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

From: Bureau of Eligibility and Enrollment Policy

Re: **Medicaid Eligibility Handbook Release 24-02**

Release Date: 08/22/2024

Effective Date: 08/22/2024

EFFECTIVE DATE		The following policy additions or changes are **effective 08/22/2024** unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY UPDATES		
2.5.1.1	**Signatures From Representatives**	Corrected typo.
6.1.2	**Migrant Workers**	Updated to clarify migrant worker residency policy.
7.2.4	**U.S. Citizenship Verification through Documentation**	Updated to reflect that the SAVE Database and Birth Query are now stand-alone documentation of U.S. citizenship.
7.2.4.1	**Stand-Alone Documentation of U.S. Citizenship**	Updated to reflect that the SAVE Database and Birth Query are now stand-alone documentation of U.S. citizenship.
7.2.4.2	**Evidence of U.S. Citizenship**	Updated to reflect that the SAVE Database and Birth Query are now stand-alone documentation of U.S. citizenship.
7.2.4.3	**Evidence of Identity**	Updated to reflect that the SAVE Database and Birth Query are now stand-alone documentation of U.S. citizenship.
7.2.4.4	**Reasonable Opportunity Period for Verification of Citizenship**	Updated to reflect that there is no limit to the number of reasonable opportunity periods a person may receive.
7.2.7.5	**Non-U.S. Citizens**	Updated to reflect that the SAVE Database and Birth Query are now stand-alone documentation of U.S. citizenship.
7.3.2.2	**Reasonable Opportunity Period for Verification of Immigration Status**	Updated to reflect that there is no limit to the number of reasonable opportunity periods a person may receive.
7.3.3.3	**Iraqis and Afghans with Special Immigrant Status**	Updated class of admission codes for special immigrants from Iraq or Afghanistan.
7.3.3.5	**Ukrainian Parolees**	Updated to remove the Class of Admission Codes table, and linking to Process Help for further information on mapping to CARES Immigration Status Codes.

15.3.14	**Payments to Native Americans**	Added information for payments to Michigan Indian Claims Settlement Act (MICSA).
15.3.31	**Cash and In-Kind Items Received in Conjunction with Medical and Social Services**	Updated to reflect that in-kind items received in conjunction with medical or social services are not counted as income.
15.3.36	**Guaranteed Income Payments**	Removed the $500 monthly limit from the guaranteed income exemption.
16.7.26	**Uniform Gifts/Transfers to Minors Act**	Updated to reflect the age of majority for Uniform Gifts to Minors may be up to 21 years old.
16.7.34	**Guaranteed Income Payments**	New section regarding asset treatment of guaranteed income payments.
16.7.36	**Medicare Set-Aside Arrangements**	New section.
20.3.1	**Mandatory Verification Items Introduction**	Updated list and links to reflect current CARES processing information.
20.3.11	**Tribal Membership, Descent, or Eligible to Receive Indian Health Services**	New section.
20.7.1.2	**Eligibility Renewals**	Updated the length of time for required verification from the 10th day to the 20th day.
20.7.1.3	**Late Renewals**	Removed 2014 effective date.
21.6.4.1	**Automatic Disenrollment**	Removed "Becoming eligible for Medicare" as HMO disenrollment reason.
21.11.3	**Determining the Copay Limit**	Removed CLA information to reflect CLAs no longer being subject to premiums.
22.4.5	**Required Documentation**	Updated the VCL due date from 10 days to 20 days.
26.2.2	**Begin Month**	Updated to clarify initial premium payment requirements.
26.3.1	**Medicaid Purchase Plan Nonfinancial Requirements Introduction**	Clarified nonfinancial requirement related to work.
26.3.8	**Institutionalization**	Updated terminology to "premium gross income."
26.3.9	**Community Waivers**	Updated terminology to "premium gross income."
26.4.1.1	**Independence Accounts**	Clarified how non-retirement accounts lose their independence account status.
26.5	**MAPP Premiums**	Section rewritten.
26.5.2	**Initial Premium**	Updated to clarify initial premium payment requirements.
26.5.3.1	**Payment Methods**	Updated to clarify initial premium payment requirements.
26.5.4	**Ongoing Cases**	Clarified that members enrolled in EFT do not get premium statements mailed to them each.
26.5.5	**Late Payments**	Section rewritten.
26.5.5.1	**Between Due Date and Adverse Action of the Benefit Month**	Deleted section.
26.5.5.2	**Between Adverse Action of the Benefit Month and the Last Day of Benefit Month**	Deleted section.

26.5.5.3	**Anytime in Month After the Benefit Month**	Deleted section.
26.5.5.4	**Late Payments**	Deleted section.
26.5.6	**Non-Payment**	Section rewritten.
26.5.6.1	**Insufficient Funds**	Updated to reflect removal of MAPP RRPs.
26.5.6.2	**Partial Payments**	New section.
26.5.7	**Opting Out**	Updated to reflect removal of MAPP RRPs.
26.6	**MAPP Restrictive Re-Enrollment Period (MAPP)**	Deleted section and marked Reserved.
27.11	**Institutions for Mental Disease (IMDs)**	Updated list of IMDs.
28.6.4.2.1	**Family Maintenance Allowance Calculation - Minor Child**	Updated to reflect change to non-spousal impoverishment family maintenance allowance for minor children. Now based on 100% FPL rather than AFDC limits.
31.1	**Migrant Workers**	Reorganized Chapter 31 Migrant Workers for clarity. These policies will be situated primarily in the BadgerCare Plus Handbook. Added cross reference to BadgerCare Plus Migrant Workers chapter.
31.2	**Reserved**	Deleted section and marked Reserved.
31.3	**Reserved**	Deleted section and marked Reserved.
31.4	**Reserved**	Deleted section and marked Reserved.
34.1.2	**Determination of Emergency Services Eligibility**	Clarified that the child support agency and cooperation policies apply to Emergency Services members in the note.
37.4.1	**Group A**	Removed phrase about BadgerCare Plus premiums.
39.6	**COLA Disregard**	Updated the COLA disregard table to align with the annual update.
39.9	**BadgerCare Premiums Income Exceeds 150% of the FPL**	Deleted section and marked Reserved.

Contents

2.5 Valid Signature

2.5.1 Valid Signature Introduction

2.5.1.1 Signatures ~~F~~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, and public assistance programs.

   If the applicant only has a guardian of the person, and the applicant's guardian does not have the authority to enroll the person in BadgerCare Plus, Medicaid, or public assistance programs, the guardian can sign the application since they are acting responsibly for an incompetent or incapacitated person. A guardian of the person who does not have the authority to enroll the person in Medicaid or public assistance programs cannot appoint an authorized representative. The applicant must be the one to appoint an authorized representative if they choose to have one.

   The applicant may appoint their guardian of the person to be their authorized representative. If the applicant has appointed their guardian of the person to be their authorized representative, the guardian may sign the application as the authorized representative.

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

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

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

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

4. **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 agency 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 the durable power of attorney for finances authority continues notwithstanding any subsequent disability or incapacity of the applicant.

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

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

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

6.1 Residency Eligibility

6.1.2 Migrant ~~Farm Worker~~Workers

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

~~A migrant who meets the following conditions is a Wisconsin resident:~~

1. ~~His or her primary employment in Wisconsin is in the agricultural field or cannery work, and~~
2. ~~He or she is authorized to work in the US, and~~
3. ~~He or she is not related (immediate family) by blood or marriage to the employer (as distinguished from a "crewleader"), and~~
4. ~~He or she routinely leaves an established place of residence to travel to another locality to accept seasonal or temporary employment.~~

7.2 Verifying U.S. Citizenship

7.2. 4 U.S. Citizenship Verification Through Documentation

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

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

~~Those who are not exempt from the citizenship verification requirement and have not had their citizenship verified by the Social Security Administration~~

If verification cannot be obtained through the SSA, birth record query, or SAVE, the individual must provide verification of U.S. citizenship~~. Verification will consist of~~ through either stand-alone documentation of citizenship (see SECTION 7.2.4.1 STAND-ALONE DOCUMENTATION OF CITIZENSHIP) or both documentation of citizenship (see SECTION 7.2.4.2 EVIDENCE OF CITIZENSHIP) and identity (see SECTION 7.2.4.3 EVIDENCE OF IDENTITY). Whether benefits may be granted while waiting for documentation to be provided and for how long are discussed under the Reasonable Opportunity Period ~~section~~ for Verification of Citizenship (see SECTION 7.2.4.4 REASONABLE OPPORTUNITY PERIOD FOR VERIFICATION OF CITIZENSHIP).

If an individual has provided proof of U.S. citizenship in a state other than Wisconsin, the IM worker can either request that the individual resubmit the documentation or request and obtain a copy or electronic copy of the original documentation reviewed by the other state to keep on file in Wisconsin.

If an applicant/member contacts the agency for help with verifying citizenship, work with him or her to determine if anything on the document list in Process Help, Section 68.3 Acceptable Citizenship and Identity Documentation is readily available to the applicant/member. In certain circumstances the agency can authorize payment of documentation for an applicant/member. See SECTION 7.2.5 AGENCIES PAYING FOR DOCUMENTATION

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

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

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

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

7.2.4.1 Stand ~~alone~~ Alone Documentation of U.S. Citizenship

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

An applicant or member who does not provide a stand-alone document must provide documentation of both U.S. citizenship and identity (see SECTION 7.2.4.2 EVIDENCE OF CITIZENSHIP and SECTION 7.2.4.3 EVIDENCE OF IDENTITY).

Stand-Alone Document	Description/Explanation
Certificate of Naturalization	Form N-550 or N-570. Issued by the Department of Homeland Security for naturalization.
Certificate of Citizenship	Form N-560 or N-561. The Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.
A State-issued Enhanced Driver's License	A special type of driver's license identified specifically as an "Enhanced Driver's License". It requires proof of U.S. citizenship to obtain. Five states currently issue enhanced driver's licenses (Minnesota, Michigan, New York, Vermont, and Washington), but more states are expected to issue these licenses in the future. Accept an Enhanced Driver's License issued by any U.S. state. REAL IDs are not Enhanced Driver's Licenses. REAL IDs only provide documentation of identity, not citizenship.
U.S. Passport	The Department of State issues this. A U.S. passport does not have to be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation. Do not accept any passport as evidence of U.S. citizenship when it was issued with a limitation. Passports issued with a limitation may only be used as proof of identity.
Tribal Identification Documents	Documentary evidence issued by a federally recognized Indian tribe, which meets all the following criteria: • Identifies the federally recognized Indian tribe that issued the document • Identifies the individual by name • Confirms the individual's membership, enrollment, or affiliation with the tribe

	Such Tribal identification documents include, but are not limited to: • A Tribal enrollment card; • A Certificate of Degree of Indian Blood; • A Tribal census document; and • Documents on Tribal letterhead, issued under the signature of the appropriate Tribal official A photograph is not required to be part of these documents.
SAVE Database	Using the SAVE system to verify citizenship status for non-citizens who gained U.S. citizenship.
Birth Query	A birth record query confirms a person's birth in Wisconsin.

