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

To: Medicaid Eligibility Handbook Users

From: Bureau of Eligibility and Enrollment Policy

Re: **Medicaid Eligibility Handbook Release 24-03**

Release Date: 12/18/2024

Effective Date: 12/18/2024

EFFECTIVE DATE		The following policy additions or changes are **effective 12/18/2024** unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY UPDATES		
1.2.11	**Certification Period Changes for Children in Continuous Coverage Periods**	New section.
2	**Applications and Reviews**	Updated section title.
3.1.1	**Renewals Introduction**	Update terminology for consistency.
3.1.1.1	**Redeterminations for Changes in Circumstance**	New sub-section.
3.1.2	**Choice of Renewal**	Updated terminology for consistency.
3.1.3	**Renewal Processing**	Updated terminology for consistency.
3.1.4	**Signature at Renewal**	Updated terminology for consistency.
3.1.5.2	**Administrative Renewal Selection Criteria**	Added details about admin renewals.
3.1.5.3	**Administrative Renewal Process**	Updated terminology for consistency.
3.1.6	**Late Renewals**	Updated with Wisconsin Well Woman MA and Katie Becket Medicaid changes.
7.3.2.1	**Reverification of Immigration Status**	Updated text to be gender neutral.
7.3.2.2	**Reasonable opportunity period for Verification of Immigration Status**	Updated HHS terminology.
7.3.3	**Immigrants Eligible for Medicaid**	Section rewritten and reorganized for clarity. Several new subsections were created to hold reorganized content.

7.3.5	**Immigration and Customs Enforcement (ICE) Reporting**	Updated terminology, clarified that Medicaid member information cannot be used for immigration enforcement.
7.3.6	**Continuous Presence**	Content moved to section 7.3.3.1.5
7.3.6	**Undocumented Non-Citizens**	Section renumbered from 7.3.7, updated USCIS to display full acronym and updated wording in Examples.
7.3.7	**Immigration Status Chart**	Section renumbered from 7.3.8, clarified language regarding five-year waiting period for victims of trafficking, minor editorial changes.
15.1.5	**Availability**	Updates to reflect policy change announced in OM 24-29 No Longer Counting Potential Cash Benefits as Available Income.
15.3.31	**Cash Benefits Received in Conjunction with Medical and Social Services**	Removal of "in-kind items" from section to reflect that "unearned" in-kind benefits are not counted regardless of who provides them. "Earned" in-kind benefits are counted in accordance with MEH 15.5.1.
15.3.32	**Medicare Advantage Supplemental Benefits**	New section. 15.3.32 was previously marked "reserved."
15.6.4	**Self-Employed Income Sources**	Clarification related to personal capital gains.
16.7.35	**Medicare Advantage Supplemental Benefits**	Section title and content updated to reflect that all Medicare advantage supplemental benefits are disregarded, not just D-SNP wellness benefits.
17.2.7.4	**Avoiding Receipt**	Added text to clarify that failure to apply for cash benefits is not divestment.
18.4.3	**Calculate the Community Spouse Asset Share**	Updated table used to calculate spousal asset share to reflect 2024 COLA updates – OM 23-42 (this section was missed with earlier COLA updates).
20.3.11	**Tribal Membership, Descent, or Eligible to Receive Indian Health Services**	Minor clarification.
21.6.4.1	**Automatic Disenrollment**	Updated disenrollment date for disenrollments due to incarceration or institutionalization.
21.6.4.2	**Voluntary Disenrollment**	Added additional reason for a qualifying disenrollment.
23.2.4	**Continued Benefits**	Updates to reflect changes from OM 23-10 Health Care Overpayments.
25	**Special Status Medicaid**	Section rewritten and reorganized for clarity.
27.6.1	**Intermediate and Long-Term Care Monthly Need Introduction**	Removed "other deductible expenses" from list of monthly needs.
36.1	**WWWMA Introduction**	Added new policy information regarding Wisconsin Well Woman MA (OM 24-24). Effective 10/19/2024.
36.2	**WWWMA Enrollment**	Added new policy information regarding Wisconsin Well Woman MA.

36.2.1	**WWWMA Backdated Eligibility**	New header and new content.
36.2.2	**Enrollment through the Wisconsin Well Women Program**	Updated with Wisconsin Well Woman MA policy per OM 24-24.
36.2.2.1	**WWWMA LCA Process for Assisting with WWWMA Application**	New header and new content added.
36.2.2.2	**Temporary Enrollment (TE) Available only to Persons Enrolling through WWWP**	Moved from 36.2.2.1 and updated Wisconsin Well Woman MA.
36.2.3	**WWWMA Enrollment for Family Planning Only Services Members**	Moved from 36.2.4, 36.2.4.1 and updated content with Wisconsin Well Woman MA.
36.2.4	**WWWMA Enrollment for BadgerCare Plus Members**	New section added.
36.3	**WWWMA Nonfinancial Requirements**	Updated with Wisconsin Well Woman MA policy.
36.4	**WWWMA Financial Requirements**	Updated with Wisconsin Well Woman MA policy.
36.5.1	**Member Loses Eligibility**	Updated with Wisconsin Well Woman MA policy.
36.6	**WWWMA Renewals**	Updated with Wisconsin Well Woman MA policy.
36.7	**EM CAPO Contact Information**	New section added with Contact Information.
39.4.4	**LTC Spousal Impoverishment Post-Eligibility Allowances and Community Spouse Asset Share**	Updated table with new amounts effective 7/1/2024 - OM 24-08.
39.6	**COLA Disregard**	Moved COLA table to Section 25.3.3 and marked section 39.6 Reserved.

Contents

1.2 Continuous Coverage for Qualifying Children

1.2.11 Certification Period Changes for Children in Continuous Coverage Periods

When an individual opens for a new health care certification period on a case, new 12-month certification periods will be established for other eligible health care members in the household, with some exceptions. See BadgerCare Plus, Section 1.2.10 Certification Period Changes for Children in Continuous Coverage Periods for more information.

App[lications]~~s~~ and ~~Reviews~~ [Renewals] (Chs. 2-3)

3.1 Renewals

3.1.1 Renewals Introduction

A renewal is the process during which all eligibility factors subject to change are reexamined and ~~a decision is made if~~ eligibility ~~should continue.~~is redetermined. The group's continued eligibility depends on its timely completion of a renewal and receipt of required verification. Each renewal results in a determination to continue or discontinue eligibility.

The first required eligibility renewal for a Medicaid case is 12 months from the certification month except for cases open with a deductible. A renewal is not scheduled for a case that did not meet its deductible unless someone in the case was open for Medicaid. For cases that did meet the deductible, the renewal date is six months from the start of the deductible period.

Note~~:~~	For manually certified Medicaid cases, send a manual renewal notice 45 days prior to the end of the renewal month.

Agency Option

The agency may renew any case at any other time when the agency can justify the need. Examples include:

1. Loss of contact, or
2. Member request

Note~~:~~	Shortening certification periods in an attempt to balance agency workload is not permissible.

If an early renewal is completed for a child within their continuous coverage period, and that child would be adversely impacted by the early renewal (for example, they would be ineligible, or would have a new or higher premium), then the child will remain in their current continuous coverage period. However, other household members can be renewed and may qualify for new 12-month certification periods.

3.1.1.1 Redeterminations for Changes in Circumstance

Health care eligibility must be promptly redetermined between regular renewals whenever information is received about a change in a member's circumstances that may affect their eligibility. Requests for information or verification must be limited to information related to the change. If enough information is available to determine eligibility following the change, new certification periods may begin.
When an individual opens for a new health care certification period on a case, new 12-month certification periods will be established for other eligible health care members in the household, with some exceptions.

New certification periods will be established for existing eligible members when an individual opens following a change in circumstances, person-add, new program request, or renewal. For example, new certification periods can be established when a person joins the household and opens for health care, changes health care categories, or a previously ineligible person becomes eligible due to a change (for example, a reduction in income puts them under the program limit).
New certification periods will not be established for an existing member when:

- A newly added person is found ineligible.
- A new assistance group is pending.
- The member is open for time-limited benefits.

- The member is a child who is in their 12-month continuous coverage period and the change would result in a negative action or would move the child from Medicaid to CHIP.
- The existing member is ineligible based on the change in circumstances.

Example 1	Margaret and Phillip are enrolled in BadgerCare Plus as childless adults with a certification period of January 1, 2025, through December 31, 2025. On July 2, 2025, 11-year-old William joins the household and requests health care. William does not have continuous coverage from another case. William is enrolled in BadgerCare Plus with continuous coverage from July 1, 2025, through July 31, 2026. Margaret and Phillip are now eligible for BadgerCare Plus as parents and will also start a new certification period from August 1, 2025, through July 31, 2026.

Example 2	Santhosh and Reema are enrolled in BadgerCare Plus and their 4-year-old daughter Kashvi is enrolled in Medicaid from February 1, 2025, through January 31, 2026. On August 8, 2025, Santhosh's 11-year-old daughter Amara joins the household and requests health care. Amara has had BadgerCare Plus on another case since January. Her BadgerCare Plus is closed on the other case, she is determined eligible on Santhosh's case with a new continuous coverage period, and is enrolled in BadgerCare Plus from September 1, 2025, through August 31, 2026. Santhosh, Reema, and Amara remain eligible for BadgerCare Plus and start a new certification period from September 1, 2025, through August 31, 2026. Kashvi remains eligible in Medicaid and starts a new certification period from September 1, 2025, through August 31, 2026.

Example 3	Bill and Carrie are enrolled in BadgerCare Plus as parents and their 12-year-old daughter Kiley is disabled and enrolled in SSI-Related Medicaid. Their certification period is January 1, 2025, through December 31, 2025. Kiley is determined to no longer be disabled on June 5, 2025. There was no other change. Kiley transitions from SSI-Related Medicaid to BadgerCare Plus with a new certification period of July 1, 2025, through June 30, 2026. A new 12-month certification period is established for Bill and Carrie from July 1, 2025, through June 30, 2026.

Example 4	Edith is enrolled in SSI-Related Medicaid from January 1, 2025, through December 31, 2025. In July, Edith gets married and requests health care for her husband, Chester. Chester is eligible and enrolled in SSI-Related Medicaid. Edith continues to be eligible. Because someone is newly opening for a health care certification period, a new 12-month certification period is established for Edith and Chester.

Example 5	Davis is enrolled in SSI-Related Medicaid from July 1, 2024, through June 30, 2025. In October, Davis gets married and requests health care for his wife, Polly. Polly is not a US citizen or qualifying immigrant and is found ineligible. Davis' SSI-Related Medicaid certification period does not change.

Time-Limited Benefits

New certification periods will not be established for members enrolled in time-limited health care benefits, including:

- Pregnant and postpartum individuals enrolled in BadgerCare Plus,
- Continuously Eligible Newborns,
- People in a four or twelve-month BadgerCare Plus Extension, and

- People who need to meet or have met a deductible to enroll in BadgerCare Plus or Medicaid.

Example 6	Matthew and his child Lee are enrolled in BadgerCare Plus from January 1, 2025, through December 31, 2025. Lilly, Lee's mother, is enrolled in BadgerCare Plus as a pregnant individual with a renewal date of September 30, 2025. In May, their other child Silas joins the household. Lilly remains pregnant. Silas's information is verified and there is no other change. Silas is enrolled in BadgerCare Plus from May 1, 2025, through May 31, 2026. A new 12-month certification period is established for Matthew and Lee from June 1, 2025, through May 31, 2026. Lilly's certification period does not change.

However, a new time-limited health care benefit will result in other members getting a new 12-month certification period.

Example 7	Deepak, Fatima, and their son Ravi are enrolled in BadgerCare Plus from July 1, 2025, through June 30, 2026. In August 2025, Fatima's pregnancy is reported, and she moves from BadgerCare Plus as a parent to BadgerCare Plus as a pregnant individual through May 31, 2026. There are no other changes, and Deepak and Ravi remain eligible. A new 12-month certification period is established for Deepak and Ravi from September 1, 2025, through August 31, 2026.

Children in Continuous Coverage Periods

If a child would be negatively impacted or move to a CHIP category of health care because of a change, person-add, or new program request during their 12-month continuous coverage period, the child will not get a new 12-month certification period. They will remain in their current period. However, other eligible household members can get new 12-month certification periods. Households may also have different health care renewal dates. See BadgerCare Plus Handbook, Section 1.2.10 Certification Period Changes for Children in Continuous Coverage Periods for examples.

Other Health Care Programs

If an individual opens for a new certification period for Wisconsin Well Woman Medicaid, Katie Beckett Medicaid, the SeniorCare Prescription Drug Program, or benefits outside of the CARES eligibility system, new 12-month certification periods will not be established for existing members on the case.

3.1.2 Choice of Renewal

The member has the choice of the following methods for any Medicaid renewal:

- Face-to-face Interview~~,~~
- Telephone Interview~~.~~
- Mail in: Mail in renewals can be submitted using the paper application (F-10101) or the ~~pre-printed renewal packet~~ Pre-Printed Renewal Form (PPRF) generated through CWW. Cases requesting to complete a Mail-in renewal must be sent the ~~pre-printed renewal packet~~ PPRF if the case includes a blind or disabled child~~, or~~

~~1. ACCESS~~

- ACCESS (https://access.wisconsin.gov/access/)

3.1.3 Renewal Processing

A Medicaid eligibility renewal ~~notice is~~ letter and a Pre-Printed Renewal Form (PPRF) are generated on the first Friday of the 11th month of the certification period. The notice states that "some or all of your benefits will end" if a renewal is not completed by the end of the following month. Do not process a renewal until after adverse action in the month prior to the month of renewal.

Example 1~~:~~	CARES sends out the renewal letter on July 7 for a renewal due in August, do not process the renewal prior to July 18.

Do not require a new ~~Authorized Representative~~authorized representative form at renewal if the person signing the renewal is the ~~Authorized Representative~~authorized representative on file.
If the renewal is not completed by the end of the certification period, the case will close. The closure notice is generated through CARES at adverse action in the renewal month.

3.1.4 Signature at Renewal

The member must include a valid signature at the time of renewal. This includes either signing telephonically, electronically or providing a handwritten signature on one of the following:

- The paper application form or Pre-Printed Renewal Form (PPRF)
- The signature page of the Application Summary
- The ACCESS or FFM application form with an electronic signature

The signature requirements for renewals are the same as those for applications (see Section 2.5 Valid Signature). The signature requirements do not apply to people whose renewal is completed through the administrative renewal process.

3.1.5 Administrative Renewals

3.1.5.2 Administrative Renewal Selection Criteria

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

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

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

~~Some members in a household may have their~~A member's health care eligibility cannot be administratively renewed ~~while~~if they meet any of the following criteria:

- Have income on file that cannot be verified through a data exchange, such as self-employment income, in-kind income, income from trusts, and other ~~members~~types of countable income for Medicaid.
- Are age 14 or older and have a missing or unverified SSN.
- Are pregnant and the due date is on or before the renewal month.
- Are enrolled in ~~the household must complete~~Medicaid after having met a deductible.
- Are enrolled in Institutional Medicaid.
- Are enrolled in Group A Community Waiver based on 1619(b) or EBD Medicaid Eligibility.
- Are enrolled in Group B/B+ Community Waivers.
- Are already in the process of completing a regular renewal ~~to continue their eligibility~~.

