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 25-02**

Release Date: 04/09/2025

Effective Date: 04/09/2025

EFFECTIVE DATE		The following policy additions or changes are **effective 04/09/2025** unless otherwise noted. **Underlined text denotes new text. Text with a strike through it denotes deleted text.**
POLICY UPDATES		
2.5.1.1	**Signatures from Representatives**	Updated to reflect changes announced in Operations Memo 24-07.
2.7.1	**Multiple Application Submission**	New subsection with policies related to duplicate/multiple application scenarios.
2.9.1	**Termination**	Updated to align with BadgerCare Plus Handbook

7.3.2	**Verification**	Content reorganized into numbered subsections for readability. The following new subsections were added:
		• 7.3.2.1 Verification through FDSH or SAVE
		• 7.3.2.2 Other Verification
		  ○ 7.3.2.2.1 Military Service/Connection
		  ○ 7.3.2.2.2 Date of Arrival
		  ○ 7.3.2.2.3 Continuous Presence
		Subsequent subsections renumbered accordingly. Minor updates to terminology throughout section. Examples added for clarity.

7.3.3.1	**Qualifying Immigrants**	Table updated to reflect that COFA citizens who become Lawful Permanent Residents are NOT subject to the five-year waiting period.
7.3.3.1.3	**Citizens of the Compacts of Free Association Countries**	Updated to reflect that COFA citizens who become Lawful Permanent Residents are NOT subject to the five-year waiting period.
7.3.3.1.4	**Victims of Trafficking**	“Five year wait” updated to “five-year waiting period” for consistency.
13.2	**Covered Services**	Added cross reference to new section 13.8.5. Effective 1/1/2025.
13.3.3	**Existing Members**	Removed obsolete information.
13.8.5	**Services for Youth**	New section related to coverage changes for justice-involved youth. Effective 1/1/2025.
15.3.26.3	**Patient Liability Calculation for State Veterans Home Residents Without Dependents**	Updated PNA increase that went into effect on July 1, 2024.

15.3.36	**Guaranteed Income Payments**	Clarified requirements for excluding guaranteed income payments for all categories of Medicaid.
15.4.26	**Virtual Currency**	Clarified definition of virtual currency.
15.5.19	**Virtual Currency**	Clarified definition of virtual currency.
15.7.1	**Maintaining Home or Apartment**	Updated PNA increase that went into effect on July 1, 2024.
16.7.4.6	**Remainder Beneficiary Designation Requirement for Long-Term Care**	Added clarifying information and removed obsolete information.
16.7.34	**Guaranteed Income Payments**	Clarified requirements for excluding guaranteed income payments for all categories of Medicaid.
18.6.1	**Spousal Impoverishment Income Allocation Introduction**	Updated PNA increase that went into effect on July 1, 2024.
21.7.5	**Lost or Stolen Cards**	Removed processing information now situated in Process Help.
22.1.1	**Estate Recovery Program Definition**	Updated to align with BadgerCare Plus Handbook.
22.1.2	**Recoverable Services**	Updated to align with BadgerCare Plus Handbook.
22.1.10	**Incentive Payments**	Updated 'We' to 'DHS'.
24.7.3.5	**Insufficient Funds**	Removed obsolete information.
26.3.5	**Health and Employment Counseling Program**	Updates to clarify HEC policies.
26.4.2	**Income**	Updated cross references to Special Status Medicaid sections that were reorganized in release 24-03.
28.6	**HCBWLTC Eligibility Groups and Cost Sharing**	Introductory section removed and subsequent section numbering updated.
31.1	**Migrant Workers**	Minor rephrasing for clarity.
33.6.8.1	**Allocated Income From a Medicaid Member Spouse**	Updated PNA increase that went into effect on July 1, 2024.
39.13	**VA Allowance Rules**	Updated figures for 2025.

Table of Contents

2.5 Valid Signature

2.5.1 Valid Signature Introduction

2.5.1.1 Signatures From Representatives

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

1. Guardian

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

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

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

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

Note	The guardian of the person may ask the court to update their letters of guardianship to grant them the authority to enroll their ward in public assistance programs.

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

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

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

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

3. Authorized Representative

   The applicant may authorize someone to represent them. An authorized representative can be an individual or an organization (see Section 22.5 Representatives). If the applicant needs to

appoint an authorized representative when applying by telephone or in person, the applicant must complete the Appoint, Change, or Remove an Authorized Representative form (F-10126). When appointing an authorized representative, someone other than the authorized representative must witness the applicant's signature. If the applicant signs with a mark, two witness signatures are required.

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

4. Agent with Durable Power of Attorney for Finances (Wis. Stat. ch. 244)
   An agent with durable power of attorney for finances is a person to whom the applicant has given power of attorney authority and agrees that the authority will continue even if the applicant later becomes disabled or otherwise incapacitated. Only an agent with activated durable power of attorney for finances (may also be known as a durable power of attorney for finances and property) is considered to have power of attorney for the purpose of providing a valid signature on the application. An agent with power of attorney for health care is not considered to have power of attorney for the purpose of providing a valid signature on the application.

   When a submitted application is signed by someone claiming to be the applicant's agent with activated durable power of attorney for finances, the agency must do both of the following:
   - Obtain a copy of the document the applicant used to designate the signer of the application as an agent with durable power of attorney for finances.
   - Review the document for a reference that indicates the durable power of attorney for finances authority continues notwithstanding any subsequent disability or incapacity of the applicant.
5. Do not consider the application properly signed unless both of the above conditions are met. An individual's agent with activated durable power of attorney for finances may appoint an authorized representative for purposes of making a health care application, if authorized on the Durable Power of Attorney for Finances form.

   The Durable Power of Attorney for Finances form will specify what authority is granted. The appointment of an agent with durable power of attorney for finances does not prevent an individual from filing their own application, nor does it prevent the individual from granting authority to someone else to apply for public assistance on their behalf.
6. A superintendent of a state mental health institute or center for the developmentally disabled
7. A warden or warden's designee
   A warden or warden's designee for an inmate of a state correctional institution who is a hospital inpatient for more than 24 hours.
8. The superintendent of a county psychiatric institution
   The superintendent of a county psychiatric institution may sign an application for a resident of the institution provided that the county social or human services director has delegated to them (in writing) the authority to sign and witness applications for residents of the institution. Retain a copy of this written authorization. The social or human services director may end the delegation when there is reason to believe that the delegated authority is not being carried out properly.

2.7 Application Processing Period

All applications received by an agency must be processed and eligibility approved or denied as soon as possible. The health care application processing period is 30 days. This means that, as a rule, the agency must process the application, determine eligibility, and issue a notice of decision no later than the 30th calendar day after the date on which the application is received by the agency (or the next business day if the 30th day falls on a weekend or holiday). However, the application processing period is extended as needed to ensure the applicant has at least 20 days from the mailing date of a verification request to provide verification.

Note	For applications submitted electronically, the "date received," for purposes of determining when the application processing period begins, may be different from the filing date (see SECTION 2.6 FILING DATE). For ACCESS and Marketplace applications, the date received is the date on which the application is delivered to the agency or the next business day if delivered weekdays after 4:30 p.m., on a weekend, or on a holiday. For MSP applications originating from LIS data sent by SSA, the date received is the contact date of the request for assistance (RFA).