7.2.4.2 Evidence of U.S. Citizenship

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

If an applicant whose U.S. citizenship has not been verified by SSA, birth query, or SAVE database is unable to provide stand-alone documentation of U.S. citizenship (see SECTION 7.2.4.1 STAND-ALONE DOCUMENTATION OF U.S. CITIZENSHIP), they must provide other documentation proving U.S. citizenship.

Any document used to establish U.S. citizenship must show either a birthplace in the U.S. or that the person is otherwise a U.S. citizen (see the chart below or Process Help, Section 68.3 Acceptable Citizenship and Identity Documentation).

If an applicant is unable to provide any of the acceptable documents of U.S. citizenship, they may submit an affidavit signed by another person under penalty of perjury, who can reasonably attest to the applicant's U.S. citizenship. The affidavit must contain the applicant's name, date of birth, and place of U.S. birth. The affidavit does not have to be notarized. The applicant may submit a Statement of Citizenship and/or Identity (F-10161) or another affidavit.

Applicants whose U.S. citizenship cannot be verified by SSA or through stand-alone documentation of U.S. citizenship must also provide documentation of identity (see SECTION 7.2.4.3 EVIDENCE OF IDENTITY).

Acceptable Documentation of Citizenship Only	**Description/Explanation**
Final Adoption Decree	The adoption decree must show the child's name and U.S. place of birth. Where an adoption is not finalized and the state in which the child was born will not release a birth certificate prior to final adoption, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.
Birth Certificate	A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986). The birth record document may be recorded (previously 'issued') by the ~~State, Commonwealth, Territory~~state, commonwealth, territory, or local jurisdiction. Note: A Puerto Rican birth certificate used to verify U.S. citizenship of anyone applying for health care benefits must have been issued on or after July 1, 2010. Older birth certificates that were used to verify citizenship for persons when they previously applied for any IM program before October 1, 2010, are still considered valid.
~~**Birth Query**~~	~~A birth record query confirms a person's birth in Wisconsin.~~
U.S. birth record amended more than 5 years after person's birth	An amended U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after January 13, 1941), Guam (on or after April 10, 1899), the Virgin Islands of the U.S. (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986). Must show a U.S. birthplace.
Acquired citizenship through parent(s) as outlined in the Child Citizenship Act 2000 (CCA)	An individual demonstrates that s/he has gained his/her U.S. Citizenship through the Child Citizenship Act of 2000.
US Citizen ID Card or Northern Mariana Card	U.S. Citizen ID Card The Immigration and Naturalization Service (INS) issued the I-179 and the I-197 from 1960 until 1983 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Northern Mariana Card Form I-873. Issued by INS for those born in the Northern Mariana Islands before November 4, 1986.

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

	Island, or the Northern Mariana Islands (after November 4, 1986). The birth record document may be recorded (previously 'issued') by the ~~State, Commonwealth, Territory~~state, commonwealth, territory, or local jurisdiction.
Religious Record or Baptismal Certificate	An official religious record. The document must show a US birthplace and either the date of birth or the individual's age at time the record was made.
Certification of Report of Birth	The Department of State issues a DS-1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth.
Certification of Birth Abroad	Form FS-545. Issued by the Department of State consulates prior to November 1, 1990.
Consular Report of Birth Abroad of a US Citizen	Form FS-240. The Department of State consular office prepares and issues this. Children born outside the U.S. to U.S. military personnel usually have one of these.
~~**SAVE database**~~	~~Using the SAVE system to verify citizenship status for non-citizens who gained US citizenship.~~
Written Affidavit (Form F-10161)	If the applicant cannot produce the accepted documents verifying U.S. citizenship, ~~then~~ a ~~Written Affidavit~~written affidavit may be used. ~~If the documentation requirement needs to be met through an affidavits, the following rules apply:~~The affidavit must: • ~~It must be~~Be signed under penalty of perjury by ~~an individual~~a person other than the applicant~~,~~ who can reasonably attest to the ~~applicant's~~applicant's citizenship~~, and~~ • ~~That contains~~.Include the ~~applicant's~~applicant's name, date of birth, and place of U.S. birth. ~~The affidavit must be signed under penalty of perjury.~~ The affidavit ~~does not have~~doesn't need to be notarized. The "Citizenship Statement" section of the Statement of Citizenship and/or Identity form (F-10161) may be used for the affidavit.

7.2.4.3 Evidence of Identity

If an applicant whose U.S. citizenship is not verified by SSA is unable to provide stand-alone documentation of citizenship (see Section 7.2.4.1 Stand-alone Documentation of Citizenship), they must provide evidence of both citizenship (see Section 7.2.4.2 Evidence of Citizenship) and identity.
As a reminder, for health care, verification of identity must not be requested or required for:

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

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

In addition, the IM agency may accept proof of identity from a Federal agency or another State agency, including but not limited to a law enforcement, revenue, or corrections agency, if the agency has verified and certified the identity of the person. If the applicant does not have any documentation of identity and identity is not verified by another Federal or State agency, they may submit an affidavit, signed under penalty of perjury, by a person other than the applicant who can reasonably attest to the applicant's identity. Such affidavit must contain the applicant's name and other identifying information establishing identity, as described above. The affidavit does not have to be notarized. The applicant may submit a Statement of Citizenship and/or Identity (F-10161) or another affidavit.

Acceptable Documentation of Identity Only	Description/Explanation
State or Territory Driver's license	Driver's license issued by a U.S. State or Territory either with a photograph of the individual or other identifying information of the individual such as name, age, sex, race, height, weight, or eye color. REAL IDs only provide documentation of identity, not citizenship. Note: Real IDs only provide documentation or identity, not citizenship.
Education Document	For children under age 19, school records providing the name and other identifying information. School records would include, but not be limited to report cards, daycare, or nursery school records.
FoodShare Identification Requirement met	Verifying the identity of the primary person is a requirement for a FoodShare application. Once this requirement is met for FoodShare, it is also met for the identity verification requirement for health care.
Identification card issued by Federal, State, or local government	Must have the same information as is included on driver license.

Institutional Care Affidavit (Form F-10175)	If the applicant cannot produce the accepted documents verifying identity, a signed Statement of Identity for Persons in Institutional Care Facilities (F-10175)– may be used. A residential care facility administrator signs this form under penalty of perjury attesting to the identity of a disabled individual in the facility.
U.S. Military card or draft record, Military dependent's identification card, or US Coast Guard Merchant Mariner card	Must show identifying information that relates to the person named on the document.
Medical record	Doctor, clinic, or hospital records for children under age 19 only.
Motor Vehicle Data Exchange	This is a data exchange update with the Division of Motor Vehicles or when verifying an individual's identity through the DOT Driver License Status Check website.
Multiple Identity documents	An individual may provide 2 or more corroborating ID documents to verify his/her identity. Examples include marriage license, divorce decree, high school or college diploma, or an employer ID card.
Other MA Program Verified Identity	An individual has already provided proof of identity while they were receiving Wisconsin Medicaid outside of CARES. For example, use this for members previously enrolled through the Katie Beckett program.
State ID Paid by Agency	Must have the same information as is included on driver license.
School Identification card	School identification card with a photograph of the individual ~~and/~~or other identifying information.
Written Affidavit for Children (Form F-10154)	If the applicant cannot produce the accepted documents verifying identity for children under 18 years of age, a– Statement of Identity for Children Under 18 Years of Age (F-10154)is acceptable. The affidavit must be signed under penalty of perjury by a parent, guardian or caretaker relative stating the date and place of birth of the child. The affidavit does not have to be notarized.
Written Affidavit (Form F-10161)	If the applicant cannot produce the accepted documents verifying identity, ~~then a Written Affidavit~~a written affidavit may be used. ~~If the documentation requirement needs to be met through an affidavit, the following rules apply:~~ ~~It~~The affidavit must ~~be~~: • Be signed under penalty of perjury by an individual other than the applicant, who can reasonably attest to the applicant's identity~~, and~~.

	• ~~That contains~~ Contain the applicant's name, and other identifying information such as, age, sex, race, height, weight, eye color, or address. • The affidavit doesn't need ~~must be signed under penalty of perjury. The affidavit does not have~~ to be notarized. The "Identity Statement" section of the Statement of Citizenship and/or Identity form (F-10161) may be used for the affidavit.~~A signed may be used for individuals who are unable to obtain any level of acceptable documentation.~~

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

Applicants who are otherwise eligible for Medicaid or other health care benefits and are only waiting for verification of U.S. citizenship must be certified for health care benefits within the normal application processing timeframe (see Section 2.7 Application Processing Period). They can continue receiving health care benefits for which they are eligible while the IM agency waits for U.S. citizenship verification. Applicants have 90 days after receiving a request for U.S. citizenship verification to provide the requested documentation. This 90-day period is called the reasonable opportunity period (ROP). The 90-day ROP starts on the date after the member receives the notice informing them of the need to provide U.S. citizenship verification by the end of the reasonable opportunity period. Federal regulations require that states assume a minimum five-day time frame for applicants to receive notices. For this reason, the end of the ROP must be no less than 95 days after the date on the notice, even when the member receives the notice in less than five days. 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 citizenship verification is needed from a person at any time: applications, reviews, and when a person is newly requesting benefits on an existing case.

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

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

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

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

7.2.7 Situations which Require Special Documentation Processing

7.2.7.5 Non-U.S. Citizens

IM agencies must not request or require citizenship verification from persons who have not declared that they are U.S. citizens. Non-U.S. citizens who apply for IM programs are not subject to ~~this~~citizenship verification policy. ~~Legal~~Documented non-U.S. citizens are subject to the verification process through Federal Data Services Hub (FDSH) and Systematic Alien Verification for Entitlements (SAVE), and undocumented non-U.S. citizens do not have any status that can be verified (see Process Help, Chapter 82 SAVE)

Undocumented non-U.S. citizens can apply for Emergency Medicaid or BadgerCare Plus Prenatal Program and are not subject to the citizenship verification policy. They also do not have to verify their identity.

~~When a~~A person who had legal non-U.S.-citizen status and subsequently ~~gains~~gained U.S. citizenship, ~~this is recorded in~~ should be verified through SAVE. Therefore, SAVE can be used to verify these persons' U.S. citizenship. The verification result from SAVE will be "individual is a US Citizen~~" (see Process Help,). These persons still must provide proof of identity.~~."