3.1.5.3 Administrative Renewal Process

The administrative renewal process begins in the 11th month of a member's certification period. CARES determines who qualifies for an administrative renewal, verifies and updates information based on data exchanges, tests employment income and SWICA and FDSH results for reasonable compatibility, and runs through batch eligibility (see Process Help, Section 4.7 Administrative Renewals).

3.1.5.3.1 Successful Administrative Renewals

Members who have a successful administrative renewal will have health care eligibility redetermined and will be certified for a new 12- month certification period and will receive a ~~notice~~Notice of ~~decision~~Decision.

If all members in the household can be administratively renewed, they will be sent a letter notifying them that their eligibility has been renewed, along with a case summary (except for cases open only for Group A Community Waivers and/or QMB based on SSI eligibility). The member(s) must review the information on the case summary and report if any of the information is incorrect within 30 days of the mailing date. The member(s) can make the changes on the summary and mail or fax it to their agency, or they can report their changes through ACCESS or by phone. If all of the information on the case summary is correct, the member(s) will not need to take any other action.

If any members of the household cannot be administratively renewed, the household will be sent ~~a~~an eligibility renewal letter and a ~~pre-printed renewal form.~~Pre-Printed Renewal Form(PPRF). If the household does not complete this renewal process, then only the members who were administratively renewed will continue to be eligible in the next 12-month certification period.

If a successfully administratively renewed case is open only for Group A Community Waivers and/or QMB based on SSI eligibility, the member will be sent a different administrative renewal letter that does not include a case summary. Because these members are categorically eligible based on their SSI eligibility, the letter informs them that their benefits have been renewed because they continue to receive SSI. These members will not need to review a case summary and do not need to take any other action.

3.1.5.3.2 Unsuccessful Administrative Renewals

Benefits may not be terminated or reduced (for example, being charged a greater premium amount) during the administrative renewal process based solely on information obtained from a data exchange. This includes information obtained from SSA, UIB, FDSH, or SWICA data exchanges. If benefits cannot be continued through the administrative renewal process, the member will be excluded from the administrative renewal process, and they will be sent ~~a 45-day~~ an eligibility renewal letter and a Pre-Printed Renewal Form (PPRF). The member will have at least 30 days to complete, sign, and return the PPRF or to complete their renewal by phone, in-person, or through ACCESS.

3.1.5.3.3 Change Reporting After Administrative Renewal

Members who have a successful administrative renewal remain subject to change reporting requirements. The administrative renewal letter instructs a member to review and report any changes to the information provided in the attached case summary. In addition, members who are administratively renewed will receive a Notice of Decision that identifies program-specific change reporting requirements. Changes reported for a member who has undergone an administrative renewal should be processed under existing policy.
Changes reported as part of a renewal for another program should also be applied to health care.

3.1.6 Late Renewals

Most health care renewals received within three months of the renewal month can be processed as a late renewal instead of requiring a new application. This policy applies for the following health care programs:

- BadgerCare Plus
- FPOS
- SSI-Related Medicaid
- HCBW
- Institutional Medicaid
- MAPP
- Medicare Savings Programs (QMB, SLMB, SLMB+, QDWI)
- Wisconsin Well Woman Medicaid (WWWMA)
- Katie Beckett Medicaid

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

Late renewals are only permitted for people whose eligibility has ended due to lack of renewal and not for other reasons. Late renewals and renewal-related verifications must be accepted for up to three calendar months after the renewal month. Members whose health care benefits are closed more than three months due to lack of renewal must reapply.

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

Example 1	Jenny's renewal is due on January 31. She submits an online renewal via ACCESS on March 10. If the renewal is processed on the same day and verification is requested, the verification would be due on March 30. If she provides verification on or before this due date and meets all other eligibility criteria for Medicaid, her eligibility and certification period would start on March 1. Her next renewal would be due February 28 of the following year.

Note	The late renewal three-month period starts after the month the renewal was due. It does not restart when a late renewal has been submitted. If Jenny submits her renewal on March 15 but does not provide verification until May 20, she will need to reapply since she submitted her verification after the three-month period that started with her January renewal date and ended April 30.

7.3 Immigrants

7.3.2 Verification

Primary verification of immigration status is done through the Department of Homeland Security (DHS) by use of the Federal Data Services Hub (FDSH) or SAVE, which is an automated telephone and computer database system. A worker processing an application can simply enter the immigrant's alien number and immigration document type into CWW. That information, along with demographic information of the individual, is sent in real time to the FDSH. The FDSH will immediately return verification of the immigrant's status, date of entry, and the date the status was granted if it's available from the Department of Homeland Security, along with other information. If the FDSH cannot provide verification of the immigration status, workers are directed to seek secondary verification though SAVE or take other action.

The verification query via the FDSH or SAVE most likely results in returning the latest date of any qualified alien status update for an individual, not his or her original date of arrival. The only way to obtain an accurate date of arrival for those who do not meet an exemption category and who report a date of arrival prior to August 22, 1996, is through the secondary verification procedure. The FDSH or SAVE will describe the immigrant's current status which may have changed from the original status. In some situations described later workers will need to maintain the original status in CARES.

It may be necessary to complete a secondary or third level verification procedure with the U.S. Citizenship and Immigration Services (USCIS), including confirming the date of arrival, in the following situations:

- The applicant does not fall into any of the categories of non-citizens who are exempt from the five-year ban (e.g., refugees, asylees, those with military service).
- An IM worker has made an initial or primary verification inquiry using the SAVE database. The information from the inquiry conflicts with information on the applicant's immigration documents or what he or she is telling the IM worker.
- A non-citizen applicant tells an IM worker that he or she came to the U.S. prior to August 22, 1996. If he or she arrived in a legal or documented status, the IM worker needs to verify the date of arrival to ensure that the correct alien eligibility rules are being applied.
- The FDSH or SAVE returns the message "Institute Secondary Verification."
- The IM worker finds any questionable information in the initial verification process.
- Cuban/Haitian entrants when SAVE or the Hub indicates the need.

An Immigration Status Verifier at DHS will research the alien's records and complete the response portion of the verification request.

Consult the SAVE manual for more information.

Additional verifications from sources other than the Department of Homeland Security are sometimes required as well. For example, persons who are in an immigration status subject to the 5-year bar and who indicate that they, their spouse or parent is in the military service or is a veteran, that military status must also be verified.

The following documents are considered valid verification of military service:

- A signed statement or affidavit form from an applicant attesting to being a veteran, surviving spouse, or dependent child
- Military records

To establish a date of arrival for a qualified immigrant who originally arrived as an undocumented immigrant prior to August 22, 1996, the applicant must provide at least one piece of documentation that shows their presence in the U.S. prior to August 22, 1996. The following documents are considered valid verification of presence in the U.S.:

- Pay stubs

- A letter from an employer
- Lease
- Rent receipts
- Utility bills

To establish continuous presence, require a signed statement from the applicant stating they were continuously present for the period in question. The signed statement will be sufficient unless a worker believes the information is fraudulent or further information received now indicates that it is questionable.

Signed Statement Example	I, first and last name, hereby declare that I have continuously resided in the United States between the day I arrived in the United States, date here, and the date I received qualified immigrant status, date here. I have not left the United States in that time for any single period longer than 30 days or for multiple periods totaling more than 90 days. Applicant or Authorized Representative Signature, Date

Immigration statuses for most immigrants are permanent and most often change when the immigrant become a U.S. citizen. For this reason, immigration status for most members should only be verified once, unless the status for an individual is questionable or it's a status subject to reverification (see Section 7.3.2.1 REVERIFICATION OF IMMIGRATION STATUS). Even if an immigrant loses health care eligibility for a period of time, his or her immigration status does not need to be re-verified unless the status is subject to reverification.
See Process Help, Section 44.3.9 Immigrant/Refugee Information Page for additional information on using the FDSH or the procedures in the SAVE Manual.

7.3.2.1 Reverification of Immigration Status

The following persons with a Registration Status Code of 20 – Lawfully Residing are required to verify their immigration status at application and renewal, even if they have previously verified their immigration status:

- Immigrant children under age 19
- Youths under age 21 in an Institution for Mental ~~Disease~~Diseases (IMD)
- Pregnant ~~women~~people

Typically, these ~~persons~~ people will be labelled with a "Non-immigrant" status by the United States Citizenship and Immigration Services. Reverifications are not to be done for children and pregnant ~~women~~ people with other Registration Status Codes, as those statuses are permanent.

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

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 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 five days. It also means that if a member shows that a notice was received more than five days after the date on the notice, the deadline must be extended to 90 days after the date the member received the notice.

The 90-day ROP applies when immigration 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.

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

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

Example 1:	Vladimir is a 12-year-old lawfully present in the United States on a visa applying for health care benefits with his parents. When verification is attempted through the FDSH, the response requires a secondary verification request to SAVE. Vladimir is otherwise eligible for Medicaid and is enrolled in Medicaid and the ROP notice is sent to the family while waiting for the SAVE response. A week later, SAVE verifies the child is lawfully present in the U.S. under a Temporary Protected Status and the reasonable opportunity period ends. A year later, the case is up for renewal. Since Vladimir has a Registration Status Code of 20 – Lawfully Residing, his immigration status must be verified again. Once more, the FDSH response requires verification of the child's status through SAVE. If Vladimir is otherwise eligible for Medicaid, they will be enrolled without delay and be sent a new reasonable opportunity period notice to the family. Again, Vladimir may be eligible for up to 90 days after receiving the notice while his immigration status is being verified.

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~~ on Trafficking in Persons (HHS ~~ORR~~OTIP). She is enrolled in BadgerCare Plus ~~eligibility~~ and is sent the ROP notice requesting Sasha submit a letter from HHS ~~ORR~~OTIP. Sasha never submits a letter from HHS ~~ORR~~OTIP and her benefits end when the ROP expires. One year later, Sasha again applies for health care benefits. Once more, the FDSH returns the same results. 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~~OTIP. Again, Sasha is eligible for BadgerCare plus for 90 days after receiving the notice while waiting for Sasha to provide a letter from HHS ~~ORR~~OTIP.

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

7.3.3 Immigrants Eligible for Medicaid

Immigrants may be eligible for Medicaid if they meet all other eligibility requirements and are either Qualifying Immigrants ~~or are Lawfully Present as described below.~~(see Section 7.3.3.1 Qualifying Immigrants) or are Lawfully Present (see Section 7.3.3.2 Lawfully Present Immigrant Children, Young Adults, and Pregnant People).

7.3.3.1 Qualifying Immigrants

Immigrants of any age meeting the criteria listed below are considered Qualifying Immigrants. Unless otherwise specified, categories of qualifying immigrants are enumerated in 8 U.S.C.§ 1641(b) and (c).

1. ~~A refugee admitted under Immigration and Nationality Act (INA) Section 207. A refugee is a person who flees their country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group. An immigrant admitted under this refugee status may be eligible for Medicaid even if their immigration status later changes.~~
2. ~~An asylee admitted under INA Section 208. Similar to a refugee, an asylee is a person who seeks asylum and is already present in the U.S. when they request permission to stay. An immigrant admitted under this asylee status may be eligible for Medicaid even if their immigration status later changes.~~
3. ~~An immigrant whose deportation is withheld under INA Section 243(h) and such status was granted prior to April 1, 1997, or an immigrant whose removal is withheld under INA Section 241(b)(3) on or after April 1, 1997. An immigrant admitted under this status may be eligible for Medicaid even if their immigration status later changes.~~
4. ~~A Cuban/Haitian entrant. An immigrant admitted under this Cuban/Haitian entrant status may be eligible for Medicaid even if their immigration status later changes. Haitians paroled into the U.S. through the Haitian Family Reunification Parole Program are considered Cuban-Haitian entrants (see Section 7.3.3.6 Cuban & Haitian Entrants).~~
5. ~~An American Indian born in Canada who is at least 50% American Indian by blood or an American Indian born outside the U.S. who is a member of a federally recognized Indian tribe.~~
6. ~~Victims of a severe form of trafficking in accordance with 107(b)(1) of the Trafficking Victims Protection Act of 2000 (P.L. 106-386) (see Section 7.3.11 Victims of Trafficking).~~
7. ~~An immigrant lawfully admitted for permanent residence under the INA 8 USC 1101 et seq.*~~
8. ~~An immigrant paroled into the U.S. under INA Section 212(d)(5) for at least one year.*~~
9. ~~An immigrant granted conditional entry under immigration law in effect before April 1, 1980 [INA Section 203(a)(7)]*~~

10. An immigrant who has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.*
11. An immigrant whose child has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.*
12. An immigrant child who resides with a parent who has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.*
13. Citizens of the Compacts of Free Association (COFA) countries (see Section 7.1.3 Compacts of Free Association).

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

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

7.3.3.2 Lawfully Present Immigrant Children, Young Adults, and Pregnant Women

Children younger than 19 years old, adults younger than 21 years old who are residing in an IMD, and pregnant women do not have to wait five years to be eligible for full-benefit Medicaid and BadgerCare Plus if they meet one of the following criteria:

- Are lawfully admitted for permanent residence (see Registration Code #1 in the Immigration Status Chart in Section 7.3.8)
- Are lawfully present under Section 203(a)(7) (see Code #3 in the Immigration Status Chart in Section 7.3.8)
- Are lawfully present under Section 212(d)(5) (see Code #6 in the Immigration Status Chart in Section 7.3.8)
- Have suffered from domestic abuse and are considered to be a battered immigrant (see Code #16 in the Immigration Status Chart in Section 7.3.8)

Women who have an immigration status requiring a five-year waiting period before being eligible for BadgerCare Plus will have the waiting period lifted when their pregnancy is reported to the agency. The lift on the five-year waiting period continues for an additional 60 days after the last day of pregnancy and through the end of the month in which the 60th day occurs.

