~~ 5/1/2026	Yes

Non-Spousal- Impoverishment Family Maintenance Allowance Maximum	\$1,173.77	1/1/2026	Yes
Community Waivers Basic Needs Allowance	~~\$1,174.00~~ <u>\$1,192</u>	~~1~~ 5/1/2026	Yes
Community Waivers Personal Maintenance Allowance Maximum	\$2,982.00	1/1/2026	Yes

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

Description	Amount	Effective	Updated Annually?
Community Spouse Lower Income Allocation Limit	\$ <u>3,606.66</u> ~~3,525.00~~	7/1/ ~~2025~~ <u>2026</u>	Yes
Shelter Base Amount	~~\$1,057.50~~ <u>1,082.00</u>	7/1/ ~~2025~~ <u>2026</u>	Yes
Community Spouse Income Allocation Maximum	\$4,066.50	1/1/2026	Yes
Dependent Family Member Income Allowance Maximum	~~\$881.25~~ <u>901.67</u>	7/1/ ~~2025~~ <u>2026</u>	Yes
Dependent Family Member Income Allowance Standard	\$ <u>2,705.00</u> ~~2,643.75~~	7/1/ ~~2025~~ <u>2026</u>	Yes
Community Spouse Asset Share (CSAS) Maximum	\$162,660	1/1/2026	Yes

39.4.7 SSI Reference Values

Item	Group Size 1	Group Size 2	Effective	Updated Annually?
Federal SSI Payment Level	\$994.00	\$1,491.00	1/1/2026	Yes

State Supplementary Payment (SSP)	~~\$83.78~~ <u>92.16</u>	~~\$132.05~~ <u>145.26</u>	~~1994~~ <u>05/1/2026</u>	No
SSI E Supplement	~~\$95.99~~ <u>105.59</u>	~~\$345.36~~ <u>379.90</u>	~~1994~~ <u>05/1/2026</u>	No
Substantial Gainful Activity Threshold for Non-Blind Disabled Individuals	\$1,690.00	N/A	1/1/2026	Yes
Substantial Gainful Activity Threshold for Blind Individuals	\$2,830.00	N/A	1/1/2026	Yes