7.3 Immigrants

7.3.2 Verification

7.3.2.2 Reasonable Opportunity Period for Verification of Immigration Status

Applicants who have declared that they are in a satisfactory immigration status, are otherwise eligible and are only pending for verification of immigration status must be certified for health care benefits within the normal application processing timeframe (30 days from the filing date). They are to continue receiving health care benefits for which they are eligible, while the IM agency waits for immigration status verification. Applicants who are otherwise eligible and are only pending for verification of immigration will have 90 days after receiving a request for immigration 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 ~~for the member~~ to provide immigration verification by the end of the reasonable opportunity period. Federal regulations require that we assume a minimum five-day time frame for applicants to receive notices. For this reason, we must set the end of the ROP no less than 95 days after the date on the notice, even when the member receives the notice in less than ~~5~~ five days. It also means that if a member shows that a notice was received more than ~~5~~ five days after the date on the notice, the deadline must be extended to ~~we must extend the deadline to~~ 90 days after the date the member received the notice.

The 90-day ROP applies when immigration verification is needed from a person at any time: applications, renewals 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.

~~Applicants who fail to provide verification of immigration status and later reapply for health care benefits are not eligible for another ROP. If verification of immigration status is still needed, eligibility may not be granted until verification is provided. The regular verification deadlines apply.~~

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. ~~in the following situations:~~

- ~~The person was not a U.S. citizen when first applying for benefits and received a reasonable opportunity period to verify immigration status. Later, the person became a U.S. citizen and applied for benefits. The person may receive a reasonable opportunity period to verify U.S. citizenship.~~
- ~~The person is an immigrant who must reverify his or her immigration status at renewal (see Section Reverification of Immigration Status). This person may receive an additional reasonable opportunity period for each subsequent renewal, as long as he or she provided the requested verification during the previous reasonable opportunity period.~~

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 ~~the worker to submit~~ a secondary verification request to SAVE. Vladimir is otherwise eligible for Medicaid~~, so the worker confirms~~ and is enrolled in Medicaid ~~eligibility~~ and ~~sends~~ 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 – Lawfully Residing, his immigration status must be verified again. Once more, the FDSH ~~informs the worker that~~response requires verification of the ~~child's~~child's status ~~must be done~~ through SAVE. If Vladimir is otherwise eligible for Medicaid, ~~the worker must again confirm eligibility~~they will be enrolled without delay and ~~send~~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 ~~the worker is waiting to verify~~ his immigration status~~.~~ is being verified.1

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 of Refugee Resettlement (HHS ORR). She is enrolled in BadgerCare Plus eligibility and is sent the ROP notice requesting Sasha submit a letter from HHS ORR. Sasha never submits a letter from HHS ORR 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. 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 ORR. Again, Sasha is eligible for BadgerCare plus for 90 days after receiving the notice while waiting for Sasha to provide a letter from HHS ORR.

Benefits issued during a reasonable opportunity period to a person otherwise eligible for Medicaid or BadgerCare Plus are not subject to recovery, even if the person turns out to have an immigration status that makes him or her ineligible for Medicaid or BadgerCare Plus benefits.

7.3.3 Immigrants Eligible for Medicaid

7.3.3.3 Iraqis and Afghans with Special Immigrant Status

Special Immigrants from Iraq or Afghanistan (Class of Admission Codes SI and SQ-1, 2, 3, 6, 7, and 8 and SW1, 2 and 3) are to be treated like they are refugees when determining their eligibility for Medicaid for as long as they have this Special Immigrant status. This policy applies to these immigrants regardless of when they received this status.

Class of Admission Code	Description	CARES Alien Registration Status Code
SI1 or SQ1	~~Nationals of Iraq or Afghanistan serving as interpreters with the U.S. Armed Forces~~Principal Applicant Afghan or Iraqi Special Immigrant	Code 04
SI2 or SQ2	~~Spouses of an SI1~~Spouse of Principal Applicant Afghan or Iraqi Special Immigrant	Code 04
SI3 or SQ3	~~Children of an SI1~~Unmarried Child under 21 Years of Age of Afghan or Iraqi Special Immigrant	Code 04
SI6 or SQ6	~~Nationals of Iraq~~Principal Applicant Afghan or ~~Afghanistan serving as interpreters with~~Iraqi Special Immigrant Principal Adjusting Status in the U.S. ~~Armed Forces~~	Code 04
SI7 or SQ7	~~Spouses of an SI6~~Spouse of Principal Applicant Afghan or Iraqi Special Immigrant Principal Applicant Adjusting status in the U.S.	Code 04
SI8 or SQ8	~~Children of an SI6~~Unmarried Child Under 21 Years of Age of Afghan or Iraqi Special Immigrant Principal Applicant Adjusting Status in the U.S.	Code 04
SW1	Surviving Spouse or Child of an SQ1-eligible person	Code 04
SW2	Current spouse of SW1	Code 04
SW3	Unmarried child of SW1	Code 04

In addition, immigrant Afghan spouses and children of former Special Immigrants who have become United States citizens are also to be treated like they are refugees when determining their eligibility for Medicaid. This treatment is to continue for as long as they have a status of Special Immigrant Conditional Permanent Resident (SI CPR). The Class of Admission codes for SI CPRs are CQ1, CQ2, and CQ3.

7.3.3.5 Ukrainian Parolees

Ukrainians and persons with no nationalities who were residing in Ukraine and subsequently paroled into the United States between February 24, 2022, and September 30, ~~2023~~2024, are to be treated as refugees when determining their eligibility for Medicaid.

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

- The spouse or child of a person described above paroled between February 24, 2022, and September 30, ~~2023~~2024.
- The parent or legal guardian, or primary caregiver(s) of an unaccompanied child described above who was paroled between February 24, 2022, and September 30, ~~2023.~~2024.

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

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

See Process Help, Section 82.6 SAVE Responses Mapping to CARES Immigration Status Codes Chart for detailed information including class of admission codes for Ukrainian humanitarian parolees.

15.3 Exempt/Disregarded Income

15.3.14 Payments to Native Americans

Disregard the following payments to Native Americans:

1. Menominee Indian Bond interest payments
2. All judgment payments to tribes through the Indian Claims Commission or Court of Claims
3. Payments under the Alaskan Native Claims Settlement Act
4. Payments under the Maine Indian Claims Settlement Fund
5. Payments under PL 93-124 to the Sisseton-Wahpeton Sioux Tribe, except individual shares over $2,000
6. Payments under PL 93-134 to the Maricopa Ak-Chin Indian Community, Navajo Tribe, Coast Indian Community of the Resighini Rancheria, Stillaguamish Tribe, Pueblo of Taos Tribe, Walker River Paiute Tribe, and White Earth Band of the Minnesota Chippewa Tribe, except individual shares over $2,000
7. Payments under PL 94-114 to the Bad River Band and Lac Courte Oreilles Band of Chippewa Indians and the Stockbridge-Munsee Indian Community of Mohicans
8. Payments under PL 96-318 to the Delaware Tribe of Kansas and of Idaho
9. Payments under PL 96-420 to the Houlton Band of Muliseet Indians, the Passamoquoddy, and Penobscot
10. For EBD Medicaid cases, under PL 98-64, disregard all Indian judgment funds held in trust by the Secretary of the Interior for an Indian tribe and distributed on an individual basis to members of the tribe. Also disregard interest and investment income from these funds
11. Payments under PL 99-346, Saginaw Chippewa Indian Tribe of Michigan
12. Payments under PL 99-377 to the Mille Lacs, Leech Lake, and White Earth, Minnesota reservations
13. Payments under PL 101-41, Puyallup Tribe of Indians Settlement Act of 1989
14. Payments under the Distribution of Judgment Funds Act of 1987 to the Cow Creek Band, Umpqua Tribe
15. Payments under the Distribution of Indian Judgment to the Crow Creek and Lower Brule Sioux except individual shares over $2,000
16. Payments under the settlement of the Cobell v. Salazar class-action trust case
17. Non-gaming tribal income from the following sources:
    a. Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from one of the following:
        i. Rights of ownership or possession in any lands held in trust, subject to federal restrictions, located within the most recent boundaries of a prior federal reservation or otherwise under the supervision of the Secretary of the Interior
        ii. Federally-protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources
    b. Distributions resulting from real property ownership interests related to natural resources and improvements:
        i. Located on or near a reservation or within the most recent boundaries of a prior federal reservation or
        ii. Resulting from the exercise of federally-protected rights relating to such real property ownership interests.

18. Disregard Tribal Per Capita payments from gaming revenue up to the first $500 of the monthly payment per individual. If the payments are received less than monthly, prorate the gross This applies to eligibility determinations for all Medicaid subprograms for elderly, blind, or disabled persons except the following:
    a. SeniorCare
    b. LTC programs, such as the following:
        i. Institutional Medicaid
        ii. HCBW
        iii. Managed LTC or IRIS

        For these subprograms, which are treated differently because they are covered under a different section of federal law, count all income from Tribal Per Capita payments from gaming revenue as unearned income.
19. Per capita payments from a tribe that come from natural resources, usage rights, leases, or royalties
20. Payment from natural resources, farming, ranching, fishing, leases, or royalties from land designated as Indian trust land by the Department of Interior (including reservations and former reservations)
21. Money from selling things that have cultural significance
22. Tribal general welfare payments that are based on the individual's demonstration of need, even if the source of the payment is gaming revenue
23. Payments under the Michigan Indian Claims Settlement Act (MICSA) to the Sault Ste. Marie Tribe of Chippewa Indians and the Bay Mills Indian Community

15.3.31 Cash and In-Kind Items Received in Conjunction with Medical and Social Services

The treatment of cash and in-kind items received in conjunction with medical and social services depends on whether ~~they are~~ it is provided by a governmental or nongovernmental organization.

To be considered governmental, the program must be authorized by federal, state, or local law, statute, or ordinance to provide medical or social services. ~~An example of~~This includes entities that are under contract with a ~~governmental medical and social~~federal, state, or local government to provide services ~~program is~~ . For example, a managed care organization for Medicaid for dual eligible special needs plans (D-SNPs).

Disregard any cash provided by a governmental medical or social services program. ~~Disregard in-kind items (including food or shelter) provided by a governmental medical or social services program unless the items are provided as payment for sheltered employment or as incentive payments.~~

Example 10	Mariel received a prepaid debit card from her D-SNP plan as a "wellness benefit" that she can use to purchase healthy food and over-the-counter medications. The funds on the debit card are disregarded.

~~For~~Disregard cash provided by a nongovernmental medical or social services organization if either of the following conditions is met:~~, and in-kind items disregard the following:~~

- ~~Room and board provided during an inpatient stay.~~
- ~~In-kind items (other than food or shelter) provided for medical or social services purposes. Food or shelter is not exempt unless excluded under some other provision (such as room and board provided during an inpatient stay).~~

~~Cash,~~

- The cash ~~is~~ for approved medical or social services already received.
- The cash is only for the future purchase of medical- or social service-related items

In-kind benefits (including food or shelter) received in conjunction with medical and social services are not counted as income for Wisconsin Medicaid programs regardless of whether they are provided by a governmental or nongovernmental program.