Children younger than 19 years old, young adults younger than 21 years old who are residing in an IMD, and pregnant women

Types of Qualifying Immigrants

Short Name	Qualifying Immigrant Description	Eligible if:	Additional Eligibility Information	CWW Registration Status
Refugee	A refugee admitted under Immigration and	No additional criteria.	An immigrant admitted under	04

	Nationality Act (INA) Section 207. A refugee is a person who flees their country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group.		this status may be eligible for Medicaid, without a 5-year wait, even if their immigration status later changes.	
Refugee - Like	An immigrant who has benefits eligibility to the same extent as refugees due to an act of Congress.	See Section 7.3.3.1.1 "Refugee-Like" Immigrants who have Benefits Eligibility as Refugees Because of an Act of Congress for more information.	N/A	04
Asylee	An asylee admitted under INA Section 208. an asylee is a person who seeks asylum and is already present in the U.S. when they request permission to stay.	No additional criteria.	An immigrant admitted under this status may be eligible for Medicaid, without a 5-year wait, even if their immigration status later changes.	05
Deportation Withheld	An immigrant whose deportation is withheld under INA Section 243(h) and such status was granted prior to April 1, 1997, or an immigrant whose removal is withheld under INA Section 241(b)(3) on or after April 1, 1997.	No additional criteria.	An immigrant admitted under this status may be eligible for Medicaid, without a 5-year wait, even if their immigration status later changes.	15
Cuban-Haitian Entrant	Cuban-Haitian Entrants are defined as certain nationals of Cuba or Haiti who have permission to reside in the U.S. based on humanitarian considerations or	No additional criteria.See Section 7.3.3.1.2 Cuban-Haitian Entrants for more information.	The term "Cuban-Haitian Entrant" (CHE) relates to benefit eligibility rather than an immigration status. Individuals who meet the	11

	under Section 501(e) of the Refugee Education Assistance Act of 1980 (REAA).		definition of a CHE may be eligible for certain public benefits.	
Foreign Born American Indian	An American Indian born in Canada who is at least 50% American Indian by blood, as defined by §289 of the Immigration and Nationality Act or An American Indian born outside the U.S. who is a member of a federally recognized Indian tribe, as defined in 25 U.S.C. 450b(e).	No additional criteria.	N/A	18
COFA Citizen	A person who is a citizen~~s~~ of a country in the Compacts of Free Association (COFA) See Section 7.3.3.1.3 COFA for more information	No additional criteria. See Section 7.3.3.1.3 Citizens of the Compacts of Free Association Countries for more information.	COFA Citizens who later become lawful permanent residents must meet additional criteria at the time they become LPRs.	22
Trafficking Victim's child, spouse, or parent	Victims of a severe form of trafficking, and their child, spouse, or parent in accordance with 107(b)(1) of the Trafficking Victims Protection Act of 2000 (P.L. 106-386). See 7.3.3.1.4 Victims of Trafficking for more information.	See 7.3.3.1.4 Victims of Trafficking for more information.	An immigrant admitted under this status may be eligible for Medicaid, without a 5-year wait, even if their immigration status later changes.	19
Trafficking victim		Meet one additional criterion: 1. Have been in a qualifying immigration status for at least five years. 2. Be a child younger than 19 years old. 3. Be younger than 21 years old and reside	Be certified by the Department of Health and Human Services as victim of trafficking (applies to T1 visa holders and others).	19 - Meets one additional criterion or is certified by HHS as a victim of trafficking. Or

		in an i~~l~~nstitutions for Mental Diseases. 4. Be pregnant. 5. Have arrived in the U.S. before August 22, 1996, and have been continuously present. 6. Have a military service/connection. 7. Be an Amerasian immigrant. 8. See Section 7.3.3.1.5 Additional Criteria for Certain Qualifying Immigrants for more information.		21- 5-year wait applies
LPR	An immigrant lawfully admitted for permanent residence under INA 8 USC 1101 et seq		LPRs who were first refugees, asylees, Cuban or Haitian entrants, certain trafficking victims, or had their deportation withheld maintain that status for benefits eligibility purposes.	01
Parolee	An immigrant paroled into the U.S. under INA Section 212(d)(5) for at least one year		Certain parolees are treated as refugees for benefits eligibility purposes due to acts of Congress (see Section 7.3.3.1.1 "Refugee-Like" Immigrants who have Benefits Eligibility as Refugees Because of an Act of Congress). Parolees who are nationals of Cuba or Haiti may be Cuban Haitian Entrants for benefits eligibility purposes (see Section 7.3.3.1.2 Cuban- Haitian Entrants).	06
Conditional Entrant	An immigrant granted conditional entry under immigration law in effect before April 1,		N/A	03

	1980 [INA Section 203(a)(7)].			
Battered Immigrants	An immigrant as described at 8 U.S.C. §1641(c)(1) who has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements		N/A	16
	An immigrant as described at 8 U.S.C. §1641(c)(2) whose child has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.		N/A	16
	An immigrant child as described at 8 U.S.C. §1641(c)(3) who resides with a parent who has been battered or subjected to extreme cruelty in the U.S. and meets certain other requirements.		N/A	16

7.3.3.1.1 "Refugee-Like" Immigrants who have Benefits Eligibility as Refugees Because of an Act of Congress

~~may qualify for BadgerCare Plus or Medicaid if they are lawfully present in the U.S. under many of the immigrant and non-immigrant statuses. For those who are not in a qualifying Immigrant category, but are lawfully present, use the Registration Status Code of 20. Please see Process Help, Section 82.6 VIS SAVE Verification Responses Table for a list of SAVE Responses and the appropriate Registration Status Code in CWW to apply.~~

~~Immigrants who are not a qualifying immigrant nor lawfully present (for example, someone with a status of DACA) and who apply for Medicaid and meet all eligibility requirements, except for citizenship and immigration status, are entitled to receive Medicaid Emergency Services only (see Chapter 34 Emergency Services).~~

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

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

~~7.3.3.3~~ 7.3.3.1.1.1 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 (COA) Code	**Description**	**CARES Alien Registration Status Code**
SI1 or SQ1	Principal Applicant Afghan or Iraqi Special Immigrant	Code 04
SI2 or SQ2	Spouse of Principal Applicant Afghan or Iraqi Special Immigrant	Code 04
SI3 or SQ3	Unmarried Child under 21 Years of Age of Afghan or Iraqi Special Immigrant	Code 04
SI6 or SQ6	Principal Applicant Afghan or Iraqi Special Immigrant Principal Adjusting Status in the U.S.	Code 04
SI7 or SQ7	Spouse of Principal Applicant Afghan or Iraqi Special Immigrant Principal Applicant Adjusting status in the U.S.	Code 04
SI8 or SQ8	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.

7.3.3.4~~1~~1.1.2 Afghan Humanitarian Parolees

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

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

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

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

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

Class of Admission Code	**Description**	**CARES Alien Registration Status Code**
SQ4, SQ5	Special Immigrant Parolee (SI Parolee)	Code 04
DT, OAR, OAW, PAR	Humanitarian Parolee	Code 04

7.3.3.~~5~~1.1.3 Ukrainian Humanitarian 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, 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, 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, 2024.

Ukrainian Humanitarian Parolees are to continue to be treated as refugees until the date their parole status expires or as long as they remain in a qualifying immigrant status.

The table below shows the Class of Admission ~~Codes~~(COA) 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.

7.3.3.~~6~~1.2 Cuban ~~&~~ Haitian Entrants

The term "Cuban-Haitian Entrant" (CHE) relates to benefit eligibility rather than an immigration status. Cuban-Haitian entrants are defined as certain nationals of Cuba or Haiti who have permission to reside in the U.S. based on humanitarian considerations or under Section 501(e) of the Refugee Education Assistance Act of 1980 (REAA). CHE are qualified immigrants with no waiting period.

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

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

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

~~7.3.5 Immigration and Naturalization Service (INS) Reporting~~

~~Do not refer an immigrant to INS unless information for administering the Medicaid program is needed. For example, if Medicaid needs to determine an individual's location for repayment or fraud prosecution, or to determine his or her immigration status.~~

7.3.3.1.3 Citizens of the Compacts of Free Association Countries

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

As of December 27, 2020, COFA citizens may be eligible for health care if they meet all other eligibility requirements. In addition, COFA citizens are not subject to the 5-year waiting period. However, COFA citizens who have a change in their status and become Lawful Permanent Residents are subject to the 5-year waiting period.

7.3.~~6 Continuous~~3.1.4 Victims of Trafficking

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

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

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

Trafficking victims who are confirmed as eligible for Medicaid without a five-year wait and who later adjust their status and become Lawful Permanent Residents are not subject to the five-year waiting period as Lawful Permanent Residents.

7.3.3.1.5 Additional Criteria for Certain Qualifying Immigrants

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

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

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

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

~~1.~~5. Arrived in the U.S. before August 22, 1996, and have been continuously present. Applicants who alleged an arrival date in the U.S. before August 22, 1996, and obtained ~~legal~~a qualified immigrant status after August 22, 1996, ~~are not subject to the five-year ban and~~ may be eligible to receive ~~federal BadgerCare Plus enrollment~~ Medicaid. The immigrants described below, who apply for ~~BadgerCare Plus~~Medicaid and meet all eligibility requirements, are entitled to receive ~~BadgerCare Plus~~Medicaid benefits:

- A non-citizen who
  - Arrived in the U.S. before August 22, 1996, in a legal, but non-qualified, immigration status and
  - Had a change in ~~his or her~~their status to a qualified immigrant on or after August 22, 1996~~. This individual would not be subject to the five-year ban if he or she~~ and
  - R~~r~~emained continuously present from ~~his or her~~their date ~~or~~of arrival in the U.S. until the date ~~he or she~~they gained qualified immigration status.
- A non-citizen who:
  - A~~a~~rrived in the U.S. before August 22, 1996, in undocumented status, or
  - ~~who o~~Overstayed ~~his or her~~their original visa ~~is treated the same as someone who arrived~~ and
  - ~~r~~Remained ~~in the U.S. with valid immigration documents. Therefore, if this individual remained~~ continuously present from ~~his or her~~their date of arrival in

the U.S. until the date ~~he or she~~they gained qualified immigration status~~, he or she would not be subject to the five-year ban~~.

- For those non-citizens who arrived in the U.S. ~~with or without documentation on or after~~before August 22, 1996, ~~or for those~~but whose continuous presence cannot be verified, the five-year ~~ban~~waiting period applies from the date the individual obtained a qualified immigrant status.

An individual meets the "continuous presence" test if ~~he or she~~they:

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

To establish continuous presence, require a signed statement from the applicant stating ~~he or she was~~they were continuously present for the period ~~of time~~ in question. The signed statement will be sufficient unless a worker believes the information is fraudulent or further information received now indicates that it is questionable.

~~Below is one example of a signed statement:~~
~~I, first and last name, hereby declare that I have continuously resided in the United States between the day I arrived in the United States, date here, and the date I received qualified alien status, date here. I have not left the United States in that time for any single period of time longer than 30 days or for multiple periods totaling more than 90 days.~~
~~Applicant/authorized representative Signature, Date~~

~~7.3.7 Undocumented Non-Citizens~~

~~In cases in which it is known that the applicant originally arrived in the U.S. in undocumented status, do not attempt to verify his or her status with the USCIS.~~

Signed Statement Example:	I, first and last name, hereby declare that I have continuously resided in the United States between the day I arrived in the United States, date here, and the date I received qualified immigrant status, date here. I have not left the United States in that time for any single period longer than 30 days or for multiple periods totaling more than 90 days. Applicant or Authorized Representative Signature, Date

6. Have a military service/connection.

~~Undocumented immigrants do not have any official documentation regarding their date of arrival. Therefore, if a worker needs to establish a date of arrival for a qualified immigrant who originally arrived as an undocumented immigrant prior to August 22, 1996, alternative methods need to be used. In such cases, the applicant must provide at least one piece of documentation that shows his or her presence in the U.S. prior to August 22, 1996. This may include pay stubs, a letter from an employer, lease or rent receipts, or a utility bill in the applicant's name.~~

~~Example 2:~~	~~The legal status conferred on a non-citizen by immigration law—Toshi entered the U.S. February 2, 2004, with qualified immigrant status. She is applying for Medicaid in February 2008. The IM worker should first determine if she is in one of the immigrant categories exempt from the five-year ban. If Toshi is not exempt, then she must wait five years before qualifying for Medicaid. She can be enrolled in Medicaid after February 2, 2009 if she meets other financial and non-financial criteria.~~

Example 3:	Shariff arrived as a student in June 2002. On June 5, 2006 he was granted asylum. The five-year ban does not apply because asylees are exempt from the ban. Secondary verification is not necessary. Shariff is eligible to be enrolled in Medicaid if he meets other financial and non-financial criteria.

Example 4:	Katrin entered the U.S. March 3, 1995, and gained qualified immigrant status June 20, 1995. She is applying for Medicaid in February 2008. She is a qualified immigrant who entered the U.S. prior to August 22, 1996. There is no need to apply the five-year ban. She is eligible for Medicaid if she meets other financial and non-financial criteria.

Example 5:	Juan entered the U.S. as an undocumented immigrant on April 1, 1996. He applied for Medicaid on February 1, 2008. His immigration status changed to lawful permanent resident on March 3, 2005. He has signed a self-declaration stating he remained continuously present in the U.S. between April 1, 1996, and March 3, 2005. Additionally, Juan provided a copy of a lease showing a date prior to August 1996. He is eligible for Medicaid if he meets other financial and non-financial criteria.

Example 6:	Elena entered the U.S. on July 15, 1999, on a temporary work visa and obtained qualified immigration status on October 31, 2004. She applied for Medicaid February 1, 2008, and has been in the U.S. for over five years. Elena is not in one of the immigrant categories exempt from the five-year ban. Therefore, the five-year ban would have to be applied since Elena's original entry date is after August 22, 1996. The five-year clock starts from the date she obtained qualified immigration status, so she would be able to apply for Medicaid after October 31, 2009.

Example 7:	Tomas entered the U.S. on April 8, 1996, on a visitor's visa. He obtained qualified alien status on September 22, 2003. Tomas applied for Medicaid on May 5, 2008. The IM worker completed primary verification and USCIS responded with the date of entry as September 22, 2003, since that was the last updated date on his status. The IM worker needs to confirm with the applicant that this is the original date he arrived in the U.S. Tomas explained that he arrived in 1996; therefore, the IM worker needs to conduct secondary verification. USCIS responds and confirms that the original date of arrival was April 8, 1996. Additionally, the IM worker needs to confirm that the applicant was continuously present between April 8, 1996, and September 22, 2003. Tomas signs a self-declaration confirming this and is found eligible. If the IM worker had used September 22, 2003, as the date of entry in CARES, Tomas would have been incorrectly subject to the five-year ban and not eligible until September 22, 2008.

7.3.801	Lawfully admitted for permanent residence	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009 Eligible
02	Permanent resident under color of law (PRUCOL)		Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
03	Lawfully present under	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009 Eligible

	Section 203(a)(7)					
04	Lawfully present under Section 207(c)	Eligible	Eligible	Eligible	Eligible	Eligible
05	Lawfully present under Section 208	Eligible	Eligible	Eligible	Eligible	Eligible
06	Lawfully present under Section 212(d)(5) and paroled for at least one year	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009 Eligible
07	IRCA (No longer valid)	N/A	N/A	N/A	N/A	N/A
08	Lawfully admitted - temporary	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
09	Undocumented Immigrant	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
10	Illegal Immigrant	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
11	Cuban/Haitian Entrant	Eligible	Eligible	Eligible	Eligible	Eligible
12	Considered a Permanent Resident by USCIS	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
13	Special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
14	Additional special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
15	Withheld deportation - Section 243(h)	Eligible	Eligible	Eligible	Eligible	Eligible
16	Battered Immigrant	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009 Eligible
17	Amerasian	Eligible	Eligible	Eligible	Eligible	Eligible
18	Foreign-Born Native American	Eligible	Eligible	Eligible	Eligible	Eligible
19	Victims of Trafficking **	Eligible	Eligible	Eligible	Eligible	Eligible
20	Lawfully Residing	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
21	Victims of Trafficking Subject to 5 Year Bar	Eligible	Eligible	Ineligible for 5 years	Eligible	Eligible
22	Citizens of Compacts of Free Assoc (COFA)	Eligible	Eligible	Eligible	Eligible	Eligible

* "Veteran" includes certain veterans and active duty servicemen and women, their spouses, dependent children, or certain surviving spouses.