Example 1	A signed application is received on March 15. The worker processes the application on April 7 and requests verification. Verification is due on April 27 but is not received by that date. Even though April 14 is the 30th day after the filing date, the application must not be denied for lack of verification until April 27 to allow the applicant at least 20 days to provide verification.

Changes that occur between the filing date and the confirmation date should be used in the initial eligibility determination.

For more information on application denials for failure to provide verification, see Section 20.7 When to Verify.

If an agency fails to act on an application within the 30-day application processing period, the agency must still honor the application's filing date when determining eligibility.

Example 2	A signed application was received on May 15. The first day of the 30-day period was May 16. The end of the 30-day period was June 14. The application was approved on June 20, and the applicant is determined eligible beginning May 1.

2.7.1 Multiple Application Submission

When an applicant submits more than one application within the same application filing period, the earliest received application establishes the filing date. However, the information from the latest received application must be used in the eligibility determination since that is the most current information reported by the household.

Example 1	Charlie applies for health care on June 15. Charlie moves from Superior to Green Bay on June 20. Charlie applies for health care again on June 21, because Charlie didn't know a new application was not needed. The filing date for Charlie's health care request is June 15. Some information from the June 15 application might be valid, but information from Charlie's more recent June 21 application must be used in Charlie's eligibility determination, contact details, and agency administration.

The application processing timeline is based on the established filing date from the earliest received application (see Section 2.7 Application Processing Period).

2.9 Denials and Terminations

2.9.1 Termination

~~If less than a~~ During the calendar month ~~has passed since~~ after a member's enrollment has been terminated for a reason other than not completing a renewal, Medicaid can be reopened without requiring a new application~~.~~ or a new signature. The certification period for the health care assistance group (AG) prior to termination will be reinstated. The person may need to provide ~~required~~ verification~~.~~ ~~If the person re-requests Medicaid after~~ if required to complete the eligibility ~~was terminated and the case is open for another program of assistance, do not require him or her to re-sign his or her application or sign a new application~~determination.

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

~~If EBD Medicaid, HCBW, Institutional Medicaid, MAPP, or MSP eligibility~~

Example 1	Leroy is enrolled in MAPP with a renewal date of December 31. On September 3, he reports to his IM agency that he received a raise at work which requires verification to be provided. Leroy does not submit the required verification by the due date, so his eligibility for MAPP ended of September 30. On October 7, Leroy contacts his IM agency to request that his health care be re-opened, and he provides the required verification of his income. Since this is within the calendar month after his MAPP was terminated, Leroy does not need to submit a new application or new signature. Leroy remains eligible for MAPP and his MAPP certification period is reinstated with a renewal date of December 31.
Example 2	Linda is enrolled in BadgerCare Plus and her husband Leo is enrolled in MAPP with a renewal date of January 31. On September 2, she reports to her IM agency that Leo received a gift from his aunt, which increased his assets to $16,000. Leo's assets are over the MAPP program asset limit, so his MAPP ends as of September 30. On December 10, Linda contacts her IM agency to request that Leo's health care be reopened, as he purchased a vehicle (which is their only vehicle) and is no longer over the MAPP asset limit. It has been more than a calendar month since his MAPP was terminated, but because Linda is open for BadgerCare Plus, they do not need to submit a new application or new signature. Leo's eligibility for MAPP is reinstated and his MAPP certification period is reinstated with a renewal date of January 31.

If a case closed at renewal due to failure to complete the renewal, including providing verification for that renewal, the ~~person may~~person's case can be reopened for Medicaid without filing a new application if ~~he or she provides~~they provide the necessary information within three months of the renewal date (see Section 3.1.6 Late Renewals).

7.3 Immigrants

7.3.2 Verification

7.3.2.1 Verification through FDSH or SAVE

Primary verification of immigration status is done through the ~~Department of Homeland Security (DHS~~U.S. Citizenship and Immigration Services (USCIS) by use of the Federal Data Services Hub (FDSH) or ~~SAVE, which is~~Systematic Alien Verification for Entitlement (SAVE), an ~~automated telephone and computer database system.~~online service used to verify immigration status and naturalized/acquired U.S. citizenship. A worker processing an application can simply enter the immigrant's ~~alien~~A-number or USCIS 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~~it's available from ~~the Department of Homeland Security~~UCIS, 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~~ immigration status update for an individual, not ~~his or her~~their 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 CWW (see the Additional Eligibility Information column in the table in Section 7.3.3.1 Qualifying Immigrants~~CARES.~~).

It may be necessary to complete a secondary or third level verification procedure with ~~the U.S. Citizenship and Immigration Services (~~USCIS~~),~~ via SAVE, 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.,~~waiting period (for example, refugees, asylees, those with military service).
- ~~An IM~~A 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~~they are telling the ~~IM~~ worker.
- A non-citizen applicant tells ~~an IM~~a worker that ~~he or she~~they came to the U.S. prior to August 22, 1996. If ~~he or she~~they arrived in a legal or documented status, the ~~IM~~ worker needs to verify the date of arrival to ensure that the correct ~~alien~~immigrant 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~~USCIS will research the ~~alien's~~individual's records and complete the response portion of the verification request.

~~Consult the~~

Example 1	Shariff arrived as a student in June 2002. On June 5, 2006, he was granted asylum. The five-year waiting period does not apply to those granted asylum. Secondary verification via SAVE is not necessary. Shariff is eligible to be enrolled in BadgerCare Plus if he meets other financial and non-financial criteria.
Example 2	Tomas entered the U.S. on April 8, 1996, on a visitor's visa. He obtained qualified immigration status on September 22, 2003. Tomas applied for Medicaid on May 5, 2008. The 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 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 worker needs to conduct secondary verification. SAVE responds and confirms that the original date of arrival was April 8, 1996. Additionally, the worker needs to confirm that the applicant was continuously present (see Section 7.3.2.2.3 Continuous Presence) between April 8, 1996, and September 22, 2003. Tomas signs a self-declaration confirming this and is found eligible. If the 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 and not eligible until September 22, 2008.

See Process Help, Chapter 82 SAVE for more information.

7.3.2.2 Other Verification

Additional verifications from sources other than ~~the Department of Homeland Security~~ Federal Data Services Hub (FDSH) or SAVE are sometimes required~~ as well. For example,~~.

7.3.2.2.1 Military Service/Connection

The following documents are considered valid verification of military service for persons who are in an immigration status subject to the ~~5~~five-year ~~bar~~waiting period 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

7.3.2.2.2 Date of Arrival

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
- School enrollment records

7.3.2.2.3 Continuous Presence

To establish continuous presence, ~~require~~ a signed statement is required 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

7.3.2.3 Reverification of Immigration ~~statuses for most immigrants are permanent and most often change when the immigrant become a U.S. citizen. For this reason, immigration~~Status

Immigration status for ~~most~~many members should only be verified once, unless the status for an individual is questionable or ~~it's a status subject to reverification (see).~~they have a Registration Status Code of 20. Even if an immigrant loses health care eligibility for a period of time, ~~his or her~~their immigration status does not need to be re-verified~~ unless the status is subject to reverification~~.