15.3.36 Guaranteed Income Payments

Guaranteed income from a privately funded, non-profit organization ~~up to $500 per month is excluded.~~ is excluded for all categories of Medicaid.

~~This includes but is not limited to payments from the Madison Forward Fund~~ Guaranteed income includes, but is not limited to, payments from the Madison Forward Fund and The Bridge Project in Milwaukee.

See SECTION 16.7.34 GUARANTEED INCOME PAYMENTS for information about asset treatment of guaranteed income payments.

16.7 Liquid Assets

16.7.26 Uniform Gifts/Transfers to Minors Act

~~Do not count funds held in an account for the benefit of a minor that are the result of transfers under the~~The Uniform Gifts to Minors Act~~. This act is also called~~ (UGMA) and the Uniform Transfers to Minors Act~~.~~ (UTMA) allow property to be transferred to an adult or trust company who holds the property as custodian for the minor. UGMA/UTMA property is required by statute to be transferred to the beneficiary when they reach the age of majority (usually at the age of 18 or 21 depending on state law). ~~There~~

Funds held in a UGMA or UTMA custodial account are unavailable to the beneficiary.

When the beneficiary reaches the age of majority and the custodianship ends, the property becomes available to the beneficiary. It is ~~no~~counted as income in the month of transfer and as an asset ~~test for minors for EBD eligibility determinations~~in the following month.

16.7.34 ~~Reserved~~Guaranteed Income Payments

Guaranteed income from a privately funded, non-profit organization that is retained in the month after the month of receipt is excluded as an asset indefinitely if separately identifiable (See section 16.3 Separate and Mixed Assets).

Guaranteed income includes, but is not limited to, payments from the Madison Forward Fund and the Bridge Project in Milwaukee.

See SECTION 15.3.36 GUARANTEED INCOME PAYMENTS for information about income treatment of guaranteed income payments.

16.7.35 ~~Reserved~~D-SNP Wellness Benefits

Wellness benefits provided by a dual eligible special needs plan (D-SNP), including, but not limited to, debit cards that can be used to purchase healthy food and over-the-counter medications, are disregarded as assets.

For income treatment of D-SNP wellness benefits, see SECTION 15.3.31 CASH RECEIVED IN CONJUNCTION WITH MEDICAL AND SOCIAL SERVICES.

16.7.36 ~~Reserved~~Medicare Set-Aside Arrangements

A Workers Compensation Medicare Set-Aside Arrangement (WCMSA) or Medicare Set-Aside Arrangement (MSA) is an agreement between Medicare and the Medicare beneficiary to take a portion of a workers' compensation or other injury-related insurance settlement and set those funds aside for all future injury-related medical expenses that would normally be paid by Medicare.

Medicare set-aside arrangements are not subject to any special treatment under Medicaid rules. WCMSA/MSA funds must be evaluated to determine if they meet the Medicaid definition of an available asset (see SECTION 16.2.1 ASSETS AVAILABILITY INTRODUCTION).

Note	There may be cases in which WCMSA/MSA funds are placed into a trust that is exempt for Medicaid purposes, such as a special needs trust (see SECTION 16.6.5 SPECIAL NEEDS TRUSTS) or pooled trust (see SECTION 16.6.6 POOLED TRUSTS), in which case the WCMSA/MSA funds may be disregarded under those trust provisions.

20.3 Mandatory Verification Items

20.3.1 Mandatory Verification Items Introduction

The following items 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 ~~and incapacitation~~(see SECTION 5.2 DETERMINATION OF DISABILITY)
- Income (see SECTION 15.1 INCOME INTRODUCTION)
- Assets ~~for the Elderly, Blind, and Disabled (see~~(see SECTION 16.1 ASSETS INTRODUCTION)
- Divestment, for Medicaid long-term care programs (see CHAPTER 17 DIVESTMENT)
- Medical expenses~~, for deductibles only~~ used to meet a deductible (see SECTION 24.2 MEDICAID DEDUCTIBLE INTRODUCTION)
- ~~Medical/~~Out-of-pocket medical/remedial expenses for ~~noncovered services for an institutionalized person (see Section 27.7.7.2 Disallowed~~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)~~Section 31.2 Simplified Application), if applicable~~)
- ~~For the~~ Institutional Medicaid patient liability home maintenance ~~allowance income~~ deduction (see SECTION 15.7.1 MAINTAINING HOME OR APARTMENT~~), physician certification (verbally or in writing) that an applicant or member who resides in a medical institution is likely to return to their home within six months~~)
- Temporary hardship for MAPP premium waiver (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.

20.3.11 Tribal Membership, Descent, or Eligible to Receive Indian Health Services

The following people are exempt from Medicaid copayments (see Section 21.5 Copayment):

- Members of American Indian and Alaska Native tribes
- Children of members of American Indian and Alaska Native tribes
- Grandchildren of members of American Indian and Alaska Native Tribes
- People eligible to receive Indian Health Services (IHS)

To receive these exemptions, verification of tribal membership, descent from a tribal member, or eligibility to receive IHS services is required. Verification may be done with a:

- Tribal Enrollment Card
- Written verification or a document issued by the tribe indicating tribal affiliation
- Certificate of degree of Indian blood issued by the Bureau of Indian Affairs
- Tribal census document
- Medical record card or similar documentation that specifies an individual is an Indian that is issued by an Indian health care provider
- Statement of Tribal Affiliation (F-00685)

20.7 When to Verify

20.7.1 Application and Renewal

20.7.1.2 Eligibility Renewals

~~Do~~Eligibility must not ~~deny the group's eligibility~~be denied for failure to provide the required verification until the ~~10th~~20th day after requesting verification~~.~~ or the end of the renewal month, whichever is later.

Example 1:	Fred's eligibility renewal is due in April. He submits a paper renewal form on April ~~10~~8. The worker requests verification of his income on April~~.~~9. Because his renewal was returned by adverse action and verification requested, his health care is extended by one month. ~~11 with a due date of April 21~~If the verification is not submitted by ~~April 21, the worker would update the verification code~~May adverse action, his eligibility will end on May 31.~~April 21 to QV and close benefits effective April 30. If Fred submits the verification by April 30 and is otherwise eligible, his benefits would reopen for May~~

Example 2:	~~Shannon's eligibility~~Shannon's renewal was due in June. At~~-~~ adverse action in June, a notice was sent to Shannon to let her know her Medicaid eligibility would end June 30 because she ~~had~~did not ~~yet~~complete her renewal. Shannon called the agency on June 30 and completed her renewal. ~~A telephone interview was conducted on June 30. A request for verification,~~Verification of income is requested with a July ~~10~~20 due date~~, was sent to~~. Shannon~~. Because~~ did not submit the required verification ~~(including signature) was not submitted~~ by July ~~10,~~ 20, so her eligibility beginning July 1 was denied. If Shannon submits the requested verification by September 30, it must be treated as a late renewal (see Section 3.1.6.1 Verification Requirements for Late Renewals)

20.7.1.3 Late Renewals

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

This policy applies to the following programs:

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

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

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

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

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

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

21.6 HMO Enrollment

21.6.4 HMO Disenrollment

~~Members may be disenrolled from the HMO for a variety of reasons. Some disenrollments are automatic, meaning the disenrollment occurs based on changes to the member's eligibility or enrollment status. There are also voluntary disenrollments, which can be requested by the member, the member's family, or a legal guardian, and involuntary disenrollments, which are requested by the HMO.~~

21.6.4.1 Automatic Disenrollment

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

Reason for Disenrollment	Disenrollment Date
Loss of Medicaid eligibility	End of the month in which Medicaid eligibility ends.~~the loss/termination occurred, even if that is prior to when the loss of benefits is effective~~
Date of Death entered	Date of Death
Moving outside of the HMO's service area	End of the month in which the move was reported
Incarceration or Institutionalization	End of the month in which the incarceration or institutionalization was reported
Enrollment in a Waiver program or Long-Term Care MCO	End of the month prior to the month waiver program or LTC MCO enrollment starts
~~Becoming eligible for Medicare~~	~~Depending on when notification of Medicare eligibility was received and the Medicare eligibility start date, if the notification is received:~~ ~~• Prior to the Medicare eligibility begin date, the disenrollment date is the end of the month in which notification was received.~~ ~~• After the Medicare eligibility begin date, the disenrollment date is the end of the month prior to the month of notification.~~

21.11 Five Percent Cost Share Limit

21.11.3 Determining the Copay Limit

For members enrolled in ~~BadgerCare Plus or EBD Medicaid subprograms~~ a health care program that ~~have~~has a copay limit, copay limits will be based on the assistance group's income used to determine eligibility. Per-member copay limits will be set based on the income tiers (see Section 39.12 Five Percent Copay Limit Tiers).

If the member is married and both spouses are enrolled in a health care program that has a copay limit (and neither spouse is exempt from copays), the copay limit will be prorated between them. If one spouse is exempt from copays (for example, due to pregnancy), the other spouse will have the full individual copay limit for their income tier.

Example 1:	Jane and Benji are married and enrolled in ~~medically needy~~ SSI-~~related~~Related Medicaid. The assistance group has counted income which puts their household income in the 50-100% of FPL income tier for an assistance group size of ~~2.~~two. Since both Jane and Benji are eligible and have to pay copays, the $26 copay limit for the household will be prorated between Jane and Benji. They will each have a monthly copay limit of $13.

Note:	If needed, use the following formula to determine the assistance group income FPL percentage and the appropriate tier: Assistance Group Income / (100% FPL for the group size) = Assistance Group Size % FPL.

If spouses are enrolled in two different health care programs (and both programs have a copay limit), the copay limit for the household will be calculated based on the assistance group with lower income and prorated between spouses. This will prevent the spouse with lower income from paying cost sharing expenses in excess of the five percent limit.

Example 2:	Dave, his wife Debbie, and their son Derek receive health care benefits. Dave is enrolled in SSI-Related Medicaid and Debbie and Derek are enrolled in BadgerCare Plus. Due to the different income budgeting rules for SSI-Related Medicaid and BadgerCare Plus: • The countable income for SSI-Related Medicaid is 69% of the FPL for a group size of two. That puts the SSI-Related Medicaid assistance group income in the >50-100% of FPL income tier. • The countable income for BadgerCare Plus is 48% of the FPL for a group size of three. That puts the BadgerCare Plus assistance group income in the 0-50% of FPL income tier. To determine the copay limit for the household, the lower BadgerCare Plus assistance group income tier of 0-50% of FPL will be used. Debbie, Dave, and Derek each have a $0 copay limit, meaning they will not be charged any copays.

If a member who is enrolled in a health care program that has a copay limit is married to someone who is enrolled in a program that has no copay limit (MAPP or SeniorCare), the member will have the full individual copay limit for his or her income tier.