**Some victims of trafficking may need to provide certain verification to be exempt from the five-year bar. See Section 7.3.11 Victims of Trafficking for more information.

7.3.9 Refugee Assistance Programs

The federal Office of Refugee Resettlement (ORR) provides resources for refugees, asylum seekers, and other new arrivals to the U.S. to assist with their integration into their new community. Several benefit programs overseen by the ORR and operated by the Bureau of Refugee Programs in the Department of Children and Families are discussed here.

7.3.9.1 Counting Refugee Related Income

Refugee Cash Assistance (RCA) program payments are not counted as income for Medicaid. RCA is administered by Wisconsin Works (W-2) agencies and is made available for refugees who do not qualify for W-2.

Refugee "Reception and Placement" (R&P) payments are not counted as income for Medicaid. R & P payments are made to refugees during the first 30 days after their arrival in the U.S. R & P payments are made by voluntary resettlement agencies and may be a direct payment to the refugee individual/ family or to a vendor.

7.3.9.2 Refugee Medical Assistance

If an individual does not meet the other eligibility requirements for Medicaid, they may apply for Refugee Medical Assistance (RMA), which is not funded by Medicaid. Refugee Medical Assistance is considered a separate benefit from Medicaid but provides the same level of benefits. Refugee Medical Assistance is available only in the first 12 months after a special immigrant's date of entry. If it is not applied for in that 12-month period, it cannot be applied for later.

While W-2 agencies have contractual responsibility for providing Refugee Medical Assistance, they need to coordinate with economic support agencies to ensure eligibility for all regular Medicaid subprograms is tested first.

More information about this program is in Wisconsin Works (W-2) Manual, Section 18.3 Refugee Medical Assistance.

Note: The federal Medicaid eligibility for all other refugees admitted under Registration Status Code 04 remains the same.

7.3.10 Military Service

Applicants with an immigration status that requires them to be in that immigration status for five years before being eligible for health care benefits are exempt from this five-year bar

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

- Honorably discharged veterans of the U.S. Armed Forces. This is defined as persons who were honorably discharged after any of the following:
  - Serving for at least 24 months in the U.S. Armed Forces.
  - Serving for the period for which the person was called to active duty in the U.S. Armed Forces.
  - Serving less than 24 months but was discharged or released from active duty for a disability incurred or aggravated in the line of duty.
  - Serving less than 24 months but was discharged for family hardship.
  - Serving in the Philippine Commonwealth Army or as a Philippine Scout during World War II.
- On active duty (other than active duty for training) in the U.S. Armed Forces.

- The spouse, unmarried and non-emancipated child under age 18, or surviving spouse of either an honorably discharged veteran or a person on active duty in the U.S. Armed Forces. A surviving spouse is defined as meeting all ~~of~~ the following criteria:
  - A spouse who was married to the deceased veteran for at least one year.
  - A spouse who was married to the deceased veteran either:
    - Before the end of a 15-~~-~~year time span following the end of the period of military service, or
    - For any period ~~of time~~ to the deceased veteran and a child was born of the marriage or was born before the marriage.
  - A spouse who has not remarried since the marriage to the deceased veteran.

~~7.3.11 Victims of Trafficking~~

~~Applicants claiming to be victims of trafficking (or have a Class of Admission (COA) code indicating that they are a victim – ST6 or T1), have not resided in the United States for at least five years, and are at least 18 years of age, must have a victim certification from the federal Office of Refugee Resettlement (ORR) in the Department of Health and Human Services to be treated like a refugee and be exempt from the five-year bar.~~

~~Persons with a COA code indicating they are a child, spouse, or parent of a trafficking victim (Codes ST0, ST1, ST7, ST8, ST9, T2, T3, T4, T5, or T6) are exempt from the five-year bar and do not need certification from the ORR. Victims of trafficking who are under 18 at the time they apply do not require a certification from the ORR. Victims of Trafficking who are 18 or older and do not have the certification will be subject to the five-year bar.~~

7. Are an Amerasian immigrant.
   - Amerasian immigrants, defined under §584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988, may be eligible for BadgerCare Plus.
8. Also be considered a Cuban/Haitian Entrant.
9. Lawful permanent residents who were previously a refugee, asylee, or had their deportation withheld under INA Section 243(h).
   - Immigrants admitted under these statuses continue to be treated as refugees, asylees or immigrants who had their deportation withheld for benefits eligibility.
   - See Section 7.3.3.1.4 Victims of Trafficking for additional details.

7.3.3.2 Lawfully Present Immigrant Children, Young Adults, and Pregnant People

Children younger than 19 years old, young adults younger than 21 years old who are residing in an IMD, and pregnant people may qualify for BadgerCare Plus or Medicaid if they are lawfully present in the U.S. under many of the immigrant and non-immigrant statuses. For those who are not in a qualifying Immigrant category, but are lawfully present, use the Registration Status Code of 20. Please see Process Help, Section 82.6 VIS SAVE Verification Responses Table for a list of SAVE Responses and the appropriate Registration Status Code in CWW to apply.

7.3.3.3 Immigrants Eligible for Other Health Care Programs

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

Pregnant immigrants who are not a qualifying immigrant nor lawfully present and who apply for the BadgerCare Plus Prenatal Program and meet the eligibility requirements except for citizenship and

immigration status, are entitled to receive BadgerCare Plus Prenatal Program benefits (see BadgerCare Plus Handbook, Chapter 41 BadgerCare Plus Prenatal Program) Emergency Services (see BadgerCare Plus Handbook, Chapter 39 Emergency Services), or both.

7.3.5 Immigration and Customs Enforcement (ICE) Reporting

Medicaid member information cannot be used for immigration enforcement purposes. Do not refer an immigrant to *ICE* .

7.3.6 Undocumented Non-Citizens

In cases in which it is known that the applicant originally arrived in the U.S. in undocumented status, do not attempt to verify his or her status with the U.S Citizenship and Immigration Services (USCIS). Undocumented immigrants do not have any official documentation regarding their date of arrival. ~~Therefore, if a worker needs to establish a date of arrival for a qualified immigrant who originally arrived as an undocumented immigrant prior to August 22, 1996, alternative methods need to be used. In such cases, the applicant must provide at least one piece of documentation that shows his or her presence in the U.S. prior to August 22, 1996. This may include pay stubs, a letter from an employer, lease or rent receipts, or a utility bill in the applicant's name.~~

~~Example 1:~~	~~Toshi entered the U.S. February 2, 2004, with the qualified immigrant status of parolee. She is still a parolee, and she is applying for Medicaid in February 2008. As a parolee Toshi must meet one additional criterion before qualifying for Medicaid. If the only additional criterion Toshi is able to meet is being in a qualified immigration status for five years. Toshi may be able to enroll in Medicaid after February 2, 2009, if she meets other financial and non-financial criteria.~~

~~Example 2:~~	~~Shariff arrived as a student in June 2002. On June 5, 2006, he was granted asylum. Asylees do not have to meet any additional immigration related criteria and secondary verification is not necessary. Shariff is eligible to be enrolled in Medicaid if he meets other financial and non-financial criteria.~~

~~Example 3:~~	~~Katrin entered the U.S. March 3, 1995, and gained qualified immigrant status June 20, 1995. She is applying for Medicaid in February 2008. She is a qualified immigrant. Because she entered the U.S. prior to August 22, 1996, she meets the necessary additional criteria. She is eligible for Medicaid if she meets other financial and non-financial criteria.~~

~~Example 4:~~	~~Juan entered the U.S. as an undocumented immigrant on April 1, 1996. He applied for Medicaid on February 1, 2008. His immigration status changed to lawful permanent resident on March 3, 2005. He has signed a self-declaration stating he remained continuously present in the U.S. between April 1, 1996, and March 3, 2005. Additionally, Juan provided a copy of a lease showing a date prior to August 1996. He is eligible for Medicaid if he meets other financial and non-financial criteria.~~

~~Example 5:~~	~~Elena entered the U.S. on July 15, 1999, on a temporary work visa and obtained qualified immigration status on October 31, 2004. She applied for Medicaid February 1, 2008, and has been in the U.S. for over five years. Elena is in one of the immigrant categories, which requires the individual to meet one additional criterion. The five-year waiting period must be~~

	~~applied since Elena's original entry date is after August 22, 1996. The five-year clock starts from the date she obtained qualified immigration status. Elena may be able to enroll in Medicaid after October 31, 2009.~~

~~Example 6:~~	~~Tomas entered the U.S. on April 8, 1996, on a visitor's visa. He obtained qualified alien status on September 22, 2003. Tomas applied for Medicaid on May 5, 2008. The IM worker completed primary verification and USCIS responded with the date of entry as September 22, 2003, since that was the last updated date on his status. The IM worker needs to confirm with the applicant that this is the original date he arrived in the U.S. Tomas explained that he arrived in 1996; therefore, the IM worker needs to conduct secondary verification to establish Tomas' original arrival date since it was before August 22, 1996, and Tomas' should not be subjected to the five-year wait period. USCIS responds and confirms that the original date of arrival was April 8, 1996. Additionally, the IM worker needs to confirm that the applicant was continuously present between April 8, 1996, and September 22, 2003. Tomas signs a self-declaration confirming this and is found eligible. If the IM worker had used September 22, 2003, as the date of entry in CARES, Tomas would have been incorrectly subject to the five-year waiting period in the additional criteria and not eligible until September 22, 2008.~~

7.3.7 Immigration Status Chart

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

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

05	Lawfully present under Section 208	Eligible	Eligible	Eligible	Eligible	Eligible
06	Lawfully present under Section 212(d)(5) and paroled for at least one year	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009, Eligible
07	IRCA (No longer valid)	N/A	N/A	N/A	N/A	N/A
08	Lawfully admitted - temporary	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
09	Undocumented Immigrant	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
10	Illegal Immigrant	Ineligible	Ineligible	Ineligible	Ineligible	Ineligible
11	Cuban/Haitian Entrant	Eligible	Eligible	Eligible	Eligible	Eligible
12	Considered a Permanent Resident by USCIS	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
13	Special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
14	Additional special agricultural worker under Section 210(A)	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
15	Withheld deportation - Section 243(h)	Eligible	Eligible	Eligible	Eligible	Eligible
16	Battered Immigrant	Eligible	Eligible	Ineligible for 5 years	Eligible	Effective October 1, 2009, Eligible
17	Amerasian	Eligible	Eligible	Eligible	Eligible	Eligible
18	Foreign-Born Native American	Eligible	Eligible	Eligible	Eligible	Eligible
19	Victims of Trafficking **	Eligible	Eligible	Eligible	Eligible	Eligible

20	Lawfully Residing	Ineligible	Ineligible	Ineligible	Ineligible	Eligible
21	Victims of Trafficking Subject to 5 Year Waiting Period	Eligible	Eligible	Ineligible for 5 years	Eligible	Eligible
22	Citizens of Compacts of Free Assoc (COFA)	Eligible	Eligible	Eligible	Eligible	Eligible

* "Veteran" includes certain veterans and active duty servicemen and women, their spouses, dependent children, or certain surviving spouses.
**Some victims of trafficking may need to provide certain verification to be exempt from the five-year waiting period. See Section 7.3.3.1.4 Victims of Trafficking for more information.

7.3.8 Refugee Assistance Programs

The federal Office of Refugee Resettlement (ORR) provides resources for refugees, asylum seekers, and other new arrivals to the U.S. to assist with their integration into their new community. Several benefit programs overseen by the ORR and operated by the Bureau of Refugee Programs in the Department of Children and Families are discussed here.

7.3.8.1 Counting Refugee Related Income

Refugee Cash Assistance (RCA) program payments are not counted as income for Medicaid. RCA is administered by Wisconsin Works (W-2) agencies and is made available for refugees who do not qualify for W-2.

Refugee "Reception and Placement" (R&P) payments are not counted as income for Medicaid. R & P payments are made to refugees during the first 30 days after their arrival in the U.S. R & P payments are made by voluntary resettlement agencies and may be a direct payment to the refugee individual/ family or to a vendor.

7.3.8.2 Refugee Medical Assistance

If an individual does not meet the other eligibility requirements for Medicaid, they may apply for Refugee Medical Assistance (RMA), which is not funded by Medicaid. Refugee Medical Assistance is considered a separate benefit from Medicaid but provides the same level of benefits. Refugee Medical Assistance is available only in the first 12 months after a special immigrant's date of entry. If it is not applied for in that 12-month period, it cannot be applied for later.
While W-2 agencies have contractual responsibility for providing Refugee Medical Assistance, they need to coordinate with economic support agencies to ensure eligibility for all regular Medicaid subprograms is tested first.

More information about this program is in Wisconsin Works (W-2) Manual, Section 18.3 Refugee Medical Assistance.

Note	The federal Medicaid eligibility for all other refugees admitted under Registration Status Code 04 remains the same.

15.1 Income Introduction

15.1.5 Availability

~~General Rules:~~

~~1. Only count income when it is available.~~

~~2. Some income is disregarded (see Section 15.3 Exempt and Disregarded Income).~~

~~Always use gross income when calculating~~

Available income can include more than a person actually receives if any of the following are true:

- A benefit payment (such as a Social Security benefit) has been reduced to recover a previous overpayment.
- Amounts are being withheld because of a garnishment or to pay a debt or other legal obligation.
- Amounts are being withheld to make another payment (such as Medicare premiums).

Available income can include less than a person actually receives if part of the payment is for an expense the person had in getting the payment. For example, if someone is paid for damages they received in an accident, the medical, legal, or other expenses connected with the accident are subtracted from countable income.

If the person receives a retroactive check from a benefit program other than SSI, legal fees connected with the claim are subtracted.

~~3.~~ Any part of taxable income~~.~~

~~4. Some~~ used to pay personal income~~, even though it~~ taxes is ~~unavailable income, must be counted (e.g., garnishments).~~

~~Income~~not subtracted, because the payment of taxes is ~~available if all the following are true:~~

~~1. It is actually available.~~

~~2. The person has a legal interest in it.~~

~~The~~not an expense the person has ~~the legal ability to make it available for support and maintenance~~in getting the income.

Note~~:~~	~~Available income can include more than a person actually receives if amounts are withheld from earned or unearned income because of a garnishment or to pay a debt or any other legal obligation.~~Applicants and members are not required to apply for cash benefits such as Social Security disability or retirement benefits, Supplemental Security Income (SSI), unemployment benefits, pensions, etc., as a condition of eligibility for Medicaid. Cash benefits that a person might potentially be eligible for that they do not actually receive must not be counted as income.