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

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

~~Typically, these 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 people with other Registration Status Codes, as those statuses are permanent.~~

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

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

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

7.3.2.~~2~~ 4 Reasonable Opportunity Period for Verification of Immigration Status

Applicants who have declared that they are in a satisfactory immigration status, are otherwise eligible and 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 on Trafficking in Persons (HHS OTIP). She is enrolled in BadgerCare Plus and is sent the ROP notice requesting Sasha submit a letter from HHS OTIP. Sasha never submits a letter from HHS OTIP and her benefits end when the ROP expires. One year later, Sasha again applies for health care benefits. Once more, the FDSH returns the same results. Sasha is otherwise eligible for BadgerCare Plus. She must be enrolled in BadgerCare Plus without delay and sent a new ROP notice to Sasha requesting a letter from HHS OTIP. Again, Sasha is eligible for BadgerCare plus for 90 days after receiving the notice while waiting for Sasha to provide a letter from HHS OTIP.

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

7.3.3 Immigrants Eligible for Medicaid

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

7.3.3.1 Qualifying Immigrants

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

Types of Qualifying Immigrants

Short Name	Qualifying Immigrant Description	Eligible if:	Additional Eligibility Information	CWW Registration Status
Refugee	A refugee admitted under Immigration and Nationality Act (INA) Section 207. A refugee is a person who flees their country due to persecution or a well-founded fear of persecution because of race, religion, nationality, political opinion, or membership in a social group.	No additional criteria.	An immigrant admitted under this status may be eligible for Medicaid, without a ~~5~~five-year ~~wait~~waiting period, even if their immigration status later changes.	04
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~~five-year ~~wait~~waiting period, even if their immigration status later changes.	05
Deportation Withheld	An immigrant whose deportation is withheld under INA Section 243(h)	No additional criteria.	An immigrant admitted under this status may be	15

	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.		eligible for Medicaid, without a ~~5~~five-year ~~wait~~waiting period, even if their immigration status later changes.	
Cuban-Haitian Entrant	Cuban-Haitian Entrants are defined as certain nationals of Cuba or Haiti who have permission to reside in the U.S. based on humanitarian considerations or under Section 501(e) of the Refugee Education Assistance Act of 1980 (REAA).	No additional criteria. See Section 7.3.3.1.2 Cuban-Haitian Entrants for more information.	The term "Cuban-Haitian Entrant" (CHE) relates to benefit eligibility rather than an immigration status. Individuals who meet the definition of a CHE may be eligible for certain public benefits.	11
Foreign Born American Indian	An American Indian born in Canada who is at least 50% American Indian by blood, as defined by §289 of the Immigration and Nationality Act or An American Indian born outside the U.S. who is a member of a federally recognized Indian tribe, as defined in 25 U.S.C. 450b(e).	No additional criteria.	N/A	18
COFA Citizen	A person who is a citizen 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.~~N/A	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	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~~five-year ~~wait~~waiting period,	19

	(P.L. 106-386). See 7.3.3.1.4 Victims of Trafficking for more information.		even if their immigration status later changes.	
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 in an institution for Mental Diseases. 4. Be pregnant. 5. Have arrived in the U.S. before August 22, 1996, and have been continuously present. 6. Have a military service/connection. 7. Be an Amerasian immigrant. 8. See Section 7.3.3.1.5 Additional Criteria for Certain Qualifying Immigrants for more information.	Be certified by the Department of Health and Human Services as victim of trafficking (applies to T1 visa holders and others).	19 - Meets one additional criterion or is certified by HHS as a victim of trafficking. Or - 21- ~~5~~five-year ~~wait~~waiting period 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	06

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

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.

7.3.3.1.1.2 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

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

7.3.3.1.1.3 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 (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.

7.3.3.1.2 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.

7.3.3.1.3 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 five-year waiting period. ~~However,~~ COFA citizens who have a change in their status and become Lawful Permanent Residents are not subject to the five-year waiting period.

7.3.3.1.4 Victims of Trafficking

The U.S. Department of Health and Human Services (HHS) Office on Trafficking Persons (HHS OTIP) provides adult victims of trafficking with Certification Letters which allow those whose immigration status would otherwise prevent them from being eligible to receive Medicaid to be eligible to receive benefits. The certification process typically takes 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.

- 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~~waiting period 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 waiting period to receive federal benefits (including BadgerCare Plus and Medicaid), other than emergency services. For these immigrants, the five-year waiting period is calculated beginning when they first receive their qualifying immigration status.
2. Are less than 19 years old.

3. Are less than 21 years old and reside in an Institution for Mental Diseases.
4. Are pregnant.
    - Pregnant applicants are eligible for full-benefit Medicaid and BadgerCare Plus.
    - Pregnant people will have the five-year waiting period lifted when their pregnancy is reported to the agency. The waiting period will be lifted until 60 days after the last day of pregnancy and through the end of the month in which the 60th day occurs.
5. Arrived in the U.S. before August 22, 1996, and have been continuously present. Applicants who alleged an arrival date in the U.S. before August 22, 1996, and obtained a qualified immigrant status after August 22, 1996, may be eligible to receive Medicaid. The immigrants described below, who apply for Medicaid and meet all eligibility requirements, are entitled to receive Medicaid benefits:
    - A non-citizen who:
        - Arrived in the U.S. before August 22, 1996, in a legal, but non-qualified, immigration status and
        - Had a change in their status to a qualified immigrant on or after August 22, 1996, and
        - Remained continuously present from their date of arrival in the U.S. until the date they gained qualified immigration status.
    - A non-citizen who:
        - Arrived in the U.S. before August 22, 1996, in undocumented status, or
        - Overstayed their original visa, and
        - Remained continuously present from their date of arrival in the U.S. until the date they gained qualified immigration status.
    - For those non-citizens who arrived in the U.S. before August 22, 1996, but whose continuous presence cannot be verified, the five-year waiting period applies from the date the individual obtained a qualified immigrant status.

    An individual meets the "continuous presence" test if they:
    - Did not have a single absence from the U.S. of more than 30 days, or
    - Did not have a cumulative number of absences totaling more than 90 days.
6. Have a military service/connection.

    Applicants may be eligible for BadgerCare Plus if they meet any of the following criteria related to military service:
    - Honorably discharged veterans of the U.S. Armed Forces. This is defined as persons who were honorably discharged after any of the following:
        - Serving for at least 24 months in the U.S. Armed Forces.
        - Serving for the period for which the person was called to active duty in the U.S. Armed Forces.
        - Serving less than 24 months but was discharged or released from active duty for a disability incurred or aggravated in the line of duty.
        - Serving less than 24 months but was discharged for family hardship.
        - Serving in the Philippine Commonwealth Army or as a Philippine Scout during World War II.
    - On active duty (other than active duty for training) in the U.S. Armed Forces.
    - The spouse, unmarried and non-emancipated child under age 18, or surviving spouse of either an honorably discharged veteran or a person on active duty in the U.S. Armed Forces. A surviving spouse is defined as meeting all the following criteria:
        - A spouse who was married to the deceased veteran for at least one year.

        - A spouse who was married to the deceased veteran either:
            - Before the end of a 15-year time span following the end of the period of military service, or
            - For any period to the deceased veteran and a child was born of the marriage or was born before the marriage.
        - A spouse who has not remarried since the marriage to the deceased veteran.
7. Are an Amerasian immigrant.
    - Amerasian immigrants, defined under §584 of the Foreign Operations, Export Financing and Related Programs Appropriations Act of 1988, may be eligible for BadgerCare Plus.
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.