Example 3:	Sean and Sandra are a married couple. Sean is enrolled in SeniorCare and Sandra is enrolled in medically needy SSI-related MA. The countable income for Sandra's SSI-Related Medicaid assistance group is 72% of the FPL, which puts this assistance group in the >50-100% of FPL income tier. Because Sean is enrolled in a program that has no copay limit, Sandra will pay the full individual copay limit of the income tier.

For members who are eligible for both QMB and a full benefit health care program that has a copay limit, the income used to determine eligibility for the full benefit program will be used to calculate the member's copay limit.

Example 4:	Dwayne is eligible for both SSI-Related Medicaid and Medicare. He also qualifies for QMB. Under SSI-Related Medicaid, Dwayne's income is in the >50-100% of FPL tier. His copay limit is $26 per month based on his SSI-Related Medicaid eligibility. Since QMB is a limited benefit program, no copay limit will be set for QMB. If Dwayne were only eligible for QMB, his copay limit would be set based on the income used to determine his eligibility for QMB.

~~For CLA members who pay a monthly premium, the premium amount will be subtracted automatically when the member's copay limit is calculated in CARES. For married couples with at least one spouse subject to CLA policy, the total household premium amount will be prorated evenly between the married couple's copay limits even if the spouses are on different benefit programs.~~

~~Example 5:~~	~~Destiny and Marcus are married. Destiny is eligible for BadgerCare Plus as a childless adult with an $8 household premium. Marcus is eligible for SSI-Related Medicaid. The income used falls within the >50-100% FPL tier. However, since Destiny has a household premium, the premium is split and deducted evenly from both copay limits (subtract $4 from each copay limit). After the premium is counted, they each have a copay limit of $9 ($13-$4=$9).~~

~~Example 6:~~	~~Alice and Barry are married and both eligible for BadgerCare Plus as childless adults with income at 85% of the FPL. They have a household premium of $6 because Alice completed a health survey and reported healthy habits while Barry did not. Their copay limit would be prorated at the >50-100% FPL tier and the $6 premium would be split evenly and deducted from their prorated copay limit (subtract $3 from both). Alice and Barry would each have a $10 copay limit.~~ ~~Alice suffers injuries from a car accident. She is verified as disabled and becomes eligible for SSI-Related Medicaid. Because Alice is no longer a childless adult, her health survey response does not result in a premium reduction for the household. Barry's household premium will increase to $8. The $8 premium would be split evenly and deducted from both Alice and Barry's copay limits (if they continue to have income greater than 50% of the FPL).~~

22.4 Undue Hardship

22.4.5 Required Documentation

An applicant or member (or his or her authorized representative, power of attorney, or legal guardian) must submit both of the following verifications of undue hardship (unless otherwise noted):

- A statement signed by the applicant or member (or his or her authorized representative) which describes the following:
    - In cases where a community spouse refuses to cooperate with the application process, documentation of all attempts to get cooperation from the community spouse,
    - In cases of divestment, whether the assets are recoverable, and if so, the attempts that were made to recover the divested assets,
    - In cases when an individual is denied due to having more than $750,000 in home equity, an explanation of why the home equity cannot be accessed
    - In cases where an individual in a spousal impoverishment case is denied due to excess assets, an explanation of why the excess assets cannot be accessed.
- Proof that an undue hardship would exist if eligibility is terminated or denied or the divestment penalty period is applied (required for all four situations to which Undue Hardship policy may apply) as follows:
- If the applicant or member is currently institutionalized, he or she must submit a copy of the notification from the long term care facility which states both of the following:
    - The date of involuntary discharge
    - An alternative placement location
- Or other proof that if the undue hardship waiver is not approved, the applicant or member will:
    - Not receive medical care resulting in his or hers health or life to be endangered
    - He or she will not have food, clothing, shelter, or other necessities of life.
- If the applicant or member is applying for HCBW, including FamilyCare, FamilyCare Partnership, PACE, or IRIS he or she must submit an estimate of the cost of the long term care services needed to meet his or her medical and remedial needs (as determined by the waivers case manager) and an estimate of costs for food, shelter, clothing, and other necessities of life.

  These two estimates must be compared to the applicant, member, or couple's income and assets. If the IM agency determines that the applicant or member does not have enough income and/or assets to pay for his or her long term care and other needs (i.e., food, shelter, etc.), consider the applicant or member's health to be endangered.

If the required documentation is not submitted with the request for an undue hardship waiver, send a written request for verification to the applicant or member, giving a verification due date of ~~10~~20 calendar days from the date the request is mailed. If the applicant or member fails to submit the required verification within ~~10~~20 calendar days after the request is mailed, deny the undue hardship waiver request and notify the applicant or member by sending a Notice of Denial of Benefits/Negative Change in Benefits (F-16001). The deadline to submit the required documentation may be extended for up to ~~ten~~10 calendar days if the individual communicates to the agency a need for additional time or assistance to obtain verification.

26.2 Application

26.2.2 Begin Month

MAPP eligibility can be backdated up to three months prior to the month of application (see SECTION 2.8.2 BACKDATED ELIGIBILITY). The member may be certified for MAPP for any backdate month in which they would have been eligible for MAPP had they applied in that month. ~~The~~ Before enrolling, the member is responsible for any premiums due (if owed) for the ~~previous~~ months in which they elect coverage, up to the current month (see SECTION 26.5.2 INITIAL PREMIUMS).

MAPP applicants can also choose to begin their eligibility:

- The month of application
- The month after the month of application
- Two months after the month of application (if processed after adverse action)

Example 1:	Jack applies for MAPP on September 30 and requests ~~a retroactive determination of eligibility~~backdated coverage for June, July, and August. His application is processed on October 21. He meets all eligibility requirements as of June. Jack can choose to begin MAPP eligibility in June, July, August, September, October, November, or December.

26.3 Nonfinancial Requirements

26.3.1 Medicaid Purchase Plan Nonfinancial Requirements Introduction

Members must:

- Meet general Medicaid nonfinancial requirements (see SECTION 4.1 WHO IS NONFINANCIALLY ELIGIBLE FOR MEDICAID?).
- Be at least 18 years old (there is no maximum age limit).
- Be determined disabled, presumptively disabled, or MAPP-disabled by the DDB, regardless of age (see Section 5.2 Determination of Disability and Section 5.10 Medicaid Purchase Plan Disability).
- Be ~~working in a paid position~~meeting or ~~participating in an HEC program~~ exempt from the work requirement (see SECTION 26.3.3 WORK REQUIREMENT and SECTION 26.3.4 WORK REQUIREMENT EXEMPTION).

Note:	People who are receiving Medicaid through SSI's 1619(b) program are nonfinancially eligible for MAPP. People who are SSI-eligible under 1619(b) can be on SSI Medicaid and MAPP at the same time. These people are not receiving an SSI cash benefit because they are working, but they meet certain specific SSI requirements that allow them to keep their categorical eligibility for Medicaid. SSI MA recipients have already had their assets verified by the Social Security Administration. Assets should not be re-verified for these individuals. Because this group is the most likely to move from SSI Medicaid to MAPP, DHS has decided to allow them to be eligible for both at the same time.

26.3.8 Institutionalization

Members in an institution may qualify for MAPP if they do not qualify for institutional Medicaid. If the member's monthly premium gross income exceeds 100~~ percent of the~~ % FPL for a group of one (see SECTION 39.5 FEDERAL POVERTY LEVEL TABLE), they are responsible to pay a monthly premium instead of a patient liability or cost share (see SECTION 27.7 COST OF CARE CALCULATION and SECTION 27.7.3 PARTIAL MONTHS).

26.3.9 Community Waivers

MAPP is a full-benefit Medicaid subprogram for community waiver participation (see SECTION 21.2 FULL-BENEFIT MEDICAID). If the member's monthly premium gross income exceeds 100~~ percent~~% of the FPL for a group of one (see SECTION 39.5 FEDERAL POVERTY LEVEL TABLE), they are responsible to pay a monthly MAPP premium instead of a cost share.

26.4 MAPP Financial Requirements

26.4.1 Assets

26.4.1.1 Independence Accounts

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

A member's deposits into an Independence Account may total no more than 50% of their gross earnings over the 12-month certification period. If the member's deposits exceed 50% of their actual gross earnings during the same 12-month certification period, a penalty is assessed (see SECTION 26.5.1.1 INDEPENDENCE ACCOUNT PENALTY). Amounts withdrawn from a MAPP Independence Account during the 12-month certification period do not affect the limit on the gross amount that may be deposited during the same period without penalty.

Example 1:	The agency is processing Fred's MAPP renewal. During the previous 12-month certification period, Fred earned $5,000 from his job and received $12,000 in unearned income. During that same period, he deposited $3,000 into his Independence Account. At one point he withdrew $500 from his Independence Account to pay for car repairs. The penalty is based solely on total deposits in excess of 50% of gross earnings over the twelve-month period. Withdrawals are not counted when determining the penalty. In this example, 50% of Fred's $5,000 earned income = $2,500. The $3,000 in deposits - $2,500 = $500 penalty

Independence Account Registration

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

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

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

Retirement Accounts

MAPP members may register their existing retirement or pension accounts as Independence Accounts. The amount that was already accumulated in the retirement or pension account before it was registered as an Independence Account is called the "Pre-Independence Account Balance." The Pre-Independence Account Balance is a countable asset. Funds may be deposited in a retirement or pension account that has been registered as an Independence Account during periods of MAPP ineligibility. However, any funds deposited during a period of MAPP ineligibility must be added to the account's Pre-Independence Account Balance and considered a countable asset.

Example 2:	Sheila is approved for MAPP. She has an established retirement account through her employer that currently has a $5,000 balance. The $5,000 was a countable asset for her eligibility determination. Sheila registers the retirement account as an Independence Account with the IM agency. The money deposited into this retirement account while Sheila is a MAPP member will be considered an exempt asset as a part of an Independence Account. The $5,000 Pre-Independence Account Balance remains a countable asset.

Example 3:	Tom is approved for MAPP. After he receives his Notice of Decision, he registers his existing IRA as an Independence Account. This IRA has a balance of $1,000 prior to registration as an Independence Account, so that $1,000 is a countable asset. Tom is eligible for MAPP from July to October, eligible for Medically Needy SSI-related Medicaid from November and December, and eligible for MAPP again in January. Although the amount deposited into his Independence Account in July, August, September, October, and January will be considered exempt assets when determining his eligibility for both MAPP and Medically Needy SSI-related Medicaid, any money deposited into the IRA during November and December would be added to the $1,000 Pre-Independence Account Balance and counted as an asset because Tom was not eligible for MAPP during those two months.