~~Examples of income sources that someone can make available are Social Security and unemployment compensation. This includes income increases such as COLAs.~~

~~When it is known that a member of the assistance group is eligible for some sort of income or an increased amount of income:~~

~~1. Count the income if the amount is known. Count it as if the person is receiving it.~~

~~2. Ignore the income if the amount is not known.~~

~~Example 3:~~	~~Ms. M. turned 62 years old and is entitled to Social Security benefits of $900. However, she opted to wait until she turns 65 years old to start collecting her benefits. Since she is entitled to $900 at 62 years old, $900 is considered available income.~~

~~Income is unavailable when it will not be available for 31 days or more. The person must document the following:~~

- ~~It will not be available for 31 days or more.~~
- ~~They have started the process to make it available.~~

~~Unavailability is usually documented by a letter from an agency stating when the person will receive the benefit. Thus, if he or she has just applied for benefits, do not add it to his or her income yet. The income is not ignored; it is only suspended until it becomes available.~~

15.3 Exempt/Disregarded Income

"Disregard" and "exempt" in this section mean "do not count." When calculating the total amount of income a person has received, disregard the following kinds of income:

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

The treatment of cash ~~and in-kind items~~ benefits received in conjunction with medical and social services depends on whether 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. This includes entities that are under contract with a federal, state, or local government to provide services. ~~For example, a managed care organization for Medicaid for dual eligible special needs plans (D-SNPs).~~
Disregard any cash benefits provided by a governmental medical or social services program.

~~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.~~

Disregard cash benefits provided by a nongovernmental medical or social services organization if either of the following conditions is met:~~.~~

- 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.~~

~~15.3.32 Reserved~~

15.3.32 Medicare Advantage Supplemental Benefits

Disregard all Medicare Advantage supplemental benefits.

A supplemental benefit is an item or service provided by a Medicare Advantage Plan that is not covered by original Medicare.

Example 10	Mariel received a prepaid debit card from her dual eligible special needs (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 must not be counted as income or assets.

15.6 Self-Employment Income

15.6.4 Self-Employed Income Sources

All self-employment income is earned income, except royalty income and some rental income.
Self-employment income is income that is reported to IRS as farm or other self-employment income or as rental or royalty income. When income is not reported to the IRS, you must judge whether or not it is self-employment income.
Self-employment income sources are:

1. Business. Income from operating a business.

2. Capital Gains. Business income from selling securities and other property is counted. ~~Personal~~This does not include personal capital gains, which are ~~not~~ counted as unearned income rather than self-employment income.
3. Rental. Rental income is rent received from properties owned or controlled. Rental income is either earned or unearned. It is earned only if the owner actively manages the property on an average of 20 or more hours per week. If rental income is not reported to the IRS, see Section 15.4.23 Rental Income.
4. Royalties. Royalty income is unearned income received for granting the use of property owned or controlled. Examples are patents, copyrighted materials, or a natural resource. The right to income is often expressed as a percentage of receipts from using the property or as an amount per unit produced.

16.7 Liquid Assets

16.7.35 ~~D-SNP Wellness~~ Medicare Advantage Supplemental 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.~~

Disregard all Medicare Advantage supplemental benefits.

A supplemental benefit is an item or service provided by a Medicare Advantage Plan that is not covered by original Medicare.

Example 12	Mariel received a prepaid debit card from her dual eligible special needs plan (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 must not be counted as income or assets.

17.2 Evaluation of Transfers for Divestment

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

17.2.7.4 Avoiding Receipt

The action of avoiding the receipt of income or assets a member is entitled to is an unallowable divestment and results in a penalty period. This type of divestment includes:

- Irrevocably waiving pension income.
- Disclaiming an inheritance.
- Not accepting or accessing injury settlements.
- Diverting tort settlements into a trust or similar device.
- Refusing to take legal action to obtain a court-ordered payment that is due to the institutionalized person, such as child support or alimony.

It is not divestment if the applicant or member fails to apply for cash benefits that they may be eligible for, such as Social Security or veterans' benefits.

18.4 Spousal Impoverishment Assets

18.4.3 Calculate the Community Spouse Asset Share

The community spouse asset share is the amount of countable assets greater than $2,000 that the community spouse, the institutionalized person, or both, can possess at the time the institutionalized person applies for Medicaid.

If the total countable assets of the couple are:	**Then the community spouse asset share is:**
$~~274,800~~ 308,280 or more	$~~137,400~~154,140
Less than $~~274,800~~ 308,280 but greater than $100,000	½ of the total countable assets of the couple
$100,000 or less	$50,000

20.3 Mandatory Verification 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~~Verification of tribal membership, descent from a tribal member, or eligibility to receive ~~IHS~~ Indian Health Service (IHS) services is required~~.~~ to receive an exemption from paying Medicaid premiums and copayments (see Section 21.5.2 Copay Exempt Populations). 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)

21.6 HMO Enrollment

21.6.4 HMO Disenrollment

21.6.4.1 Automatic Disenrollment

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

Reason for Disenrollment	**Disenrollment Date**
Loss of Medicaid eligibility	End of the month in which Medicaid eligibility ends.
Date of Death entered	Date of Death
Moving outside of the HMO's service area	End of the month in which the move was reported
Incarceration or Institutionalization	End of the month ~~in which~~prior to the month incarceration or institutionalization ~~was reported~~starts and lasts more than 30 calendar days
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

21.6.4.2 Voluntary Disenrollment

The member may ~~voluntarily~~ disenroll from the HMO for any reason as long as they are no longer in their lock-in period.

If the member is still in the lock-in period, the member, the member's family, or the legal guardian must request ~~a voluntary~~ disenrollment based on a qualifying reason.

Qualifying reasons for ~~voluntary disenrollments may~~ disenrollment include but are not limited to:

- A temporary loss of eligibility caused the member to miss their open enrollment period.
- The HMO does not cover the service the member seeks, due to moral or religious objections.
- The member needs related services (for example, a cesarean section and tubal ligation) to be performed at the same time, but not all related services are within the provider network and the member's primary care provider or another provider determines that the risk of receiving services separately would subject the member to unnecessary risk.
- The member is enrolled in both Medicaid and a Medicare Dual Eligible Special Needs Plan (D-SNP) and is requesting to align their Medicaid-HMO with their Medicare D-SNP.
- Other reasons, including poor quality of care, lack of access to services, or lack of access to providers experienced in dealing with the member's care needs.

Voluntary disenrollments are effective no later than the first day of the month following the month in which the disenrollment was requested.

If the SSI HMO fails to complete a required assessment and care plan during the first 90 days of enrollment and is able to demonstrate a good faith process to complete the assessment, the open enrollment period will be extended an additional 30 days.

23.2 Fair Hearings

23.2.4 Continued Benefits

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

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

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

25.01 Special Status Medicaid

25.1.1 Special Status Medicaid Introduction

Federal provisions require DHS to continue to consider specified groups of former SSI beneficiaries asSSI recipients in Wisconsin are automatically enrolled in SSI beneficiaries for Medicaid purposes, as long as they would otherwise beand remain eligible for SSI Medicaid as long as they continue to receive SSI. Loss of SSI payments "but for" the income disregards required to be given in eachcan result in loss of Medicaid coverage.

There are special status group.federal Medicaid continuation provisions to protect health care benefits for certain groups of former SSI recipients who receive Social Security payments. These "special status" groups are:

These "special status" Medicaid groups include the following:

- 503 cases (see Section 25.1 "503" Eligibility)
- DAC (see Section 25.2 Disabled Adult Child)
- Widows and widowers (see Section 25.3 Widows and Widowers)
- 1619 cases (see Section 25.5 1619 Cases)
- Disabled adult child (DAC) group (see SECTION 25.2 DISABLED ADULT CHILD (DAC) GROUP)
- 503 group (see SECTION 25.3 503 GROUP)
- Widow/Widower group (see SECTION 25.4 WIDOW/WIDOWER GROUP)

When determining the eligibility for Special Status Medicaid applicants and membersformer SSI recipients who belong to one of these special status groups, the appropriate COLA and OASDI amount of Social Security income disregardsmust be disregarded, as described in the policy for each group, must be given. (see sections linked above). Each Special Status Medicaid group has a specific set of requirements that a person must be met before the member can be considered a Special Status MA member (see sections listed above). meet to qualify for a special status income disregard. Simply losing SSI or receiving a DAC or Widow/Widower certain type of Social Security payment does not automatically qualify a member for a Special Status disregard. To receive the Special Status Medicaid considerations, the individual must have received SSI income in the month prior to the month in which he or she began to receive OASDI, DAC, or Widow/Widower payment. Sometimes payments will be received concurrently, but not alwayssomeone for a special status disregard.

IM agencies are responsible for:

1. Determining whether Social Security beneficiaries who received SSI in the past qualify for special status disregards as a DAC, 503, or Widow/Widower group.
2. Calculating and applying the appropriate Social Security income disregards for these groups when applicable.

Note:	"Concurrent" includes situations in which OASDI eligibility is granted retroactively for months in which the person was also receiving SSI. It also includes situations in which SSA recovers the SSI payment because the OASDI payment covers the same time period for which the person received SSI.Medicaid eligibility is also protected for "Section 1619" participants (see SECTION 25.5 SECTION 1619 GROUP). IM workers do not determine Medicaid eligibility for Section 1619 participants, who are automatically enrolled in SSI Medicaid.

"Concurrent25.1.2 Special Status Medicaid Income and Asset Limits

Special Status Medicaid has the same income and asset limits as SSI-Related Medicaid:

- The assistance group must have countable income at or below 100% FPL after "special status" Social Security disregards.

- The assistance group must have countable assets at or below $2,000 for an unmarried person or $3,000 for a married couple.

Note	DAC and 503 groups who are eligible for Special Status Medicaid are categorically eligible for QMB (see Section 32.2 QMB) if they receive Medicare. Section 1619 groups who receive Medicare receive QMB benefits as part of their SSI Medicaid benefit package.

25.2 Disabled Adult Child (DAC) Group

25.2.1 Introduction

Section 1634(c) of the Social Security Act requires states to consider disabled adult children who lose SSI eligibility as if they were still SSI recipients for Medicaid purposes so long as they would have remained otherwise eligible for SSI benefits but for their entitlement to (or increase in) Social Security disabled child (SSDC) benefits.

SSDC is a Social Security benefit for adults aged 18 and older who have a disability that began before they reached the age of 22. It is called a "child" benefit because it is based on the Social Security earnings record of the recipient's parent (or grandparent, in some cases) who is disabled, retired, or deceased.

Note	Some people who receive SSDC and qualify for the DAC disregard may also receive Social Security benefits (such as SSDI) based on their own earnings record. If that Social Security benefit was received concurrently with SSI, then the person also qualifies as a 503 group. The portion of that Social Security payment that is attributable to COLA increases since SSI was lost must be disregarded in accordance with 503 policies (see Section 25.3 503 Group).

25.2.2 Identifying a DAC Group

Someone qualifies as a DAC for Medicaid purposes if they meet the following criteria:

1. They currently receive a Social Security disabled child (SSDC) payment.
2. They previously received SSI (or they were a 1619 participant), but they became ineligible for SSI/1619 due to excess income when they started receiving the SSDC benefit (or increase).

25.2.3 Determining the Income Disregard for DAC Group

When eligibility is determined for someone who meets DAC criteria, the disregard amount depends on whether it was the initial SSDC payment or an increase to the SSDC payment that caused the loss of SSI.

25.2.3.1 Initial SSDC Payment Caused Loss of SSI

If the initial SSDC payment caused the individual to lose SSI, the disregarded amount is the gross amount of the SSDC payment. The gross amount must include any Medicare premiums being deducted from the SSDC.

Example 1	While his mother worked, Harvey received a monthly SSI payment. When his mother retired, Harvey became eligible for an SSDC payment of $1,150. The SSDC payment exceeded the SSI income limits, causing Harvey's SSI (and SSI Medicaid) eligibility to end. When Harvey applies for Medicaid, the entire amount of the initial SSDC payment ($1,150) is disregarded. Going forward, any subsequent COLA increases to his SSDC payment will be disregarded automatically as part of the annual COLA mass change.

If the initial SSDC payment caused the individual to lose SSI, and then the SSDC payment later increases (for example, when the parent passes away), the increase amount is counted as income and is not disregarded. All subsequent annual COLA increases are disregarded.

Example 2	While her father worked, Jane received a monthly SSI payment of $877.78. When her father passed away, Jane became eligible for an SSDC payment of $1,772 per month. The SSDC payment exceeded the SSI income limits, causing her SSI (and SSI Medicaid) eligibility to end. When Jane applies for Medicaid, the entire amount of the initial SSDC payment ($1,772) is disregarded. Two years later, Jane's SSDC payment increased to $2,025 when her brother

	graduated from high school and stopped receiving Social Security survivor benefits. A new disregard amount is not calculated due to this increase. The original SSDC payment will continue to be disregarded for the Special Status Medicaid eligibility determination. However, the increase that occurred when her brother graduated will not be disregarded. Going forward, any subsequent COLA increases to the SSDC payment will be disregarded automatically as part of the annual COLA mass change.

25.2.3.2 Increase to SSDC Payment Caused Loss of SSI

SSDC payments can increase, for example, when the parent whose earnings record the SSDC payment is based on passes away, or when another person in the family who was getting Social Security benefits (resulting in a lower SSDC payment amount due to SSA's "family maximum" rules) stops getting Social Security.

If an increase to the SSDC payment caused the individual to lose SSI, the disregard amount is calculated as follows:

1. Determine the gross SSDC payment amount immediately prior to the increase that caused loss of SSI.
2. Subtract that amount from the current gross SSDC payment. The gross amount must include any Medicare premiums being deducted from the SSDC.

Example 3	While his father worked, George received a monthly SSI payment. When his father retired and began receiving Social Security, George began receiving an SSDC payment of $600 per month. This caused George's SSI payment to decrease, but he remained eligible for SSI (and SSI Medicaid). Ten years later, George's father passed away and George's SSDC payment increased to $1,101, which caused George to lose SSI (and SSI Medicaid). George applies for Medicaid. The disregard amount must be determined as follows: 1. Determine through the SSA data exchange that the gross SSDC payment immediately prior to the increase that caused loss of SSI was $734 (the original $600 plus ten years of COLA increases). 2. Subtract $734 from the current gross SSDC payment amount ($1,101) to get a disregard amount of $367. Going forward, any subsequent COLA increases to the SSDC payment will be disregarded automatically as part of the annual COLA mass change.

25.3 503 Group

25.3.1 Introduction

This group, named after section 503 of Public Law 94-566 extends Medicaid eligibility to certain former SSI recipients if they would be otherwise eligible for SSI benefits if all historical COLA increases to their Social Security benefits since SSI was lost were disregarded.

25.3.2 Identifying a 503 Group

Someone qualifies as a 503 group for Medicaid purposes if they meet the following criteria:

1. They currently receive some type of Social Security benefits.
2. They were previously eligible for SSI (or they were a 1619 participant) but became ineligible for SSI/1619 for any reason.
3. In any month since April 1977, they were eligible for SSI/1619 benefits concurrently with Social Security benefits.

"Concurrently" includes situations in which Social Security benefits are granted retroactively for months in which the person was also receiving SSI. It also includes situations in which SSA recovered the SSI payment because the Social Security payment covers the same period for which the person received SSI. However, "concurrently" does not include situations in which SSI eligibility is granted retroactively for a period in which the person was also receiving ~~OASDI benefits~~Social Security benefits. To be considered a 503 group, a person must have received SSI income in the month prior to the month in which they began to receive the Social Security payment. Sometimes SSI and Social Security payments will be received in the same month, but not always.