7.3.3.4 Impact of Immigrant Status on Household

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

13.2 Covered Services

Individuals who are inmates of a public institution may be eligible for suspended SSI-related Medicaid or Wisconsin Well Woman Medicaid if they otherwise meet eligibility requirements. See Chapter 24 SSI Related Medicaid and Deductibles or Chapter 36 Wisconsin Well Woman Medicaid for information about these programs.

If a member of a different health care program becomes incarcerated, eligibility for that program will be terminated. However, the member will be evaluated for eligibility in a program that can be suspended. During the suspension, Medicaid will only cover inpatient services received while the member is outside of jail or prison for 24 hours or more.

While enrolled in suspended Medicaid, members are not eligible to enroll in an HMO.

Copay limits still apply to suspended members for any services they receive.

See Section 13.8.5 Services for Youth for information on coverage for certain pre-release and post-release services for youth.

13.3 Suspension Start Date

13.3.3 Existing Members

Existing health care members who become incarcerated and are determined eligible for the health care suspension will be certified for the suspension from the first of the month after the incarceration is reported. This policy applies even when the incarceration is reported untimely. See Section 12.1 Change Reporting Introduction. ~~An untimely change report may result in an overpayment. See Section 22.2 Corrective Action.~~

Example 5~~:~~	Olivia is open for full-benefit SSI-related Medicaid. On December 23, 2020, Olivia reports she is incarcerated as of December 20, 2020. Olivia's SSI-related Medicaid is suspended starting January 1, 2021.

13.8 Special Rules

13.8.5 Services for Youth

Youth who are incarcerated and enrolled in suspended Medicaid can receive HealthCheck screening services and targeted case management during certain times if they are either:

- Under 21 years old.
- Under 26 years old and meet the criteria to be a Former Foster Care Youth (see BadgerCare Plus Handbook Section 11.2 Former Foster Care Youth

These youth are eligible for HealthCheck screening services 30 days prior to their release and within one week (or as soon as practicable) after their release.

These youth are eligible for targeted case management 30 days prior to their release and at least 30 days after release.

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:

15.3.26 VA Allowances

15.3.26.3 Patient Liability Calculation for State Veterans Home Residents Without Dependents

For any veteran without a spouse or dependents (or for a surviving spouse without dependents) who resides at a State Veterans Home at King, Chippewa Falls, or Union Grove:

- The portion of the VA pension that is an A&A or housebound allowance or is for UME is disregarded in the eligibility determination.
- If the member receives a VA pension in an amount less than or equal to $90, the total pension amount is exempt for the patient liability calculation.
- If the member receives a VA pension in an amount greater than $90, only $90 of the VA pension is exempt for the patient liability calculation. The portion of the VA pension that is an A&A or housebound allowance or is for UME is included when calculating patient liability.

These special patient liability rules do not apply to State Veterans Home residents who have a spouse or other dependents.

If a veteran or surviving spouse in a State Veterans Home has dependents and receives a VA benefit, for Medicaid eligibility and patient liability, disregard any amount of the VA benefit that is an A&A or housebound allowance or is for UME.

Example 7	John is a single veteran with no dependents residing at the State Veterans Home at King. His total monthly income consists of a $90 VA pension and a $55 annuity payment. The $90 VA pension is totally disregarded for his Medicaid eligibility and patient liability calculation. John's budgetable income is $55. After deducting the $~~45~~55 personal needs allowance, he has a $~~100~~ patient liability.

Example 8	Scott is a single veteran with no dependents residing at the State Veterans Home at Chippewa Falls. His total monthly income consists of a $590 VA pension ($200 of which is for UME) and a $50 annuity payment. For his Medicaid eligibility determination, the $200 UME portion of his VA pension is disregarded. For his patient liability calculation, only $90 of the VA pension is disregarded. Eligibility Calculation $390 VA Pension ($590 gross VA pension – $200 UME) + $50 Annuity _____ $440 gross countable income Patient Liability Calculation $440 gross countable income + $200 UME (counted) _____ $640 adjusted gross income - $~~45~~55 (personal needs allowance) - $90 (VA allowance) _____ $ ~~505~~495 patient liability amount

Example 9	Melvin is a veteran residing at the State Veterans Home at King. He has a spouse residing in the community. His total monthly income consists of a $1,400 monthly Social Security benefit and a $410 monthly VA pension ($200 of which is for UME). The portion of the VA pension that is for UME is totally disregarded for both his Medicaid eligibility and patient liability calculation. $1,400 Social Security + $410 VA pension - $200 UME (disregarded) _____ = $1,610 budgetable income

15.3.36 Guaranteed Income Payments

~~Guaranteed income from a privately funded, non-profit organization~~ A guaranteed income payment is excluded for all categories of Medicaid~~.~~ if both of the following apply:

- The payment itself is privately funded.
- The payment is administered by a non-profit organization.

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

See Section 16.7.34 Guaranteed Income Payments for information about asset treatment of guaranteed income payments.

15.4 Unearned Income

15.4.26 Virtual Currency

Virtual currency is money that is a digital system not in U.S. dollars or other money system backed by a government. Examples may include, but are not limited to, Bitcoin, Ethereum, and Litecoin. Traditional currency, such as the U.S. dollar, is used to purchase virtual currency, and virtual currency may be sold for traditional currency. Virtual currency does not refer to Venmo or PayPal. Venmo and PayPal are payment services that facilitate the movement of funds between people or businesses; they are not currencies. Income earned via Venmo or PayPal sales would most likely fall under self-employment income policies, not virtual currency.

If virtual currency is sold, income received from the sale is counted as income. See SECTION 15.5.19 VIRTUAL CURRENCY for information about treatment of virtual currency that the applicant or member has earned through work.

15.5 Earned Income

15.5.19 Virtual Currency

Virtual currency is money that is a digital system not in U.S. dollars or other money system backed by a government. Examples may include, but are not limited to, Bitcoin, Ethereum, and Litecoin. Traditional currency, such as the U.S. dollar, is used to purchase virtual currency, and virtual currency may be sold for traditional currency. Virtual currency does not refer to Venmo or PayPal. Venmo and PayPal are payment services that facilitate the movement of funds between people or businesses; they are not currencies. Income earned via Venmo or PayPal sales would most likely fall under self-employment income policies, not virtual currency.

Virtual currency is counted as income when it is:

- Received as payment for goods or services
- Received by an independent contractor for performing services
- Received from an employer as remuneration for services (i.e., wages)

See SECTION 15.4.26 VIRTUAL CURRENCY for information about the sale of virtual currency.

15.7 Income Deductions

15.7.1 Maintaining Home or Apartment

If a person residing in a medical institution (see Section 27.1.1 Institutions Introduction) has a home or apartment or was residing in an assisted living facility prior to institutionalization, deduct an amount from their income to allow for maintaining the home, apartment, or room at the assisted living facility that does not exceed the Institutions Home Maintenance Allowance Maximum (see Section 39.4.3 LTC Post-Eligibility Allowances). The amount is in addition to the $~~45~~55 personal needs allowance. It should be enough for mortgage, rent, property taxes (including special assessments), home or renters' insurance, utilities (heat, water, sewer, electricity), and other incidental costs. If the member was residing at an assisted living facility prior to institutionalization, use the facility's room and board rate, up to the maximum, for the home maintenance deduction.

Make the deduction only when both the following conditions are met:

- A physician provides a statement (verbally or in writing) certifying that the person is likely to return to the home or apartment within six months.
- The person's spouse is not living in the home or apartment.