Non-Retirement Accounts

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

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

Non-retirement accounts registered as Independence Accounts may only have funds deposited during months when the member is eligible for MAPP. If any funds are deposited in a non-retirement account during a period of MAPP ineligibility, the entire account balance will be considered a countable asset.

Example 5:	Tom is approved for MAPP. After he receives his Notice of Decision, he opens a savings account and registers it as an Independence Account. Tom is eligible for MAPP from July to October, eligible for Medically Needy SSI-related Medicaid from November to December, and eligible for MAPP again in January. Although his Independence Account will be considered exempt when his eligibility for both MAPP and Medically Needy SSI-related Medicaid is determined, he may not deposit any money into the account during November and December because he is not eligible for MAPP during that time. If he does deposit money during those months, the Independence Account's entire balance will be considered a non-exempt asset.

For non-retirement accounts registered as Independence Accounts on or after August 1, 2020, there should be no Pre-Independence Account Balance at any time because the only deposits that are allowed into these accounts are those made while the account owner is a MAPP member.

For non-retirement accounts that were registered as Independence Accounts prior to August 1, 2020, any existing Pre-Independence Account Balance will continue to count for all Medicaid programs and the Independence Account Balance will be exempt for all Medicaid programs. However, no new funds may be deposited during months when the member is ineligible for MAPP. ~~If new funds are deposited during months when the member is ineligible, the entire asset will be counted.~~

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

26.5 MAPP Premiums

Effective August 1, 2024, MAPP applicants and members with gross monthly income over 100% of the FPL will be charged a premium.

Applicants with a filing date on or after August 1, 2024, with gross monthly income over 100% of the FPL must pay an initial premium to become eligible for MAPP.

26.5.2 Initial Premium

There are no free premium months. Before ~~eligibility confirmation~~enrolling in MAPP, the ~~member~~applicant must pay applicable premiums for the initial benefit month and for any requested backdated months for which ~~the member is~~ they are eligible and ~~requests coverage. If determining eligibility in~~are charged a premium. Premiums must be paid up to the current month, so if eligibility is not determined until the month after application, the premium for the ~~second~~current month also must be paid before ~~confirming eligibility.~~they can be enrolled in MAPP.

Example 5	Eric applies for MAPP on January 29, but his application is not processed until February 11. ~~The IM agency determines that he owes~~Eric was determined eligible for MAPP effective January 1 with a ~~$50~~monthly premium ~~per month. Before eligibility is approved (confirmed),~~of $50. Eric must pay a $50 premium for January and a $50 premium for February to open for MAPP.

Example 6	Eric applies for MAPP on January 29. Eric is requesting MAPP for February but not January. ~~CARES will not pend the case~~Eric is determined eligible for ~~February's~~MAPP effective February 1. Eric does not have to pay February's premium before MAPP opens because ~~you are processing~~ it ~~in January. Confirm the case. The Medicaid fiscal agent will pursue collection of the~~is for a future month. Eric will be enrolled in MAPP and be sent a premium ~~for~~statement to pay February's premium by the due date of February 10.

It is possible that an applicant owes a premium for some but not all initial months at application~~.~~ because premiums were suspended (before August 2024) or their income was lower. For example, ~~they request~~ if the applicant requests backdated coverage, and their monthly premium gross income was under 100% FPL during the backdated months, but their monthly premium gross income is over 100% FPL in the application month, ~~so~~ no premium is required for the backdated months, ~~but~~however, a premium is owed for application month. The premium for the application month (or the next month if the application is being processed after the application month) must be paid before the individual can enroll in MAPP. If the premium is not paid, eligibility can be granted for any months a premium was not required but will be denied for months a premium was not paid.

Example 7	Bernice applied for MAPP on March 10 and requested backdated eligibility for January and February. She had no income in January. She started a job in February, and her monthly premium gross income went over 100% FPL starting in March. On March 15, the worker determined that she met eligibility requirements effective January 1. Due to Bernice's income, she is not charged a premium for January or February but owes a premium beginning in March. Bernice must pay the March premium before her eligibility can be confirmed. If Bernice does not pay March's premium by the due date, she will only qualify for eligibility for the months of January and February.

Example 8	Jessie applied for MAPP on August 5, 2024, with a two-month backdate request. She was determined eligible for MAPP effective June 1, 2024, with a monthly premium of $25. Jessie does not owe a premium for June or July 2024, as MAPP premiums were not in effect. However, Jessie must pay the August premium to open for MAPP benefits for the month of August and ongoing. If Jessie's August premium is not paid, she will be determined ineligible for MAPP for August and ongoing, but she will be eligible for MAPP without a premium from June 1, 2024, to July 31, 2024.

The Medicaid Purchase Plan Premium Information/Payment (F-00332) is sent to the member with the verification checklist (VCL) notifying them of the premium amount due and where to submit the premium payment (see Process Help, Section 25.3 MAPP Premium Processing for Applications and Renewals).

An applicant could change or remove their request for backdated benefits if they are unable or do not want to pay the premiums.

Example 9	Vang applied for MAPP on October 8, with a two-month backdate request. He was determined eligible for MAPP effective August 1, with a monthly premium of $39. Vang must pay his monthly premium for August, September, and October to open for MAPP as of August 1. If Vang is unable to pay the premiums for all three benefit months at application, he can gain eligibility as of September 1 by paying the September and October premium, or as of October 1 by paying the October premium only.

26.5.3 Payment Information

26.5.3.1 Payment Methods

Initial premium payments required to gain MAPP eligibility must be paid by check or money order and are collected by the Income Maintenance (IM) agency. This includes initial premiums at application or re-request.

For ongoing premium payments, premium statements will be sent monthly. The statement will provide the amount due and how to pay the premium.

Members have several options to pay their ongoing monthly premiums, including:

- Check
- Money order
- Electronic Funds Transfer (EFT)
- Wage withholding
- Credit or debit card

Members are able to make one-time payments using a credit or debit card, or EFT from a checking or savings account, through the ACCESS website.

For recurring EFT payments, members must submit a complete Medicaid Purchase Plan Premium Member/Employer Electronic Funds Transfer form (F-13023). To have premiums taken out of a paycheck, the Medicaid Purchase Plan Premium Employer Wage Withholding form (F-13024) must be submitted by an employer. Members must submit payments through one of the other methods until

they get confirmation that their recurring EFT or wage withholding request has been processed. Once enrolled in EFT payments, monthly premium statements will no longer be sent.

26.5.4 Ongoing Cases

Ongoing premium payments can be paid through any of the methods listed in SECTION 26.5.3.1 PAYMENT METHODS. Ongoing premium payments paid by check are sent to the MAPP Premium Unit. Checks are made out to "Medicaid Purchase Plan." MAPP premiums are due on the 10th of the benefit month regardless of which payment method is chosen. ~~For members who have chosen "direct pay' as their payment method, the~~ The fiscal agent sends the premium ~~coupon on~~statement around the 20th of the month before the benefit month. The payment ~~must be received by the fiscal agent by~~ is due on the 10th of the benefit month. EFT occurs on the third business day of the benefit month. Members enrolled in EFT do not get premium statements mailed to them each month.

26.5.5 Late Payments

~~Cases are treated differently depending on when the late payment is received. The following explains the policy based on those time differences. Members must pay the payment that closed them, but do not have to pay the following month right away to open, unless the late pay is made after the benefit month.~~

~~Example 4~~	~~If a member owed a premium for September and does not pay it until October, then he or she will need to pay both September and October. October eligibility will pend until the payment is received by the agency and recorded in CARES.~~

If a late payment is received and processed after the 10th of the month but before the end of the month, MAPP will be reinstated, and a premium statement will be sent for the following month's premium.

Example 1:	Donald has been open for MAPP since March 2023. In early July 2024, Donald is notified that his gross monthly income is over 100% of the FPL, and he will owe a monthly premium of $56 starting August 2024. Donald receives a premium statement in mid-July for his premium due August 10, 2024. Donald does not pay his premium by the due date. On August adverse action, Donald's MAPP eligibility closes for non-payment of premium effective September 1, 2024. If Donald pays his premium before August 31, he can remain open for MAPP.

Payments received and processed in the month after the premium was due and eligibility ended will be applied to the current month to allow the member to regain MAPP eligibility, as long as the payment covers the current month's premium in full.

Example 2:	Miles has been open for MAPP since June 2024. In early July, Miles is notified that his gross monthly income is over 100% of the FPL, and he will owe a monthly premium of $60 starting August 2024. He receives a premium statement in mid-July for his premium due August 10, 2024. Miles does not pay his premium by the due date. On August adverse action, MAPP eligibility closes for non-payment of premium effective September 1, 2024. A check for $60 is received on September 5, 2024. This payment should be treated as a re-request for MAPP. Miles re-opens for MAPP effective September 1, 2024, and the $60 payment is applied to his September premium.

Payments received more than a calendar month after the premium was due and eligibility ended will be refunded, unless the member has reapplied or re-requested MAPP (other health care benefits are open on the case), and the agency pended for the premium.

Example 3:	Diego has been open for MAPP since August 2024. Diego's gross monthly income is over 100% of the FPL, and he owes a monthly premium of $80. Diego did not pay his September premium by the due date. On September adverse action, MAPP eligibility closes for non-payment of premium effective October 1, 2024. A check for $80 is received by the fiscal agent on November 15, 2024, and it is refunded. There are no health care benefits open on Diego's case, so he needs to reapply for MAPP.

Example 4:	Carol has been open for MAPP since September 2024. Carol's gross monthly income is over 100% of the FPL and she owes a monthly premium of $55. Carol did not pay her October premium by the due date. On October adverse action, MAPP eligibility closes for non-payment of premium effective November 1, 2024. On December 5, 2024, Carol reapplies for MAPP. The IM consortium pends for her $55 December premium, which needs to be sent to the IM consortium. However, Carol mails her payment to the fiscal agent instead. The fiscal agent gets the payment on December 12, and sees that Carol has re-applied for MAPP and needs to pay her premium, so they notify IM of the payment via the late payment file. The IM consortium applies the payment and reopens Carol's MAPP effective December 1,2024.