~~25.1 "503" Eligibility~~

~~25.1.1 "503" Introduction~~

~~Federal law requires that the IM agency provide Medicaid eligibility to any person for whom the following conditions exist:~~

- ~~He or she is receiving OASDI benefits.~~
- ~~He or she was receiving SSI concurrently with OASDI but became ineligible for SSI for any reason.~~
- ~~Total countable income, excluding the "503" disregarded income, is less than or equal to the categorical income limits for SSI-related Medicaid.~~
- ~~Total countable assets must be below the categorical asset limits for SSI-related Medicaid.~~

~~**Note:**~~Example	~~"Concurrent" includes situations in which OASDI eligibility is granted retroactively for months in which the person was also receiving SSI. It also includes situations in which *SSA* recovers the SSI payment because the OASDI payment covers the same time period for which the person received SSI. On the other hand, "concurrent" does not include situations in which SSI eligibility is granted retroactively for a period in which the person was also receiving OASDI benefits. To receive the 503 eligibility considerations, the individual must have received SSI income in the month prior to the month in which he or she began to receive the OASDI, DAC, or Widow/Widower payment. Sometimes payments will be received concurrently, but not always.~~Kathy received both SSI and Social Security Surviving Spouse (SSSS) payments for the past five years. She lost her SSI payment due to an increase in unearned income when she began receiving a pension in January of this year. While a COLA increase was not the reason she lost SSI, because the SSI and SSSS payments were received concurrently and then she lost SSI, when her Medicaid eligibility is determined, Kathy is entitled to a disregard of all COLA increases to her SSSS payments since the date SSI was lost.

~~An assistance group with these two characteristics is often referred to as a "503" assistance group. The name comes from Section 503 of the law that implemented this policy (Public Law 94-566).~~

25.3.3 Determining the COLA Disregard for 503 Group

To calculate the COLA disregard for 503 groups:

1. Find the gross Social Security income, which is the sum of the following:
    a. Net amount of the Social Security payment
    b. Any amount being deducted for Medicare premiums
    c. Any amount being withheld for other reasons (i.e., overpayments, garnishments)
2. In the “Month SSI Last Received” column in the table below, find the month in which the person was last eligible for and received an SSI payment.
3. Find the decimal figure that applies to that month and the year the Social Security check was received.
4. Multiply the gross Social Security income by the applicable decimal figure and round to the nearest whole dollar.

~~**Example 1:**~~Note	~~Kathy received SSI and SSSS (Social Security Surviving Spouse) payments for five years. She lost her SSI payment due to an increase in unearned income when she began receiving a pension payment in January of this year. While an increase in the COLA was not the reason for her loss of the SSI payment, she is still entitled to receive a COLA disregard on any OASDI payments she receives because she received OASDI concurrently with SSI and lost SSI.~~

	Kathy will receive COLA disregards on her SSSS payment in order to determine her eligibility for special status Medicaid.Once the disregard amount is determined and applied, going forward, all subsequent COLA increases will be disregarded automatically as part of the annual COLA mass change.

25.1.2 Identifying a "503" Assistance Group

When a "503" assistance group applies for Medicaid, disregard all OASDI COLAs the assistance group has received since the last month he or she was eligible for and received both OASDI and SSI benefits.

To identify a "503" assistance group, complete the following steps:

1. Determine whether, after April 1977, there has ever been a month in which one of the following conditions existed for the applicant or member:
    - He or she was eligible for both OASDI and SSI (a person who received SSI fraudulently does not qualify as a "503" case).
    - He or she received an OASDI check or a retroactive OASDI check and a SSI check for the same month in which he or she was eligible for both OASDI (or retroactive OASDI) and SSI.
    a. If the answer to both questions is "No," the applicant or member is not considered a "503" assistance group.
    b. If the answer to either of the questions is "Yes," the applicant or member is no longer receiving SSI. Proceed to Step 2.
2. Determine if the applicant or member is now receiving an OASDI check.
    a. If the answer is "No," he or she is not a "503" assistance group.
    b. If the answer is "Yes," he or she is a "503" assistance group and will receive a COLA disregard. Enter “Y” on the Individual Nonfinancial>Prior SSI page in CWW.

If the applicant or member was receiving SSI-E, the state SSI-E will also be deducted (see Section 39.4.1 Elderly, Blind, or Disabled Assets and Income Table). SSI-E assistance groups are SSI recipients who receive a higher state supplement than regular SSI. People who receive SSI-E payments must live in one of the following:

- In substitute care
- At home and need more than 40 hours a month of primary long-term support services.

25.1.3 Calculating the Cost-of-Living Adjustment Disregard

To calculate the COLA disregard amount, do the following:

1. Find the assistance group's current gross OASDI income. The gross OASDI income is the amount of the OASDI check plus any amount that has been withheld for a Medicare premium plus any amount withheld to repay an earlier overpayment.
2. On the COLA Disregard Amount Table (see Section 39.6 COLA Disregard), find the last month in which the person was eligible for and received a check for both OASDI (or retroactive OASDI) and SSI.
3. Find the decimal figure that applies to this month.
4. Multiply the person's current gross OASDI income by the applicable decimal figure. The result is the COLA disregard amount.

Example 2	Newby's current gross OASDI income is $820. He is not currently receiving SSI benefits. The last month in which he was eligible for both OASDI and SSI and received benefits from both was April 2013. On the COLA Disregard Amount Table (see Section 39.6 COLA Disregard), April 2013 falls between January–December 2013.

	~~The decimal figure that applies to April 2013 is 0.382657. Multiply 0.382657 by $820 to find Newby's COLA disregard amount of $313.78. Subtract the $313.78 disregard amount from $820. Newby's countable OASDI income is $506.22.~~

Month SSI Was Last Received	Multiply 2025 Social Security by:	Multiply 2024 Social Security by:
Jan 2024 - Dec 2024	0.024390	--
Jan 2023 - Dec 2023	0.054642	0.031008
Jan 2022 - Dec 2022	0.130305	0.108563
Jan 2021 - Dec 2021	0.178758	0.158227
Jan 2020 - Dec 2020	0.189298	0.169030
Jan 2019 - Dec 2019	0.202065	0.182116
Jan 2018 - Dec 2018	0.223798	0.204393
Jan 2017 - Dec 2017	0.239018	0.219993
Jan 2016 - Dec 2016	0.241294	0.222326
Jan 2015 - Dec 2015	0.241294	0.222326
Jan 2014 - Dec 2014	0.253976	0.235326
Jan 2013 - Dec 2013	0.265001	0.246626
Jan 2012 - Dec 2012	0.277287	0.259220
Jan 2011 - Dec 2011	0.302401	0.284961
Jan 2010 - Dec 2010	0.302401	0.284961
Jan 2009 - Dec 2009	0.302401	0.284961
Jan 2008 - Dec 2008	0.340644	0.324160
Jan 2007 - Dec 2007	0.355468	0.339355
Jan 2006 - Dec 2006	0.376058	0.360459
Jan 2005 - Dec 2005	0.400632	0.385648
Jan 2004 - Dec 2004	0.416390	0.401799
Jan 2003 - Dec 2003	0.428393	0.414103
Jan 2002 - Dec 2002	0.436285	0.422192
Jan 2001 - Dec 2001	0.450570	0.436835
Jan 2000 - Dec 2000	0.469150	0.455879
Jan 1999 - Dec 1999	0.481592	0.468632
Jan 1998 - Dec 1998	0.488245	0.475451
Jan 1997 - Dec 1997	0.498771	0.486240
Jan 1996 - Dec 1996	0.512897	0.500719
Jan 1995 - Dec 1995	0.525240	0.513371
Jan 1994 - Dec 1994	0.538172	0.526626

Jan 1993 - Dec 1993	0.549875	0.538622
Jan 1992 - Dec 1992	0.562985	0.552060
Jan 1991 - Dec 1991	0.578578	0.568042
Jan 1990 - Dec 1990	0.600169	0.590173
~~Month SSI was Last Received~~	~~Multiply 2025 Social Security by:~~	~~Multiply 2024 Social Security by:~~
Jan 1989 - Dec 1989	0.618117	0.608570
Jan 1988 - Dec 1988	0.632805	0.623625
Jan 1987 - Dec 1987	0.647606	0.638796
Jan 1986 - Dec 1986	0.652128	0.643431
Jan 1985 - Dec 1985	0.662588	0.654152
Jan 1984 - Dec 1984	0.673998	0.665848
Jul 1983 - Dec 1983	0.685022	0.677148
Jul 1982 - Jun 1983	0.706724	0.699393
Jul 1981 - Jun 1982	0.736263	0.729670
Jul 1980 - Jun 1981	0.769259	0.763490
Jul 1979 - Jun 1980	0.790045	0.784796
Jul 1978 - Jun 1979	0.802859	0.797930
Apr 1977 - Jun 1978	0.813842	0.809188

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

~~25.2 Disabled Adult Child (DAC)~~

~~25.2.1 Disabled Adult Child Introduction~~

~~A DAC is a person who meets the following criteria:~~

- ~~At least 18 years old at the time SSI was lost.~~
- ~~Classified by SSA as disabled before age 22.~~
- ~~Receives an OASDI (DAC) payment that is based on the earnings of a parent who is disabled, retired, or deceased.~~
- ~~Was receiving SSI but lost SSI eligibility because the OASDI (DAC) payment or an increase in the OASDI (DAC) payment exceeded the SSI income limits.~~

~~Federal law requires that the IM agency provide Medicaid eligibility to any DAC for whom the following condition exists:~~

- ~~Total countable income, excluding the "DAC" disregarded income, is less than or equal to the SSI-related categorical income limits.~~
- ~~Total countable assets are less than or equal to the categorical asset limit for SSI-related Medicaid.~~

~~25.2.2 Disabled Adult Child Payment Disregard~~

~~When a Disabled Adult Child applies for Medicaid, disregard all OASDI (DAC) payments which caused him or her to lose SSI eligibility.~~

25.4 Widow/Widower Group

25.4.1 Introduction

Section 1634(d) of the Social Security Act requires states to consider certain widows, widowers, and surviving ex-spouses who lost SSI eligibility as if they were still SSI recipients for Medicaid purposes so long as they would have remained otherwise eligible for SSI benefits but for their entitlement to Social Security Widow/Widower benefits (SSDW or SSWW).

25.4.2 Identifying a Widow/Widower Group

Someone qualifies as a Widow/Widower group for Medicaid purposes if they meet the following criteria:

1. They are currently receiving a Social Security widow/widower's (SSDW or SSWW) payment.
2. They are not entitled to Medicare Part A.
3. They received an SSI benefit (or they were a 1619 participant) the month before their SSDW or SSWW benefits began, and lost SSI/1619 due to excess income when they started receiving the SSDW or SSWW payment.

Note~~Example 1:~~	~~Disregard the entire OASDI (DAC) payment when the initial OASDI (DAC) payment caused the member~~People who lost SSI due to ~~be ineligible for SSI:~~ ~~Harvey is an SSI recipient. While his father worked, Harvey received a monthly SSI payment of $686.78. When his father retired, Harvey began~~ receiving ~~an OASDI (DAC) payment of $900. The OASDI payment exceeded the SSI income limits, causing his SSI to end. It is not necessary for the~~SSDW or SSWW payments ~~to be received concurrently (in fact, often they will not be),~~ but ~~the SSI payment must have ended~~who do not qualify for the Widow/Widower disregard because ~~of the OASDI increase.~~they receive Medicare, must be treated as a 503 group (see ~~When Harvey applies for EBD Medicaid, the entire initial OASDI (DAC) payment of $900 (and any subsequent COLA disregards) will be disregarded when his EBD Medicaid eligibility is determined.~~SECTION 25.3 503 GROUP).

25.4.3 Determining the Income Disregard for Widow/Widower Group

When Medicaid eligibility is determined for someone who meets Widow/Widower criteria, the entire SSDW or SSWW payment is disregarded.

25.5 Section 1619 Group

Section 1619 of the Social Security Act applies to people with disabilities who work. Medicaid is protected for 1619 participants. Both 1619(a) and 1619(b) participants are automatically enrolled in SSI Medicaid.

- The 1619(a) group includes working people with earnings at or above the substantial gainful activity (SGA) level who continue to receive a small SSI check.
- The 1619(b) group includes working people who no longer receive SSI cash benefits because they earn too much through work to qualify.

Note~~Example 2:~~	~~George is an SSI recipient. While his father worked, George received a monthly SSI payment of $686.78. When his father retired and began receiving social security retirement, George began receiving an OASDI (DAC) payment of $500 a month. While George's SSI payment decreased, the initial OASDI (DAC) payment did not cause him to lose SSI eligibility.~~ ~~When his father died, George's OASDI (DAC) payment increased to $750 a month. The increased amount put him over the SSI income limit, and he lost SSI.~~ ~~George applies for EBD Medicaid. The IM worker must disregard the OASDI (DAC) payment increase of $250 ($750 - $500 = $250) because it was the increase that caused George to lose SSI eligibility.~~If a 1619 participant loses their 1619 status (and SSI Medicaid) due to receiving Social Security benefits, they may qualify as a 503, DAC, or Widow/Widower group depending on the circumstances. When determining the special status disregard amount for a former 1619 participant who lost Medicaid eligibility due to receiving Social Security benefits, the date they lost SSI Medicaid is treated as the date they lost SSI.

~~Example 3:~~	~~Jane is an SSI recipient. While her father worked, Jane received a monthly SSI payment of $686.78. When her father retired and began receiving social security retirement, Jane began receiving an OASDI (DAC) payment of $1372 a month. The OASDI payment exceeded the SSI income limits, causing her SSI to end.~~ ~~When Jane applies for EBD Medicaid, the entire initial OASDI (DAC) payment of $1372 (and any subsequent COLAs) will be disregarded when her EBD Medicaid eligibility is determined. Two years later, Jane's DAC payment increased to $2539 because her brother graduated from high school. Because this increase did not cause Jane to lose her SSI, only the initial DAC payment ($1372 plus any subsequent COLAs) is disregarded.~~

~~Periods of Medicaid ineligibility do not affect this disregard. When the person reapplies, give the disregard to him or her again.~~

~~25.2.3 COLA Disregard~~

~~When a Disabled Adult Child applies for Medicaid, disregard all OASDI COLAs since the last month he or she was eligible for and received both OASDI and SSI benefits. Calculate the COLA disregard amount (25.1.2 Identifying a "503" AG).~~

~~If the Disabled Adult Child was receiving SSI-E, disregard both the state SSI-E Supplement (39.4 Elderly, Blind, or Disabled Assets and Income Tables) and the COLA.~~

~~Periods of Medicaid ineligibility do not affect this disregard. When the person reapplies, give the disregard to him or her again.~~

~~Example 4:~~	~~In Example 1, because Harvey received SSI concurrently with the OASDI (DAC) payment, he is also eligible for a COLA disregard for any OASDI payments he receives.~~

Example 5:	In Example 2, because George received SSI and an OASDI (DAC) payment concurrently and then lost SSI eligibility, he must also receive a COLA disregard on any OASDI payments he receives.