Deduct this amount for no more than six months. If the person is re-admitted to the institution, grant a six-month continuance. A physician must again certify that the person is likely to return to the home or apartment within six months.

The home maintenance allowance can be granted at any time. It is not limited to the first six months the person resides in the medical institution.

Example 1	Bob entered a nursing home in June 2013 as a private pay patient. In June 2014, he qualifies for Medicaid and is potentially eligible for the home maintenance allowance. Bob's doctor says he is expected to return home by November 2014. He is eligible for a home maintenance deduction from his income, when determining the amount of his income available for his cost of care, starting in June 2014.

Note	The home maintenance allowance may only be given for Institutional Medicaid. It does not apply to HCBW Medicaid.

16.7 Liquid Assets

16.7.4 Annuities

16.7.4.6 Remainder Beneficiary Designation Requirement for Long-Term Care

When an individual is requesting or receiving Medicaid long-term care services, they must complete an annuity designation form (Medicaid Annuity Beneficiary Designation form, F-10191) for all annuities that meet the criteria in SECTION 16.7.4.5 ANNUITY DISCLOSURE REQUIREMENT FOR LONG-TERM CARE.

After receiving the completed annuity ~~disclosure~~designation form, the IM agency must ~~send the~~ then complete the notice of obligation form (Medicaid Issuer of Annuity - Notice of Obligation, F-10190 ~~()~~) and send the completed form (along with the corresponding completed annuity designation form) to the annuity issuer, instructing them to make the Wisconsin Department of Health Services Estate Recovery Program a remainder beneficiary. The issuer must be allowed up to 30 days to confirm the designation has been made.

The Wisconsin Department of Health Services Estate Recovery Program must be the primary remainder beneficiary unless a community spouse, disabled child, or minor child is listed as the primary remainder beneficiary. If a community spouse, disabled child, or minor child is the primary beneficiary, the Wisconsin Department of Health Services Estate Recovery Program must be the secondary remainder beneficiary.

When the issuer responds and indicates that the state has been designated the remainder beneficiary or that there is no death benefit available under this annuity, the annuity must be treated as meeting the designation requirement~~, and the agency should proceed with the long-term care eligibility determination~~.

If the issuer does not respond within 30 days of the date when the Notice of Obligation form was sent, the IM agency must contact the issuer by phone and request that they respond within 10 days. If the issuer does not respond within 40 days after the Notice of Obligation form was sent, the agency should contact the CARES Problem Resolution Center for further guidance.

~~If the form from the annuity issuer indicates that the remainder beneficiary designation change is in process and provides a date by when the designation will be completed, the IM agency should treat this annuity as meeting the designation requirement and proceed with the long-term care eligibility determination.~~ If the issuer fails to confirm that the designation change has been completed by the date indicated on the form, the IM agency must contact the issuer and request that they confirm within 10 days that the changes have been completed. If the issuer has not responded 10 days after the request was made, the agency should contact the CARES Problem Resolution Center for further guidance.

Once the state has been designated as the remainder beneficiary, the annuity issuer must notify the local agency about any changes made to that annuity to ensure the annuitant does not change the terms of the annuity beneficiary designation at a later date. The issuer acknowledges this obligation by completing and returning the Notice of Obligation form.

Copies of the completed forms must be saved in the case file.

~~The IM agency should not make a final decision on the Medicaid long-term care application until one of the following occurs:~~

- ~~The applicant provides the required disclosure or beneficiary designation forms by the verification due date.~~
- ~~Verification has been received that the Wisconsin Department of Health Services has been legally named as the appropriate remainder beneficiary of the annuity or that no death benefit is available under the annuity.~~
- ~~Verification has been received that the beneficiary designation change is in process.~~

- ~~The issuer indicates that the applicant, member, or spouse failed to cooperate with the issuer's process to name the State as a remainder beneficiary.~~
- ~~The IM agency receives direction from the CARES Problem Resolution Center to certify the applicant or member for Medicaid long-term care coverage.~~

A divestment penalty period must be imposed for applicants and members who refuse to cooperate in this annuity beneficiary designation process. The divested amount is the full purchase price of the annuity.

16.7.34 Guaranteed Income Payments

~~Guaranteed~~A guaranteed income ~~from a privately funded, non-profit organization~~ payment that is retained in the month after the month of receipt is excluded as an asset indefinitely if all of the following apply:

- The payment itself is privately funded.
- The payment is administered by a non-profit organization.
- The payment is separately identifiable (See section 16.3 Separate and Mixed Assets).

Guaranteed income ~~includes~~payments that can be excluded include, but ~~is~~are not limited to, payments from the Madison Forward Fund and the Bridge Project in Milwaukee.

See Section 15.3.36 Guaranteed Income Payments for information about income treatment of guaranteed income payments.

18.6 Spousal Impoverishment Income Allocation

18.6.1 Spousal Impoverishment Income Allocation Introduction

After an institutionalized person is found eligible, they may allocate some of their income to the community spouse and any dependent family members who live with the community spouse. Dependent family members are defined as follows:

- Children under the age of 18, of either parent
- Children of any age, of either parent, who are claimed as tax dependents under the Internal Revenue Code (IRC)
- Siblings of either the institutionalized person or the community spouse who are claimed as tax dependents under the IRC
- Parents of either the institutionalized person or the community spouse who are claimed as tax dependents under the IRC

Income that is allocated to the community spouse must be given (or made available) to the community spouse each month for it to be allowed as a post-eligibility income deduction for the institutionalized person. Income that is allocated to a dependent family member does not have to be given to the dependent family member.

Note~~:~~	Income allocated to the community spouse is countable income for the community spouse if they apply for health care.

The institutionalized person must decide how much income to allocate to their community spouse. They may allocate an amount that brings the community spouse's income up to the maximum allocation (see Section 18.6.2 Community Spouse Income Allocation) or they may choose to allocate a lesser amount. Since the institutionalized person may have medical costs that are not covered by Medicaid, they may need to keep some income rather than allocating the maximum allowable amount.

Example 1~~:~~	Finella is in a nursing home and open for Institutional Medicaid. Her husband Teddy lives in the community. Finella's monthly income is $500. She incurs $80 in noncovered medical expenses each month. She decides to give $~~375~~365 to Teddy, keeping only her $~~45~~55 personal needs allowance (see Section 39.4.3 LTC Post-Eligibility Allowances) and $80 to pay for her medical expenses (see Section 27.7.7 Medical or Remedial Expenses and Payments for Noncovered Services). These post-eligibility income deductions and allowances reduce her nursing home patient liability amount to $0.

21.7 ForwardHealth Cards

21.7.5 Lost or Stolen Cards

If a member needs a replacement card, they or an authorized representative, can request a replacement card by:

1. Going to ACCESS.
    1. Create an ACCESS Account, then
    2. Go to your ACCESS Account Home Page and select a new ForwardHealth card (see ACCESS User Guide, Section 4.10 Get a New Card), or
2. Contacting Member Services at 1-800-362-3002.

~~Workers may also log into the and select "Replacement ID Card Request" under the Quick Links on the right side of the page.~~

If the member has multiple benefit ID cards, there will be a choice of which ID card to request. A new ForwardHealth card will be created the evening of the request and will be sent out the following business day.

Replacement cards are issued automatically when the card has been returned as undeliverable and the member's address changes.