~~**26.5.5.1 Between Due Date and Adverse Action of the Benefit Month**~~

~~The case will stay open for the benefit month even if no payment is received by the due date. It will close at the end of the benefit month if no payment is received by adverse action in the benefit month.~~

~~**26.5.5.2 Between Adverse Action of the Benefit Month and the Last Day of Benefit Month**~~

~~If a member pays their premium between adverse action of the benefit month and the last day of the benefit month, they can reopen without a break in coverage.~~

~~Example 5:~~	~~Adverse action is September 16. Jim's September premium was due September 10. Jim has not paid his September premium by September 16. He does pay on September 26. The case closed effective September 30. Jim will be eligible as of October without a break in service.~~

~~**26.5.5.3 Anytime in Month After the Benefit Month**~~

~~If the member pays their premium any time in the month after the benefit month, they can reopen. They must pay the premium that closed them. If they owe a premium for that following month, they must pay that premium before CARES will open MAPP. The member must pay the IM agency directly (not the fiscal agent).~~

~~When the payment(s) is received, benefits will be reopened back to the first of the benefit month and there will be no gap in coverage.~~

~~Example 6:~~	~~Adverse action is September 16. Jim has not paid his September premium by September 16. He pays on October 26. His case closed for October. Jim must pay both the premiums for September and October since they were in arrears before he will open. If Jim pays his premium arrears in October, his benefits will reopen as of October. The November premium is not due until November 10 and does not have to be paid in advance.~~

~~**26.5.5.4 Two Months After the Benefit Month**~~

~~If the member pays in the second month after the benefit month, it is a non-payment (see 26.5.6 Non-Payment below).~~

26.5.6 Non-Payment

~~If a MAPP member does not pay the monthly premium by adverse action in the benefit month, an RRP will be applied (see), unless there is good cause (see). The RRP begins with the first month of closure. If~~

~~a late payment is received by the end of the month after the benefit month, the RRP will be lifted, and benefits will be reinstated.~~

Payment of a premium is a condition of eligibility for MAPP. If a premium payment is not made, a notice will be sent at adverse action and MAPP will close for non-payment of a premium at the end of the unpaid premium month. While MAPP members can lose coverage for non-payment of a premium, they are not subject to a restrictive re-enrollment period (RRP). A member whose MAPP eligibility closes due to non-payment of a premium can re-request MAPP. They do not have to pay the unpaid premium in order to reopen MAPP after the closure. However, they must pay any premiums owed for the month(s) in which MAPP reopens.

Example 1:	Tatiana was determined eligible for MAPP in August with a monthly premium of $41. Tatiana does not pay her October premium, so her MAPP eligibility closes effective November 1. Tatiana re-requests MAPP on November 5. Because there is no RRP and Tatiana is re-requesting MAPP after the unpaid premium month has passed, she does not need to pay the October premium to regain eligibility. She only needs to pay an initial premium to gain eligibility for November. Tatiana pays the initial premium on November 6 and opens for MAPP as of November 1. Tatiana will receive a premium statement in mid-November for her premium due December 10.

26.5.6.1 Insufficient Funds

IM workers will be notified with a 056 Run SFED/SFEX alert in CARES if a MAPP member pays the monthly premium through EFT or direct payment ~~by check~~, and the payment is rejected for insufficient funds. ~~An RRP will be applied, unless there~~ If the premium is ~~good cause (anything that is beyond the member's control), and~~not paid by adverse action, the member's MAPP benefits will end~~. The RRP begins with the first month after closure~~.

26.5.6.2 Partial Payments

Unless a temporary premium waiver is in place, members with gross monthly income over 100% of the FPL must pay their entire MAPP premium by the end of each month to maintain eligibility.

Partial payments made and processed before the last day of the month will be applied to the benefit month. If the remaining balance is not received and processed before the end of the benefit month, the MAPP member will lose eligibility due to non-payment of premium.

Example 1:	Melinda was determined eligible for MAPP in September with a monthly premium of $51. Melinda pays her premiums in full until November, when she mails a check on November 1 for a partial payment of $25. On November adverse action, MAPP eligibility closes for non-payment of premium effective December 1. If she does not pay the remaining $26 before the end of the month, her MAPP eligibility will end November 30.

26.5.7 Opting Out

If a MAPP member chooses to de-request MAPP coverage, or opt out, any time prior to the beginning of the next benefit month,- MAPP eligibility will end the next possible month ~~and an RRP will not be imposed (see).~~.

A MAPP applicant's decision to opt out does not affect other family members' eligibility for Medicaid or Medicaid-related programs.

26.6 ~~MAPP Restrictive Re-Enrollment Period (RRP)~~ Reserved

~~26.6.1 MAPP Restrictive Re-enrollment Period Introduction~~

~~A MAPP member who fails to pay the premium on time will lose his or her MAPP benefits and will be subject to an RRP of three months, beginning with the month after the missing payment month. (For example, if the member does not pay the December premium by the due date (December 10), an RRP will be imposed at December adverse action from January to March). A MAPP member will be able to regain eligibility during the RRP if any of the following conditions are met:~~

- ~~The member pays all past-due premiums by the last day of the RRP. Members must pay the overdue premium(s) that resulted in case closure, but do not have to pay the premium owed for the following month, unless the late payment is made after the benefit month.~~
- ~~The member becomes eligible for MAPP without a premium (that is, the member's gross monthly income is reduced to at or below 100 percent of the FPL). Note: The RRP will still run in the background and will be reinstated if the member's income increases above 100 percent of the FPL during the RRP.~~
- ~~The member is granted a temporary premium waiver for the duration of the RRP or makes the past due payments for any RRP months not covered by the temporary premium waiver.~~

~~Example 1:~~	~~Amy is eligible for MAPP with a premium. She misses her April MAPP premium payment and an RRP is imposed for May, June, and July. In May, she applies for and is granted a temporary MAPP premium waiver for April 1 through August 31. The RRP is lifted and Amy is eligible for MAPP with no premium effective April 1. She will be required to pay premiums again starting in September.~~

~~Example 2:~~	~~Lynn is eligible for MAPP with a premium. She misses her June premium payment and is placed in an RRP on July 1. Lynn pays for June and July's premiums on July 30 to end her RRP and become eligible for MAPP. Her August premium is not due until August 10, so she is not required to pay that amount in order to end the RRP.~~

~~Example 3:~~	~~John is eligible for MAPP with a premium. He misses his January MAPP premium payment and an RRP is imposed for February, March, and April. In March, his employer decreases his work hours and John's gross income is now under 100 percent of the FPL, making him eligible without a premium starting March 1. He pays the January and February premium arrears and regains MAPP eligibility effective January 1. If John did not pay the January and February premiums, he would open as of March 1.~~

~~RRPs are tied to non-payment of premiums only. RRPs do not apply to recipients who have not met HEC requirements.~~

~~26.6.2 Good Cause~~

~~The following are good cause reasons for not paying a MAPP premium:~~

1. ~~Problems with electronic funds transfer.~~
2. ~~Problems with an employer's wage withholding.~~
3. ~~Administrative error in processing the premium.~~
4. ~~Fair hearing decision.~~
5. ~~Those you determine are beyond the member's control.~~

27.11 Institutions for Mental ~~Disease~~Diseases (IMDs)

~~Some institutions~~An institution for mental ~~disease~~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~~, and special~~. Special eligibility rules apply to IMD residents receiving residential SUD treatment (see Section 27.1.2 Institutions for Mental Disease and Section 27.4.1 Institutionalized Person). ~~Therefore, the~~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
Bellin Psychiatric Center, Green Bay
~~Libertas Center, Green Bay (aka St. Joseph's)~~
Willow Creek Behavioral Health, Green Bay

Dane
5 Door Recovery/Hope Haven/Rebos United, Madison (provides residential SUD treatment)
Acadia Psychiatric Hospital, Madison
Mendota Mental Health Institute, Madison
Miramont Behavioral Health, Middleton

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

~~Fond du Lac~~
~~Fond du Lac County Health Care Center~~
Milwaukee
Aurora Psychiatric Hospital, Milwaukee
Genesis Behavioral Services Inc. – Jeanetta Robinson House, Milwaukee (provides residential SUD treatment)
Granite Hills Hospital, West Allis
Matt Talbot Recovery Services, Milwaukee (provides residential SUD treatment)
Rogers Memorial Hospital Inc., Brown Deer
Rogers Memorial Hospital Inc., Milwaukee

~~Milwaukee County Behavioral Health, 144 bed psychiatric hospital - license #229, Milwaukee~~
Oneida
Options Counseling Services, LLC, Rhinelander (provides residential SUD treatment)

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

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

Washington

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

Waukesha

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

Rogers Memorial Hospital Inc., Oconomowoc

Winnebago

Winnebago Mental Health Institute, Winnebago

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

28.6 HCBWLTC Eligibility Groups and Cost Sharing

28.6.4 Cost Share Amount

28.6.4.2 Family Maintenance Allowance

28.6.4.2.1 Family Maintenance Allowance Calculation - Minor Child

When the waiver participant has one or more children under the age of 18 who do not live with a community spouse, an allowance for those children is calculated as follows ~~is the custodial parent of a minor child living in the home, and there's no spouse in the home, calculate the following:~~:

1. ~~Add together~~ Determine the total gross monthly ~~earned and unearned~~income of ~~all of~~ the member's children under age 18 who are not living with a community spouse. No exclusions, disregards, or deductions apply.

2. Subtract the minor children's total gross income from 100% the FPL for a family size equal to the number of minor children not living with a community spouse to get the family maintenance allowance. If the children's total gross exceeds 100% FPL, no family maintenance is deducted.

~~Minor children's gross earned income.~~
~~- $65 and ½ of gross earned income (see SECTION 15.7.5 $65 AND ½ EARNED INCOME DEDUCTION).~~
~~=_____.~~
~~+ Minor Children's total unearned income.~~
~~= _____Add (3) and (4).~~
~~AFDC Related med needy income limit _____ (see SECTION 39.3 AFDC-RELATED INCOME TABLE). (Do not include the waiver applicant in the group size.)~~
~~If (5) is greater than (6), there's no family maintenance allowance. If (5) is less than (6), the family maintenance allowance is the difference between (5) and (6).~~

31.1 ~~Introduction~~Migrant Workers

A "migrant worker" is ~~any~~a person who temporarily leaves ~~a~~their principal place of residence outside Wisconsin and comes to Wisconsin for not more than 10 months ~~in a~~per year in order to accept seasonal employment in the planting, cultivating, raising, harvesting, handling, drying, packing, packaging, processing, freezing, grading, or storing of any agricultural or horticultural commodity in its unmanufactured state.

"Migrant worker" does not include any of the following:
~~A migrant worker does not include any of the following:~~

- A person who is employed only by a ~~state~~Wisconsin resident, if the ~~resident~~employer or the ~~resident's~~employer's spouse is ~~related to~~ the ~~person as the~~person's child, parent, grandchild, grandparent, brother, sister, aunt, uncle, niece, or nephew~~, or the spouse of any such relative~~.
- A student who is enrolled ~~in~~ (or~~,~~ has been enrolled during the past six months ~~has been enrolled~~) in~~,~~ any school, college, or university, unless the student is a member of a ~~family or~~ household ~~which~~that contains a migrant worker.

~~A~~
Certain migrant ~~family includes the adults, including non-marital co-parents,~~workers and their ~~dependent children living~~families qualify for a simplified application procedure when applying for BadgerCare Plus or Medicaid in ~~the~~Wisconsin. For policies related to migrant workers, see BadgerCare Plus Handbook Chapter 12 Migrant Workers~~household.~~.