25.2.4 Disregards For People Who Lose SSI Eligibility As A Result of Initial Receipt Or An Increase in DAC Benefits

People who lose their SSI eligibility due to the receipt of an initial OASDI (DAC) benefit or increase in their current OASDI (DAC) benefit is entitled to the following disregards when their Medicaid eligibility is being determined:

1. The OASDI (DAC) payment, either the initial payment or the increase in payment, whichever made them ineligible for SSI.
2. The SSI E supplement, if they were receiving the E supplement at the time they became ineligible for SSI.
3. All COLAs received since the last month that they were eligible for and received both OASDI (DAC) and SSI benefits.

25.3 Widows and Widowers

A widow, widower, or surviving ex-spouse who lost SSI remains eligible for Medicaid if he or she meets all of the following conditions:

- Is considered elderly, blind, or disabled.
- Is at least 50 years of age.
- Is receiving OASDI benefits as a widow or widower (Section 202, Title II, Social Security Act).
- Received SSI or a State Supplementary Payment (SSP) (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables) in the month before the month in which he or she began to receive Widow/Widower OASDI payments.
- Became ineligible for SSI or SSP due to the receipt of the Widow/Widower benefits.
- Would be eligible for SSI or SSP except for the receipt of the Widow/Widower OASDI payment. Disregard the entire OASDI amount.
- Is not entitled to Medicare Part A.

Note:	In some cases a Widow/Widower, who loses eligibility for the Widow/Widower Medicaid benefit due to receipt of Medicare, may be eligible as a "503" case. See Section 25.1 "503" Eligibility.

25.4 Reserved

25.5 1619 Cases

Section 1619 of the Social Security Act applies to people with severe impairments who work. If they would be ineligible for SSI because of their earnings, they keep their SSI Medicaid eligibility.
1619(a): They are working people with earnings at or above the SGA who continue to receive a small SSI check. They retain SSI Medicaid eligibility.
1619(b): They are working people who do not receive a SSI check but are still eligible for SSI Medicaid.
For the COLAdisregard determination, use the date cash payments ended.
To determine the person's SSI status, contact the local Social Security Office. Social Security processes Medicaid eligibility for these members.

~~The SSI benefits of a 1619 person entering an institution continue for up to two months.~~
~~If a member loses 1619 status, but also is a widow/widower, DAC, or 503, he or she is entitled to all disregards that are appropriate for these special status cases when determining eligibility. Losing 1619 status is considered the same as losing SSI eligibility.~~

27.6 ILTC Monthly Need

27.6.1 Intermediate and Long-Term Care Monthly Need Introduction

Monthly need is the amount by which the institutionalized person's expenses exceed his or her income. It is computed by adding together the following monthly costs:

1. Personal needs allowance (Section 39.4 EBD Assets and Income Tables).
2. Cost of institutional care (use the private care rate of the institution where the applicant or member resides).
3. Cost of health insurance (~~27~~Section 27.6.4 Health Insurance).
4. Support payments (Section 15.7.2.1 Support Payments).
5. Out-of-pocket medical costs.
6. Work related expenses (Section 15.7.4 Impairment Related Work Expenses (IRWE)).
7. Self-support plan (Section 15.7.2.2 Self-Support Plan).
8. Expenses for establishing and maintaining a court- ordered guardianship or protective placement, including court ordered attorney or guardian fees.
9. Other medical expenses.

~~1. Other deductible expenses.~~

36.1 WWWMA Introduction

Wisconsin Well Woman Medicaid (WWWMA) is a full-benefit Medicaid plan. It covers people under age 65 who have been diagnosed with and need treatment for breast or cervical cancer or certain precancerous conditions of the breast or cervix.

WWWMA is a fee-for-service Medicaid program. Members are not enrolled in an HMO.

A person must be enrolled in one of the following entry programs before they can initially enroll in WWWMA:

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

Note	Temporary enrollment (also known as presumptive eligibility) in FPOS or BadgerCare Plus does not meet this entry program requirement for WWWMA eligibility.

The individual must also meet all requirements in Section 36.3.1 Introduction.

Once the person is enrolled in WWWMA, they do not have to reapply for any of the above programs, as they will have full-benefit Medicaid coverage through WWWMA.

36.2 WWWMA Enrollment

~~36.2.1 Administration of Wisconsin Well Woman Medicaid~~

WWWMA is administered by ~~the~~ DHS DMS Enrollment Management Central Application Processing Operation (EM CAPO). EM CAPO handles all ~~enrollments and renewals.~~
~~Temporary Enrollment/Presumptive Eligibility enrollment is processed by the fiscal agent.~~
WWWMA applications and renewals. Any applications received in local IM or tribal agencies should be faxed to the EM CAPO at 608-267-3381 immediately upon receipt to prevent any delay in eligibility determination or treatment for the applicant.
The standard Medicaid application form is not used to enroll in WWWMA.~~CONTACTS:~~
~~EM CAPO: DHSEMCAPO@dhs.wisconsin.gov~~
~~Fax: 608-267-3381~~
~~Phone: 1-877-246-2276~~
~~Customer line: 608-266-1720~~
To apply for WWWMA, the applicant must complete the Wisconsin Well Woman Medicaid Application and Renewal form (F-10075) and submit it following the instructions on the form. The applicant may apply for WWWMA at any time after the screening and diagnosis of breast or cervical cancer or certain precancerous condition of the breast or cervix.

The filing date of a WWWMA application is the day a signed, valid application is received by EM CAPO. See Section 2.4 Valid Application.

WWWMA eligibility begins the first day of the month in which the valid application is submitted and all eligibility requirements are met.

Example 1	Maria is diagnosed with cervical cancer on December 16. She applies for WWWMA on December 17. She does not request backdated coverage. Maria is determined eligible for WWWMA. Her WWWMA enrollment starts on December 1.

36.2.~~2~~1 WWWMA Backdated Eligibility

All applicants may have their WWWMA eligibility backdated to the first of the month, up to three months prior to the month of application. Eligibility may not be backdated earlier than the first of the month of the date of diagnosis.

The applicant may be certified for any backdate month in which they would have been eligible had they applied in that month.

Example 2	Yura is diagnosed with a precancerous condition of the breast on October 25. She applies for WWWMA on December 5. She requests three months of backdated coverage (September, October, November). Yura is determined eligible for WWWMA. Her WWWMA enrollment starts on October 1 since that is the first of the month of her diagnosis date. She is not eligible for WWWMA in September since that month was before her diagnosis.

36.2.2 WWWMA Enrollment through the Wisconsin Well Woman Program

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

~~The~~ In addition to the requirements in Section 36.3 WWWMA Nonfinancial Requirements and Section 36.4 WWWMA Financial Requirements, a WWWP ~~performs the financial and initial non-financial screening for WWWMA for WWWP enrollees. A WWWP enrollee~~ client must have a health screening through WWWP, be diagnosed, and need treatment for breast or cervical cancer ~~to be considered~~ or a precancerous condition of the breast or cervix to be eligible for WWWMA.

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

36.2.2.1 WWWP Process for Assisting with WWWMA Application

1. The WWWP ~~LCA~~ coordinating agency will complete the ~~F-44818 (formerly DPH-4818)~~F-44818 with the assistance of the applicant prior to the applicant's health care screening. ~~The F-44818~~The F-44818 enrolls the person in WWWP. Their WWWP eligibility will be in interChange under medical status code "CS."
2. The WWWP ~~member~~client will receive a breast and cervical cancer screening from a WWWP provider.
3. If the WWWP ~~member~~ client is diagnosed with breast or cervical cancer~~, their~~ or a precancerous condition of the breast or cervix and wants to apply for WWWMA, they will complete Part A - Applicant/Member Information in the Wisconsin Well Woman Medicaid Application and Renewal form (F-10075).They will sign and date the application,
~~2.~~4. The WWWP provider will complete Part-B Diagnosing or Recertifying Provider in the F-10075 recording the diagnosis and indicating that treatment is required. The provider will sign and date the F-10075. ~~The WWWP member will also sign and date the F-10075. The~~The applicant and provider signature dates do not have to be the same date.
~~3.~~5. **If doing a temporary enrollment determination:** The provider will fill in the ~~beginning~~ begin and end dates of the temporary enrollment~~/presumptive eligibility~~ for WWWMA in Part C – Temporary Enrollment / Presumptive Eligibility on the F-10075. The begin date is the date of diagnosis. The end date is the last day of the month following the month of diagnosis. See Section 36.2.2.2 Temporary Enrollment (TE) Available Only to Persons Enrolling Through WWWP.
~~4.~~6. The provider will forward a copy of the F-10075 to the WWWP ~~LCA~~ coordinating agency.
~~5.~~7. The WWWP ~~LCA~~ coordinating agency will provide the member with a copy of the signed F-10075 and ~~F-44818~~F-44818 forms.
~~6.~~8. **If doing a temporary enrollment determination:** The WWWP ~~LCA~~ coordinating agency will check to be sure correct temporary eligibility dates ~~(if appropriate)~~ are entered on the F-10075 and explain that the ~~member's~~client's temporary enrollment for WWWMA will end on the last day of the following calendar month. The WWWP coordinating agency will fax a copy of the completed F-10075 to the fiscal agent at 608-221-8815 within five days of the diagnosis date. The fiscal agent will enter the temporary enrollment in ForwardHealth.
9. The WWWP coordinating agency or the member will fax, mail, or scan and email the F-44818 and the F-10075 to EM CAPO. EM CAPO will process the application and determine eligibility for a 12-month certification period for WWWMA.

36.2.2.~~1~~ 2 Temporary Enrollment (TE) ~~/ Presumptive Eligibility (PE)~~ Available Only to Persons Enrolling through WWWP

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

~~The provider doing the medical screening enters the TE dates in the section "Temporary Eligibility Begin Date" and "Temporary Eligibility End Date" on the~~ WWWP coordinating agencies perform the eligibility determination for TE in WWWMA by completing the Wisconsin Well Woman Medicaid Application and Renewal form (F-10075~~. The dates should cover the time period beginning on the date of diagnosis through the last day of the following calendar month.~~

~~The WWWP Local Coordinating Agency (LCA) should then fax a copy of the completed F-10075 to the fiscal agent at 608-221-8815 within five days of the diagnosis date. The fiscal agent~~), including the TE/PE section. See Section 36.2.2.1 WWWP Process for Assisting with WWWMA Application.

TE enrollment in WWWMA is processed by the fiscal agent. When the fiscal agent receives the F-10075 from the WWWP coordinating agency, they will enter the temporary enrollment data in ForwardHealth interChange (with a medical status code of "CB") and send the member a ForwardHealth card~~-~~ with the temporary enrollment dates activated on the card. If the member had a previous ForwardHealth card, it will be reactivated.

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

1. WWWP Enrollment Form (F-44818)
2. WWWMA ~~Determination~~Application and Renewal Form (F-10075)

~~To continue receiving~~An applicant may only be temporarily enrolled once in a rolling 12-month period.TE in WWWMA~~,~~ begins on the ~~member or~~date the ~~WWWP LCA must submit an F-10075 to the EM CAPO. If the member~~ person is found temporarily eligible. TE does not ~~apply, their WWWMA benefits will end at the end~~go back to the first of the month~~-~~. TE in WWWMA ends the last day of the following ~~the month of diagnosis.~~

~~The TE period extends from the date of diagnosis on the F-10075 through the following~~calendar month.

A person can only be eligible for a new TE period ~~would only occur~~ if a new cancer diagnosis was established ~~for the same member~~ and only if it has been at least 12 months since the first day of their last TE period.

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

~~36.2.3 WWWP Members Enrolling in WWWMA~~

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

~~The standard Medicaid application form is not used to enroll in WWWMA. To apply for WWWMA through the WWWP, the applicant or the WWWP LCA must send or fax the completed F-44818 and F-~~

10075 forms to the EM CAPO. The applicant may apply for WWWMA at any time after the WWWP screening and diagnosis. Eligibility may only be backdated to the first of the month up to three months prior to the application date or from the date of diagnosis, whichever is most recent.
The date of receipt of the F-10075 is the filing date. See Chapter 20 for verification policies.
The following steps are completed to enroll the member in WWWMA:

1. Review the F-44818. There should be a "No" answer to the following questions.
    1. Does the applicant have any health insurance? (Item #32 on F-4818)
        If the applicant answers "Yes", determine if the insurance is one of those listed in Section 36.3.3 Non-Disqualifying Insurance Coverage Non-Disqualifying Insurance Coverage that covers treatment for breast or cervical cancer. If the applicant has coverage for the treatment, they are ineligible for WWWMA.
    2. Does the applicant have Medicare Part B? (Item #33 on F-4818)
    3. Does the applicant have Medicare Part A.

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

    If the applicant fails to provide an SSN, or fails to apply for an SSN within the 30-day application processing time or within 10 days (whichever is later), the EM CAPO will send a manual negative notice to the applicant indicating that they are not eligible for WWWMA because they did not provide an SSN.
4. Ask the applicant if they are a U.S. citizen.
    If the applicant is not a U.S. citizen, ask them what their immigration status is and to provide their immigrant registration card. Verify that the applicant is in a qualified immigration status using the Systematic Alien Verification for entitlement (SAVE) system.

Example 3Note:	Some applicants with breast and cervical cancer who do not meet the immigration-related eligibility criteria may be eligible to receive emergency services. If a non-qualifying immigrant has been screened by WWWP, determine their eligibility for emergency services using the criteria in 7.1 US Citizens and Nationals.Jamie is diagnosed with breast cancer on February 18. On that same day, her provider completes the Wisconsin Well Woman Medicaid Application and Renewal form (F-10075), including the TE/PE section, and finds her eligible for TE for WWWMA. Jamie is eligible for TE for WWWMA from February 18 through March 31.

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

by fax to 608-221-8815, through interChange, or by mail to:

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

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

A person cannot be enrolled in WWWMA prior to their date of diagnosis.

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

For initial WWWMA certifications, if the applicant applies during their WWWMA TE certification period and EM CAPO is not able to process their application within the 30-day processing time frame, EM CAPO will extend the applicant's eligibility for an additional 30 days from the last day of their WWWMA TE in iC with a medical status of "CB." EM CAPO will note this extension in the CARES Comments section if appropriate.

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

36.2.4 To continue receiving WWWMA, the member or the WWWP coordinating agency must submit an F-10075 to the EM CAPO. See Section 36.2.2.1 WWWP Process for Assisting with WWWMA Application. If the member does not apply, their WWWMA benefits will end at the end of the month following the month of diagnosis.

36.2.3 WWWMA Enrollment for Family Planning Only Services Members

Persons In addition to the requirements in Section 36.3 WWWMA Nonfinancial Requirements and Section 36.4 WWWMA Financial Requirements, a person enrolled in FPOS who meet meets one of the following criteria (regardless of age), will, may be eligible for WWWMA:

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

~~**36.2.4.1 Applications for**~~**A Wisconsin Well Woman Medicaid** ~~**Through Family Planning Only Services**~~ ~~A WWWMA Determination~~ Application and Renewal form (F-10075) submitted by a Family Planning Only Services (FPOS) member or their representative is a request to enroll in WWWMA and disenroll from FPOS. Individuals who are enrolled in FPOS ~~in CARES~~ and meet the criteria ~~above (see~~ in Section 36.2.4 Enrollment for Family Planning Only Services Members~~)~~ may be eligible for WWWMA. See Process Help for information on processing WWWMA applications.