22.1 Estate Recovery

22.1.1 Estate Recovery Program Definition

The state seeks repayment of certain correctly paid health and LTC benefits by Medicaid members through all of the following:

- Liens against a home
- Claims against estates
- Affidavits
- Voluntary recoveries

~~These procedures are the ERP. No ERP recovery may be made for Medicaid services provided before October 1, 1991.~~

22.1.2 Recoverable Services

Not all services provided by Medicaid are recoverable. Recoverability depends on what was provided and the member's age and residence when he or she received the benefit. ~~If a member's services do not meet the criteria listed below, they are not subject to estate recovery.~~

The following are the services for which ERP may seek recovery:

1. All Medicaid services received while living in a nursing home on or after October 1, 1991.
2. All Medicaid services received while institutionalized in an inpatient hospital on or after July 1, 1995.
3. Home health care services received by members age 55 or older on or after July 1, 1995, consisting of:
    a. Skilled nursing services.
    b. Home health aide services.
    c. Home health therapy and speech pathology services.
    d. Private duty nursing services.
    e. Personal care services received by members age 55 or older on or after April 1, 2000.

Example	Josie is 12 years old and is enrolled in Katie Beckett Medicaid. She receives home health care services that include skilled nursing services, home health therapy, and speech pathology. Because she was not 55 years or older when she received the home health care services, ~~they are~~she is not subject to estate recovery.

4. All HCBW services (COP-W, CIP 1A, CIP 1B, CIP II, Brain Injury Waiver, Community Opportunities and Recovery, and Community Supported Living Arrangements) received by members age 55 or older between July 1, 1995, and July 31, 2014:
    a. Prescription/legend drugs received by waiver participants.
    b. Benefits paid associated with a waiver participant's inpatient hospital stay. These include inpatient services that are billed separately by providers and services that are noncovered hospital services.
5. Family Care services received by members age 55 or older between February 1, 2000, and July 31, 2014:
    a. Prescription/legend drugs received by waiver participants.
    b. Benefits paid associated with a waiver participant's inpatient hospital stay. This includes inpatient services that are billed separately by providers and that are non-covered hospital services.

Note:	The Non-Medicaid Family Care no longer exists as of May 1, 2003. However, ERP could recover from members who received benefits under this program prior to

	May 1, 2003.

6. All Family Care Partnership HCBW services, prescription/legend drugs and benefits associated with an inpatient hospital stay that are received by members age 55 or older between March 1, 2009, and July 31, 2014.
7. All IRIS services, prescription/legend drugs and benefits associated with an inpatient hospital stay that are received by members age 55 or older before August 1, 2014.
8. All Medicaid services received by members age 55 or older participating in a LTC program on or after August 1, 2014.
   LTC programs include all HCBW programs (including COP-W, CIP 1A, CIP 1B, CIP II, Brain Injury Waiver, Community Opportunities and Recovery, Community Supported Living Arrangements, FamilyCare, FamilyCare Partnership, IRIS, and PACE). The capitation payment made to the MCO on or after August 1, 2014, will be recovered for members receiving LTC program services through managed care.
9. Costs that may be recovered through a lien are:
   a. Medicaid costs for services received on or after October 1, 1991, during a nursing home stay or services received while institutionalized in a hospital on or after July 1, 1995.
   b. Medicaid costs of all other recoverable services as listed in Items 1-5 that are received on or after April 1, 2000, by members age 55 or older as of the date of the service.

If a member's services do not meet the criteria listed above, they are not subject to estate recovery.

22.1.10 Incentive Payments

DHS will return to local agencies five percent of collections made through a lien, voluntary payments, and probated estate recoveries. ~~We~~DHS will pay this incentive to the last agency certifying the member for Medicaid.

The payments are discretionary. DHS will make them based on compliance with program requirements.

24.7 Meeting the Deductible

24.7.3 Prepaying a Deductible

24.7.3.5 Insufficient Funds

If the deductible is paid with a check that is returned for insufficient funds, ~~discontinue the person's eligibility, determine if an overpayment occurred and if so, establish a claim for benefit recovery~~the person is no longer eligibile.

26.3 Nonfinancial Requirements

26.3.5 Health and Employment Counseling Program

Health and Employment Counseling (HEC) is a pre-employment program for MAPP members who are not employed but are looking for work. HEC participation is one way to meet the MAPP work requirement. ~~Applicants and members~~ Individuals enrolled in or applying for MAPP who are interested in HEC can call 866-278-6440 to learn more about the program.
HEC participation can occur for up to nine months with ~~a~~one three-month extension, for a total of 12 months. ~~After six months, members~~

Members can re-enroll in HEC to meet the eligibility criteria for MAPP ~~as long as they have not already participated two times within a five-year period~~. HEC participation is limited to twice within a five-year period, and there must be six months between any two HEC participation periods.

26.3.5.1 Health and Employment Counseling Processing

~~Applicants~~ MAPP applicants or members ~~wishing to enroll~~interested in enrolling in HEC are required to complete ~~the~~and submit a HEC Application (F-00004~~) and send it~~). Applications may be printed from the Department of Health Services' website. Applicants can also contact their local agency to request a HEC application be mailed to them. The applicant can complete the ~~address listed~~application on their own, with the ~~application~~assistance of the HEC coordinator or an advocate. IM workers are not expected to assist with completing or submitting the form for the applicant.
~~The~~Once submitted, the HEC ~~Coordinator~~coordinator will make a final approval or disapproval decision within 10 ~~working~~business days. ~~-~~ If the HEC application is approved, the HEC coordinator will send the member an approval letter. The HEC period will begin as of the first of the month the approved application was submitted. If the application is not approved, the member will be informed that ~~he or she has~~they have not been approved and ~~that he or she has the~~ can contact the HEC coordinator with any questions. The right to file a fair hearing~~. If the application is approved, the HEC Coordinator will send the member an approval letter and send a copy to the CDPU/MDPU. IM workers should give the Health and Employment Counseling (HEC) Application along with the Medicaid Purchase Plan Fact Sheet () to any MAPP applicant who requests HEC. The applicant can complete the application on his or her own or with the assistance of the HEC Coordinator or an advocate. IM workers are not expected to assist with filling out or submitting the form to the HEC Coordinator~~ will be provided on their notice of decision for MAPP eligibility.

Note	Qualifying for HEC is contingent on the member having an approved disability determination. A HEC application for an individual with a pending disability determination will be processed after a disability decision has been made by DDB. If approved, retroactive HEC participation will begin the first of the month the approved HEC application was submitted.

26.3.5.2 Health and Employment Counseling Extension

~~A participant can apply to extend an HEC period by contacting HEC to request an extension.~~
If the HEC period is ending prior to the member meeting ~~his or her~~their employment plan goals, ~~but~~ the ~~goals can be met within the~~ member can apply to extend their HEC period by three months.
A HEC Extension Request form (F-00004A ~~after the regular~~) will be sent to the member two months before their 9-month HEC period will end~~,~~. To avoid any gaps in coverage, the participant should apply for an extension before the ~~HEC Coordinator can extend~~end of the seventh month of their HEC period. To be approved for an extension, the participant must request an extension before the last day of their HEC ~~participation for three months~~period. The HEC coordinator will make an approval or denial decision within 10 business days. The member will be mailed a decision letter.