31.2 ~~Simplified Application~~Reserved

~~Migrant workers and their families can have their eligibility for Medicaid determined using a simplified application process if they:~~

- ~~Have current Medicaid eligibility from another state ("Current Medicaid eligibility" means eligibility that includes at least months one and two of the application process.) or had Medicaid eligibility in Wisconsin that was certified through months one and two of the application and that ended only because the family left Wisconsin.~~
- ~~Have the same members, or fewer, in the case as there were when the case had eligibility in the other state.~~

~~The simplified application procedure is as follows:~~

1. ~~For members with current Medicaid eligibility from another state, verify the eligibility and the end date. Accomplish the verification by copying the out-of-state Medicaid card or by contacting the other state.~~
2. ~~For members previously eligible in Wisconsin find the CARES Member Assistance for Re-employment & Economic Support closure code and review date.~~
3. ~~Ask if the same members, or fewer, are in the case compared to when the group was eligible in the other state.~~
4. ~~Collect all nonfinancial information.~~
5. ~~Do not collect any financial information.~~
6. ~~Certify Medicaid benefits for the migrant family.~~

~~Example 1:~~

~~A migrant family consisting of dad, mom, and their three children comes to Wisconsin. On September 3, dad applies for Medicaid in Wisconsin for himself and his family.~~

~~The family has current Medicaid eligibility from Texas. That is, eligibility extends beyond application months one and two.~~

~~The household composition of five members is the same as listed on the Medicaid card.~~

~~The fulfillment of these two conditions indicates that the case should be processed with the simplified application procedure.~~

~~The IM worker enters nonfinancial information into CARES, and completes the asset and income screens by answering "N" to all of the financial questions. He or she also makes sure to answer "Y" to the migrant question on ANDC for all family members.~~

~~CARES passes the case for MAOU eligibility with $0 assets and $0 income. The eligibility end date from Texas is November 30. The IM worker changes the review date on AGEC to November 30 to coincide with the end date from Texas.~~

~~Example 2:~~

~~The same migrant family comes in for the November review. Verify all mandatory and questionable verification items. The family is determined eligible through October 31 of the following year.~~

~~The family leaves Wisconsin in December. Medicaid closes for failure to reside in the state. In March the family returns. There have been no non-financial changes and no changes in household composition. The family should be processed with the simplified application procedure because their case closed only for failure to reside in Wisconsin.~~

31.3 ~~Regular Application~~ Reserved

~~If migrant workers and their families have no current Medicaid eligibility or if there are additional family members who were not eligible in the prior state of residence, process the case as a regular Medicaid application with the exception of using annualized earned income. "Annualized earned income" is a prospective monthly estimate of earned income based on the estimated total gross annual earnings divided by 12. Annualized income can be based on the past 12 months of the migrant family's income if it is anticipated that last year's income is the best estimate of the current year's prospective income.~~

31.4 ~~Renewal Dates~~Reserved

~~Migrant families can do renewals:~~

- ~~By mail.~~
- ~~By phone.~~
- ~~Through a face-to-face interview.~~

~~For more information, see Section 2.2 Application Types/Methods.~~
~~Income is always annualized.~~

~~31.4.1 Simplified Application~~

~~For migrant families who have been certified through the migrant simplified application process, the first renewal coincides with the date out-of-state eligibility ends. The next renewal is 12 months from the first renewal.~~

~~31.4.2 Regular Application~~

~~For migrant families who have been certified through the regular application process, the first renewal is 12 months from the month of application.~~

34.1 Emergency Services

34.1.2 Determination of Emergency Services Eligibility

Certification of Emergency Services is not done by CARES and must be done manually. Emergency Services coverage lasts from the time of the first treatment for the emergency until the condition is no longer an emergency for adults or the end of a 12-month period for children under age 19.

Local agencies do not determine if an emergency exists. Local agency responsibility is to determine if the non-qualifying alien meets all other eligibility requirements during the dates of service and to certify if they are eligible for Emergency Services.

If a non-qualifying alien provides a "Certification of Emergency for Non-U.S. Citizens" form (F-01162) at the time of application, determine their eligibility for Emergency Services for the dates of the emergency indicated on the form (unless a child under age 19). If a non-qualifying alien does not have the form at the time of application, ask them for the dates that they received emergency services. The F-01162 is not required to certify Emergency Services eligibility.

Persons applying for Emergency Services have the same rights and responsibilities as persons applying for regular Medicaid. They must meet the eligibility requirements for their type of Medicaid, such as being elderly, blind, or disabled*,* and provide required verifications. The IM agency must provide a manual positive or negative notice regarding the applicant's eligibility. Positive notices must provide the dates of eligibility for Emergency Services. Negative notices must provide the reason(s) for the denial or termination.

*If a non-qualifying immigrant would only qualify for Medicaid if they were disabled, the normal disability determination procedures (including presumptive disability) are followed before Emergency Services eligibility is certified.

Note	Emergency Services has the same policies on referrals to child support agencies (CSA) and cooperation as Medicaid (see CHAPTER 8 MEDICAL SUPPORT).

37.4 Cost Sharing

37.4.1 Group A

Group A members are Medicaid eligible via SSI (including SSI-E Supplement and 1619a and 1619b) or a full-benefit Medicaid subprogram (see Section 21.2 Full-Benefit Medicaid) other than HCBW Medicaid. Members who have met a deductible are eligible for community waivers as Group A. The member remains eligible as Group A until the end of the deductible period. At the next review the member will be able to make a choice between meeting the deductible to receive Medicaid (remaining a Group A) or becoming eligible for community waivers as Group B or B Plus with a potential cost share.

Individuals eligible as Group A have no CARES cost share obligation~~, although BadgerCare Plus participants may be required to pay a premium and other cost sharing based on income~~.

39.6 COLA Disregard

To calculate the COLA disregard amount, do the following:

1. Find the current gross- Social Security Old Age, Survivors, and Disability Insurance Program (OASDI-) income, which is the sum of:
    a. The amount of the OASDI check.
    b. Any amount being deducted from the OASDI check for Medicare premiums.
    c. Any amount being withheld from the OASDI check to recover a previous overpayment.
2. In the table below, find the decimal figure that corresponds to the last month when the person received an SSI payment.
3. Multiply the gross OASDI income by the applicable decimal figure and round to the nearest whole dollar. The result is the historical COLA disregard amount.

Month SSI Last Received	Multiply ~~2023~~ 2024 OASDI by:	Multiply ~~2022~~ 2023 OASDI by:
Jan 2023 - Dec 2023	0.031008	--
Jan 2022 - Dec 2022	0.~~080037~~108563	~~--~~0.080037
Jan 2021 - Dec 2021	0.~~131291~~158227	0.~~055713~~131291
Jan 2020 - Dec 2020	0.~~142439~~169030	0.~~067831~~142439
Jan 2019 - Dec 2019	0.~~155944~~182116	0.~~082511~~155944
Jan 2018 - Dec 2018	0.~~178934~~204393	0.~~107501~~178934
Jan 2017 - Dec 2017	0.~~195033~~219993	0.~~125001~~195033
Jan 2016 - Dec 2016	0.~~197441~~222326	0.~~127618~~197441
Jan 2015 - Dec 2015	0.~~197441~~222326	0.~~127618~~197441
Jan 2014 - Dec 2014	0.~~210856~~235326	0.~~142201~~210856
Jan 2013 - Dec 2013	0.~~222518~~246626	0.~~154877~~222518
Jan 2012 - Dec 2012	0.~~235515~~259220	0.~~169004~~235515
Jan 2011 - Dec 2011	0.~~262080~~284961	0.~~197881~~262080
Jan 2010 - Dec 2010	0.~~262080~~284961	0.~~197881~~262080
Jan 2009 - Dec 2009	0.~~262080~~284961	0.~~197881~~262080
Jan 2008 - Dec 2008	0.~~302533~~324160	0.~~241853~~302533
Jan 2007 - Dec 2007	0.~~318214~~339355	0.~~258899~~318214
Jan 2006 - Dec 2006	0.~~339994~~360459	0.~~282574~~339994
Jan 2005 - Dec 2005	0.~~365989~~385648	0.~~310830~~365989
Jan 2004 - Dec 2004	0.~~382657~~401799	0.~~328948~~382657
Jan 2003 - Dec 2003	0.~~395354~~414103	0.~~342750~~395354
Jan 2002 - Dec 2002	0.~~403703~~422192	0.~~351825~~403703

Jan 2001 - Dec 2001	0.~~418813~~436835	0.~~368250~~418813
Jan 2000 - Dec 2000	0.~~438467~~455879	0.~~389614~~438467
Jan 1999 - Dec 1999	0.~~451628~~468632	0.~~403920~~451628
Jan 1998 - Dec 1998	0.~~458665~~475451	0.~~411569~~458665
Jan 1997 - Dec 1997	0.~~469800~~486240	0.~~423672~~469800
Jan 1996 - Dec 1996	0.~~484742~~500719	0.~~439915~~484742
Jan 1995 - Dec 1995	0.~~497799~~513371	0.~~454108~~497799
Jan 1994 - Dec 1994	0.~~511478~~526626	0.~~468976~~511478
Jan 1993 - Dec 1993	0.~~523858~~538622	0.~~482433~~523858
Jan 1992 - Dec 1992	0.~~537726~~552060	0.~~497508~~537726
Jan 1991 - Dec 1991	0.~~554220~~568042	0.~~515437~~554220
Jan 1990 - Dec 1990	0.~~577059~~590173	0.~~540263~~577059
Jan 1989 - Dec 1989	0.~~596044~~608570	0.~~560900~~596044
Jan 1988 - Dec 1988	0.~~611581~~623625	0.~~577789~~611581
Jan 1987 - Dec 1987	0.~~627237~~638796	0.~~594807~~627237
Jan 1986 - Dec 1986	0.~~632021~~643431	0.~~600007~~632021
Jan 1985 - Dec 1985	0.~~643085~~654152	0.~~612034~~643085
Jan 1984 - Dec 1984	0.~~655155~~665848	0.~~625153~~655155
Jul 1983 - Dec 1983	0.~~666816~~677148	0.~~637829~~666816
Jul 1982 - Jun 1983	0.~~689773~~699393	0.~~662783~~689773
Jul 1981 - Jun 1982	0.~~721019~~729670	0.~~696748~~721019
Jul 1980 - Jun 1981	0.~~755922~~763490	0.~~734687~~755922
Jul 1979 - Jun 1980	0.~~777909~~784796	0.~~758587~~777909
Jul 1978 - Jun 1979	0.~~791464~~797930	0.~~773321~~791464
Apr 1977 - Jun 1978	0.~~803082~~809188	0.~~785950~~803082

39.9 ~~BadgerCare Premiums- Income exceeds 150% of the FPL~~ Reserved

~~See the for BadgerCare Plus premiums~~