36.2.4 WWWMA Enrollment for BadgerCare Plus Members

In addition to the requirements in Section Section 36.3 WWWMA Nonfinancial Requirements and Section 36.4 WWWMA Financial Requirements, a person enrolled in BadgerCare Plus who meets one of the following criteria, may be eligible for WWWMA:

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

The person's enrollment in BadgerCare Plus must end prior to their enrollment in WWWMA. The person must contact their income maintenance agency to disenroll from BadgerCare Plus. EM CAPO does not manage BadgerCare Plus enrollment. See Process Help Section for information on processing WWWMA applications.

36.3 WWWMA Nonfinancial Requirements

36.3.1 Introduction

~~The~~To be eligible for WWWMA, a person must meet the following ~~are WWWMA specific non-financial~~nonfinancial requirements:

1. Live in Wisconsin~~,~~.
~~1. Meet general EBD citizenship and ID requirements.~~
2. Be a U.S. citizen or qualifying immigrant. See Chapter 7 U.S. Citizen or Qualifying immigrant.
~~2.~~3. Be under age 65.
~~3.~~4. Have been screened for breast or cervical cancer by the Well Woman Program, or enrolled in Family Planning Only Services~~.~~ or BadgerCare Plus.

Note	If BadgerCare Plus is the person's entry program for WWWMA, the person's enrollment in BadgerCare Plus must end prior to their enrollment in WWWMA.

Example	Shanice is enrolled in BadgerCare Plus. Her BadgerCare Plus is ending on November 30. Shanice is screened for and diagnosed with breast cancer. She applies for WWWMA on November 10. She is not eligible for WWWMA for the month of November because she is enrolled in BadgerCare Plus. Her enrollment in WWWMA starts on December 1.

~~4.~~5. Be diagnosed for breast or cervical cancer, or certain pre~~-~~cancerous conditions of the breast or cervix, as identified by the clinical screener.
~~5.~~6. Require treatment for the breast or cervical cancer, or pre~~-~~cancerous conditions of the breast or cervix, as identified by the clinical screener.
~~6.~~7. Not ~~be eligible for~~ enrolled in another full-benefit Medicaid program or BadgerCare Plus ~~or EBD Medicaid~~.
~~7.~~8. Meet the insurance coverage requirements listed below in ~~36.3.2 Disqualifying Insurance Coverage~~Section 36.3.2 Disqualifying Insurance Coverage.

36.3.2 Disqualifying Insurance Coverage

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

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

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

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

Health insurance coverage information is collected at application and renewal. Health insurance coverage information available to Wisconsin Medicaid from third party liability sources may also be used to identify if a person has current coverage.

36.3.3 Non-Disqualifying Insurance Coverage

1. The following health care benefits do not disqualify an applicant or member from WWWMA:
    a. Coverage only for accident or disability income insurance, or any combination thereof,
    b. Liability insurance including general liability insurance and automobile liability insurance,
    c. Workers' compensation or similar insurance, credit-only insurance,
    d. Coverage for on-site medical clinics,
    e. Other similar insurance coverage, under which benefits for medical care are secondary or incidental to other insurance benefits,
    f. Indian Health Services,
    g. Non-coverage of cancer treatment due to waiting period, or
    h. Non-coverage of breast or cervical cancer treatment due to exclusion (max out) of cancer treatment in the policy.
2. Separate health insurance benefits that are not considered health insurance if offered separately are:
    a. Limited scope dental or vision benefits, or
    b. Benefits for long-term care, nursing home care, home health care, community-based care or any combination thereof.
3. Independent uncoordinated benefits are not considered health care insurance if offered as independent and/or uncoordinated benefits (for example, coverage only for specified disease or illness, hospital indemnity or other fixed indemnity insurance).
4. Separate insurance policies are not considered health insurance if offered as a separate insurance (Wrap Around) policy:
    a. Coverage supplemental to military insurance (ex., TRICARE wrap around), or
    b. Similar "wrap around" supplemental coverage under a group health plan.
5. Creditable coverage plans that do not cover treatment for the breast or cervical cancer due to a waiting period, exclusion or carve out restrictions.

Note:	Current coverage under Medicare Parts A or B will disqualify an applicant or member from WWWMA eligibility.

36.4 WWWMA Financial Requirements

Because enrollment in Wisconsin Well Woman Medicaid- (WWWMA) is dependent on financial eligibility for ~~a gatepost program,~~one of the entry programs listed in Section 36.1 WWWMA Introduction, there are no ~~financial requirements~~income or asset tests specifically~~specially~~ for WWWMA.
~~There is no asset or income test for WWWMA enrollment.~~ Financial ~~requirements are addressed~~eligibility is determined through the Wisconsin Well Woman Program (-WWWP), Family Planning Only Services (FPOS), or BadgerCare Plus enrollment process.

For information on BadgerCare Plus financial requirements, see BadgerCare Plus Handbook, Section 16 Income, Section 17 Deductibles, Section 18 BadgerCare Plus Extensions, and Section 19 Premiums~~, and Section 20 Assets.~~. For information on FPOS financial requirements, see BadgerCare Plus Handbook, Section 40 Family Planning Only Services (FPOS).

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

36.5 WWWMA Changes

36.5.1 Member Loses Eligibility

Wisconsin Well Woman Medicaid (WWWMA) members are required to report to EM CAPO within 10 days of occurrence changes that would affect their eligibility. ~~Any of the following changes would result in a loss of WWWMA eligibility~~This includes:

1. ~~Reaching the age of~~Turning 65 years old.
~~1. No longer residing in Wisconsin~~
2. Change in address or phone number, including if the member~~s~~ is incarcerated in or released from jail or prison.
~~2.~~3. No longer needing treatment for breast or cervical cancer.
~~3.~~4. Obtaining health insurance that covers their treatment for breast or cervical cancer.
~~4.~~5. Obtaining Medicare Part A, Part B, or both.

Note	If a child under age 19 enrolled in WWWMA no longer requires treatment or gets health insurance that covers their treatment, they will not be disenrolled during their continuous coverage period (see SECTION 1.2 CONTINUOUS COVERAGE FOR QUALIFYING CHILDREN).

~~If a case closes, the EM CAPO will send a manual negative notice to the member if one of these changes is reported, indicating that they are no longer eligible for WWWMA. Offer them a BadgerCare Plus / Medicaid Application (F-10182) to test eligibility for other programs (unless they are no longer a Wisconsin resident).~~

~~36.5.2 WWWMA Interagency Case Transfers~~

~~All WWWMA cases are processed through the EM CAPO. There should be no interagency transfers.~~

36.6 WWWMA Renewals

Renewals are required every 12 months. A renewal for Wisconsin Well Woman Medicaid (To renew WWWMA) consists of submitting, the member must submit an updated Wisconsin Well Woman Medicaid Application and Renewal (F-10075). There is no financial test) or the Well Woman Renewal Form (WWRF) that is sent to them approximately 45 days before their renewal date. Enrollment in WWWP, FPOS, or BadgerCare Plus is not a requirement when completing a WWWMA renewal.

Reports identifying the WWWMA members needing renewals are sent to the EM CAPO monthly. The member is notified approximately 45 days before their renewal is due and is informed what steps they need to take to renew their WWWMA. A blank F-10075 is included with the renewal notice. In most cases the member will only need to supply an updated F-10075.

WWWMA renewals received within three months of the renewal month can be processed as a late renewal instead of requiring a new application. If a member has a gap in coverage because of a late renewal, they may request coverage of the past months in which the gap occurred. See Section 3.1.6 Late Renewals for more information.

Example 1	Jenny's renewal is due on January 31. She faxes her WWWMA renewal to EM CAPO on March 10. EM CAPO processes the renewal on the same day, and verification is requested. The verification is due on March 30. Jenny submits the verification prior to March 30, and EM CAPO determines she meets the WWWMA eligibility criteria. Her new WWWMA certification period begins on March 1. Her next renewal date is February 28 of the following year.

Example 2Note	In order to eliminate unnecessary reviews, a best practice is to check interChange to be sure that the member has not become certified for BadgerCare Plus or another type of full benefit Medicaid (for example, SSI MA), turned 65 years of age (or will turn 65 in the next twelve months), or become eligible for Medicare Part(s) A, B or both, prior to notifying the member that a review is due.LaVonne's renewal is due to January 31. She faxes her WWWMA renewal to EM CAPO on March 10. EM CAPO processes the renewal on the same day, and verification is requested. The verification is due on March 30. LaVonne submits the verification on May 20. Since she submitted the verification after the three-month period that started with her January 31 renewal date and ended April 30, she will need to reapply for WWWMA.

The member or their representative must send the F-10075 to the EM CAPO via one of the following:

1. Email: DHSEMCAPO@dhs.wisconsin.gov
2. Fax: 608-267-3381
3. Mail:
   WI DHS - EM CAPO
   1 West Wilson St.
   P.O. Box 309
   Madison, WI 53701-0309

At renewal, the member must provide a newly completed F-10075 indicating they are still in need of treatment for breast or cervical cancer, as attested by a Wisconsin licensed health care provider, including a doctor of medicine (MD), doctor of osteopathic medicine (DO), nurse practitioner (NP), physician assistant (PA), clinical nurse specialist (CNS), or clinical nurse practitioner (CNP).

Members formerly enrolled in WWWP do not need to provide a new F-44818 (formerly DPH 4818) at recertification.

The EM CAPO sends a manual positive notice if all requirements are met.

~~The EM CAPO will send a manual negative notice at least 10 days prior to the case closing if the member does not provide an updated F-10075 or if the member reports one of the changes listed in Section 36.5 Changes.~~

36.7 EM CAPO Contact Information

WWWMA applicants and members can contact EM CAPO at:

Email:	DHSEMCAPO@dhs.wisconsin.gov
Phone:	877-246-2276 or 608-266-6740
Fax:	608-267-3381
Mail:	WI DHS – EM CAPO
	1 W. Wilson St.
	PO Box 309
	Madison, WI 53701

39.4 Elderly, Blind, or Disabled Assets and Income Tables

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

Description	Amount	Effective	Updated Annually?
Community Spouse Lower Income Allocation Limit	$3,~~286~~406.66	7/1/~~2023~~2024	Yes
Shelter Base Amount	$~~986~~1,022.00	7/1/~~2023~~2024	Yes
Community Spouse Income Allocation Maximum	$3,853.50	1/1/2024	Yes
Dependent Family Member Income Allowance Maximum	$~~821~~851.67	7/1/~~2023~~2024	Yes
Dependent Family Member Income Allowance Standard	$2,~~465~~555	7/1/~~2023~~2024	Yes
Community Spouse Asset Share (CSAS) Maximum	$154,140	1/1/2024	Yes

39.6 COLA Disregard

~~To calculate the COLAdisregard 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:~~
    1. ~~The amount of the OASDI check.~~
    2. ~~Any amount being deducted from the OASDI check for Medicare premiums.~~
    3. ~~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 2024 OASDI by:~~	~~Multiply 2023 OASDI by:~~
~~Jan 2023 - Dec 2023~~	~~0.031008~~	~~--~~
~~Jan 2022 - Dec 2022~~	~~0.108563~~	~~0.080037~~
~~Jan 2021 - Dec 2021~~	~~0.158227~~	~~0.131291~~
~~Jan 2020 - Dec 2020~~	~~0.169030~~	~~0.142439~~
~~Jan 2019 - Dec 2019~~	~~0.182116~~	~~0.155944~~
~~Jan 2018 - Dec 2018~~	~~0.204393~~	~~0.178934~~
~~Jan 2017 - Dec 2017~~	~~0.219993~~	~~0.195033~~
~~Jan 2016 - Dec 2016~~	~~0.222326~~	~~0.197441~~
~~Jan 2015 - Dec 2015~~	~~0.222326~~	~~0.197441~~
~~Jan 2014 - Dec 2014~~	~~0.235326~~	~~0.210856~~

~~Jan 2013 - Dec 2013~~	~~0.246626~~	~~0.222518~~
~~Jan 2012 - Dec 2012~~	~~0.259220~~	~~0.235515~~
~~Jan 2011 - Dec 2011~~	~~0.284961~~	~~0.262080~~
~~Jan 2010 - Dec 2010~~	~~0.284961~~	~~0.262080~~
~~Jan 2009 - Dec 2009~~	~~0.284961~~	~~0.262080~~
~~Jan 2008 - Dec 2008~~	~~0.324160~~	~~0.302533~~
~~Jan 2007 - Dec 2007~~	~~0.339355~~	~~0.318214~~
~~Jan 2006 - Dec 2006~~	~~0.360459~~	~~0.339994~~
~~Jan 2005 - Dec 2005~~	~~0.385648~~	~~0.365989~~
~~Jan 2004 - Dec 2004~~	~~0.401799~~	~~0.382657~~
~~Jan 2003 - Dec 2003~~	~~0.414103~~	~~0.395354~~
~~Jan 2002 - Dec 2002~~	~~0.422192~~	~~0.403703~~
~~Jan 2001 - Dec 2001~~	~~0.436835~~	~~0.418813~~
~~Jan 2000 - Dec 2000~~	~~0.455879~~	~~0.438467~~
~~Jan 1999 - Dec 1999~~	~~0.468632~~	~~0.451628~~
~~Jan 1998 - Dec 1998~~	~~0.475451~~	~~0.458665~~
~~Jan 1997 - Dec 1997~~	~~0.486240~~	~~0.469800~~
~~Jan 1996 - Dec 1996~~	~~0.500719~~	~~0.484742~~
~~Jan 1995 - Dec 1995~~	~~0.513371~~	~~0.497799~~
~~Jan 1994 - Dec 1994~~	~~0.526626~~	~~0.511478~~
~~Jan 1993 - Dec 1993~~	~~0.538622~~	~~0.523858~~
~~Jan 1992 - Dec 1992~~	~~0.552060~~	~~0.537726~~
~~Jan 1991 - Dec 1991~~	~~0.568042~~	~~0.554220~~
~~Jan 1990 - Dec 1990~~	~~0.590173~~	~~0.577059~~
~~Jan 1989 - Dec 1989~~	~~0.608570~~	~~0.596044~~
~~Jan 1988 - Dec 1988~~	~~0.623625~~	~~0.611581~~
~~Jan 1987 - Dec 1987~~	~~0.638796~~	~~0.627237~~
~~Jan 1986 - Dec 1986~~	~~0.643431~~	~~0.632021~~
~~Jan 1985 - Dec 1985~~	~~0.654152~~	~~0.643085~~
~~Jan 1984 - Dec 1984~~	~~0.665848~~	~~0.655155~~
~~Jul 1983 - Dec 1983~~	~~0.677148~~	~~0.666816~~
~~Jul 1982 - Jun 1983~~	~~0.699393~~	~~0.689773~~
~~Jul 1981 - Jun 1982~~	~~0.729670~~	~~0.721019~~
~~Jul 1980 - Jun 1981~~	~~0.763490~~	~~0.755922~~
~~Jul 1979 - Jun 1980~~	~~0.784796~~	~~0.777909~~
~~Jul 1978 - Jun 1979~~	~~0.797930~~	~~0.791464~~
~~Apr 1977 - Jun 1978~~	~~0.809188~~	~~0.803082~~

See Section 25.3.3 Determining the COLA Disregard for 503 Groups.