26.3.5.3 Health and Employment Counseling Participation Changes

~~Whenever~~ HEC participation will end prior to a ~~member notifies the~~ member's 9-month or 12-month end date when:

- MAPP eligibility is terminated for a reason other than not meeting the work requirement.
- Employment or work activity is reported to the HEC coordinator and IM agency.

To notify the HEC coordinator of employment, the member needs to complete and submit the HEC Employment Report form (F-00004B ~~that they have stopped participating~~). When a member enrolled in ~~the HEC program and are~~ HEC notifies the IM agency that they are now employed, verification will be needed and eligibility will be redetermined.

If a member's HEC participation ends as scheduled and they are not meeting the work requirement in another way, their MAPP eligibility will be terminated with an adverse action notice.

~~When a HEC participant notifies the IM agency that they are now employed, information about the employment will be needed and eligibility will need to be redetermined.~~

Note	An 18-year-old MAPP member who does not qualify for any other full-benefit health care category cannot lose MAPP during their continuous coverage period even if they are determined no longer meeting the work requirement (see SECTION 1.2 CONTINUOUS COVERAGE FOR QUALIFYING CHILDREN).

26.4 MAPP Financial Requirements

Follow EBD rules in Chapters 15.1 Income Introduction and 16.1 Assets Introduction to determine countable assets and income. The following are MAPP financial eligibility requirements.

26.4.2 Income

The spouse and applicant or member's net income must not exceed 250% of the FPL (See 39.5 FPL) for appropriate fiscal test group size. To determine this, do the following:

1. Determine earned income. Count the member and their spouse's income if residing together.
2. Deduct the $65 and ½ of the earned income disregard from the spouse and member's earnings (see Section 15.7.5 $65 and ½ Earned Income Deduction).
3. Deduct the member's and spouse's IRWEs (see Section 15.7.4 Impairment Related Work Expenses (IRWE)). The result is the adjusted earned income.
4. Determine unearned income. Count the applicant or member's unearned income and their spouse's unearned income if residing together.
5. Add the adjusted earned and unearned income together.
6. Deduct $20 from the combined income.
7. Deduct special exempt income (see Section 15.7.2 Special Exempt Income).
8. Deduct all verified monthly out-of-pocket medical and remedial expenses incurred by a MAPP applicant or member (their spouse, if living together), if the monthly total of those expenses is above $500.
9. If a MAPP member receives Social Security payments, subtract the current COLA disregard between January 1 and the date the FPL is effective in CARES for that year (see Section 15.3.35 Temporary COLA DISREGARD FOR SOCIAL SECURITY RECIPIENTS).
10. Subtract the ~~historical COLA Disregard Amount (see Section 39.6 COLA Disregard)~~ disregard amount for MAPP members who are also determined to be a 503 (see Section 25.~~1~~ 3 503 ~~Eligibility~~Group) or Disabled Adult Child (DAC) (see Section 25.2 Disabled Adult Child (DAC~~)).~~) Group).
11. Compare the result to 250% of the FPL (see Section 39.5 FPL Table). Include the member's minor dependent legal children (biological or adoptive) when determining fiscal test group size. Include the member's dependent 18-year-old children in the fiscal test group size. Do not include the member's stepchildren.

28.6 HCBWLTC Eligibility Groups and Cost Sharing

28.6.1 ~~Home and Community-Based Waivers Long-Term Care Instructions Introduction~~

~~Financial eligibility for home and community-based waivers cases is determined in CARES.~~
~~Although Katie Beckett cases are Group A, these cases are processed manually outside of CARES by Katie Beckett staff.~~

~~28.6.2~~ Group A

Group A members are waiver functionally eligible and Medicaid eligible via any full-benefit Medicaid subprogram other than HCBW Medicaid.

- Group A members may be eligible for any of the full-benefit Medicaid programs, as listed in ~~Section~~ SECTION 21.2 Full-Benefit Medicaid, including those eligible for Special Status MA (see Section 25.~~0~~ 1 Special Status Medicaid ~~Introduction~~).
- Group A does not include someone solely eligible for any of the limited benefit Medicaid subprograms listed in ~~Section~~ SECTION 21.3 Limited Benefit Medicaid.

Group A members do not have a cost share.
Members who have met a deductible are eligible for community waivers as a Group A. The member remains eligible as a Group A until the end of the deductible period. At the next review the member will be able to make a choice between meeting the deductible to receive Medicaid (remaining a Group A) or becoming eligible for community waivers as a Group B or B Plus with a potential cost share.
Group A members are financially eligible with no cost share. They are only subject to the asset limit and any premiums associated with the full-benefit Medicaid source, if applicable. For example, if the member's Medicaid source is MAPP, s/he would be subject to the MAPP asset limit and premium calculated. If the member's Medicaid source is BadgerCare Plus, the member would not have an asset limit, but may still have a premium calculated.

Note~~:~~	Group A members do not have an asset limit if they are Group A eligible via BadgerCare Plus, Adoption Assistance Medicaid, Foster Care Medicaid, Katie Beckett Medicaid, or Wisconsin Well Woman Medicaid since these programs do not have an asset test. All Group A members, including those who are eligible for Group A through BadgerCare Plus eligibility, are subject to the divestment policy described in Chapter 17 Divestment.

28.6.~~3~~ 2 Group B and B Plus

Group B members are defined as those not in Group A, but who have gross income at or below the nursing home institutions categorically needy income limit (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables).
Group B Plus members are defined as those not in Group A, who have gross income above the nursing home institutions categorically needy income limit, but whose income does not exceed the cost of the appropriate institutional care by more than the medically needy income limit (see Section 39.4 Elderly, Blind, or Disabled Assets and Income Tables).

28.6.~~4~~ 3 Cost Share Amount

The cost share amount is the monthly amount Group B and B Plus members must pay toward the cost of their waiver services. The cost share amount is calculated in CARES by applying the cost share deductions to Group B and B Plus members' gross income. For former SSI members who are not eligible for Special Status Medicaid (Section 25.1 Special Status Medicaid Introduction) special status disregards are not used in the Cost Share calculation. Members who owe a cost share must pay one in the month that they enroll in a community waiver program, even if they only receive services for part of a month. If

the member changes from one MCO to another MCO in the same month after paying a cost share to the original MCO, they do not owe a cost share to the new MCO that month.
Family Care, Family Care Partnership, or PACE members institutionalized in a medical institution pay a patient liability calculated according to Chapter 27 Institutional Long-Term Care rather than cost share under this section.
Cost Share or Patient Liability Effective Dates
Income changes which are reported timely and result in an increased patient liability or cost share have the following effective dates:

- Before adverse action: Effective the first of the following month.
- After adverse action: Effective the first of the month after the following month.

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

28.6.43.1 Personal Maintenance Allowance

A personal maintenance allowance for room, board, and personal expenses must be deducted from income when calculating cost share.
The personal maintenance allowance is calculated as the total of the following, but must not exceed the Community Waivers Personal Maintenance Allowance Maximum (see Section 39.4.3 LTC Post-Eligibility Allowances):

1. Community Waivers Basic Needs Allowance (see Section 39.4.3 LTC Post-Eligibility Allowances)
2. Sixty-five dollars and ½ earned income deduction (see Section 15.7.5 $65 and ½ Earned Income Deduction)
3. Special housing amount equal to monthly housing costs over $350. If the waiver applicant's housing costs are over $350, add together the following costs and subtract $350 to get the special housing amount:
    1. Rent.
    2. Home or renter's insurance.
    3. Mortgage.
    4. Property tax (including special assessments).
    5. Utilities (heat, water, sewer, electricity).
    6. Room amount for members in a CBRF, Residential Care Apartment Complex, or Adult Family Home. The case manager determines and provides this amount.

    Waiver participants under age 18 do not qualify for the special housing amount deduction.

If two spouses who are both waiver participants live together (or they have separate rooms in a substitute care facility, but there is only one room and board contract) the special housing amount deduction is allocated between them in the way that results in the lowest total cost share for the couple.

Example 1	Jennifer and Markus are married and live together. Both are waiver participants. Their total housing costs are $1,600. The special housing amount is calculated as $1600 − $350 = $1250. Before deducting the special housing amount, Jennifer has a cost share of $800 and Markus has a cost share of $500. To get the lowest total cost share for the couple, $500 of the special housing amount is allocated to Markus, reducing his cost share to $0. The remaining $750 of the special housing amount is allocated to Jennifer, reducing her cost share to $50.

Example 2	Dan and Allison are married and live together. Both are waiver participants. Their total housing costs are $1,075. The special housing amount is calculated as $1,075 − $350 = $725. Before deducting the special housing amount, Dan has a cost share of $1,200. Allison is eligible

	for Group A waivers with no cost share. To get the lowest total cost share for the couple, the full $725 special housing amount is allocated to Dan, reducing his cost share to $475.

If two spouses who are both waiver participants have separate living arrangements (e.g., they reside in two different substitute care facilities, or they reside in the same substitute care facility but each has a private room and a separate room and board contract) a separate special housing amount is calculated for each based on their individual housing costs.
If the total of 1, 2, and 3 above is greater than the Community Waivers Personal Maintenance Allowance Maximum, the maximum amount is used. See SECTION 39.4.3 LTC POST-ELIGIBILITY ALLOWANCES for the current Community Waivers Personal Maintenance Allowance Maximum.

28.6.43.2 Family Maintenance Allowance

A family maintenance allowance, an amount to be used for the support of the applicant's family members, should only be deducted from income when calculating cost share in certain cases. The family maintenance allowance may not be used for a deduction when spousal impoverishment policies apply or if the member is a disabled child. For spousal cases, the institutionalized person can allocate income to the community spouse and children in the home, see Section 18.6 Spousal Impoverishment Income Allocation.

28.6.43.2.1 Family Maintenance Allowance Calculation - Minor Child

When the waiver participant has one or more children under the age of 18 who do not live with a community spouse, an allowance for those children is calculated as follows:

1. Determine the total gross monthly income of the member's children under age 18 who are not living with a community spouse. No exclusions, disregards, or deductions apply.
2. Subtract the minor children's total gross income from 100% the FPL for a family size equal to the number of minor children not living with a community spouse to get the family maintenance allowance. If the children's total gross income exceeds 100% FPL, no family maintenance allowance is deducted.

28.6.43.2.2 Family Maintenance Allowance Calculation - EBD-Related

If there are no minor children in the home, and spousal impoverishment policies do not apply, calculate the following:

1. Spouse's gross earned income.
2. -$65 and ½ of total gross earned income (see Section 15.7.5 $65 and ½ Earned Income Deduction).
3. =_____.
4. +Spouse's total unearned income.
5. =_____ (3)+(4).
6. -$20 disregard .
7. =_____(6)-(5).
8. _____Enter the Non-Spousal-Impoverishment Family Maintenance Allowance Maximum (see Section 39.4.3 LTC Post-Eligibility Allowances).

If (7) is greater than (8), there is no family maintenance allowance. If (7) is less than (8), the family maintenance allowance is the difference between (7) and (8).

28.6.43.3 Special Exempt Income

Special exempt income (see Section 15.7.2 Special Exempt Income) must be deducted from income when calculating cost share.

28.6.~~4~~3.4 Health Insurance

All health and dental insurance premiums covering the waiver person and for which he or she is responsible and pays a premium must be deducted from income when calculating cost share. This includes any Medicare Premium obligation including Medicare Part D. See Section 9.6.2 Policies Not To Report for a list of insurance types for which premium deductions are not allowed.

If the waiver participant is part of a covered group but not responsible for the premium, find his or her proportionate share by dividing the premium by the number of people covered. If both members of a couple apply, but only one pays the premium, divide the premium equally. Prorate premiums over the months payment covers.

Example 8~~:~~	Sally pays a $600 premium quarterly for her Medicare supplement policy. Six hundred dollars divided by three equals $200. Enter $200 as her monthly health insurance premium payment on the Medical Coverage page.

28.6.~~4~~3.5 Medical/Remedial Expenses

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

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

28.6.~~5~~ 4 Maximum Cost Share Amount

For Family Care, Family Care Partnership, and PACE, see Section 39.4.5 FAMILY CARE, FAMILY CARE PARTNERSHIP, OR PACE GROUP B PLUS COST SHARE CAP for maximum cost share amount.

28.6.~~6~~ 5 Waiver or Reduction Cost Share

Family Care, Family Care Partnership, or PACE members may request a waiver or reduction of their cost share from the Department. Members indicating that they are having difficulty paying cost share should be informed of this right, directed to complete the Application for Reduction of Cost Share form (F-01827), and referred to the Bureau of Adult Programs and Policy (1-855-885-0287).

31.1 Migrant Workers

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

"Migrant worker" does not include any of the following:

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

Certain migrant workers and their families qualify for a simplified application procedure when applying for BadgerCare Plus or Medicaid in Wisconsin. For policies related to migrant workers, see BadgerCare Plus Handbook~~-~~, Chapter 12 Migrant Workers.

33.6 SeniorCare Financial Requirements

33.6.8 Other Income

33.6.8.1 Allocated Income From a Medicaid Member Spouse

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

Example 3~~:~~	Betty is a Medicaid member and in a nursing home. She is allowed to allocate up to $1,000 to her spouse, Carl, according to the notice she receives. Betty only actually has $650 available, and of that, $~~45~~55 is set aside as her personal needs allowance. The $~~605~~595 per month that she allocates to Carl would be counted as unearned income for Carl. He would report $7,~~260~~140 as "Other Income" on his SeniorCare application.

A SeniorCare applicant whose spouse is a Medicaid member living in the home (e.g., a community waivers participant) should not report income that is allocated to him or her. The allocated amount must be included in the income estimate for the Medicaid member spouse because he or she is living in the home.

39.13 VA Allowance Rates

The chart below can be used to identify the value of the exempt portion of a VA payment if both the VA benefit type is known and the payment indicates the member is eligible for A&A or housebound allowance, but does not list an amount for the allowance.

The following rates are effective December 1, ~~2023~~ 2024 – November 31, ~~2024~~2025.

~~BENEFIT~~VA INCOME TYPE	AID & ATTENDANCE AMOUNT	HOUSEBOUND ALLOWANCE AMOUNT
Veteran's pension (see note)	~~$922~~up to $945	~~$306~~up to $314
Surviving spouse pension (see note)	~~$553~~up to $567	~~$205~~up to $211
Veteran's disability compensation	Benefit could include A&A for the spouse. Amount depends on veteran's disability rating.	N/A
Surviving spouse dependency and indemnity compensation (DIC)	$~~399.54~~409.53	$~~187.17~~191.85
Surviving parent DIC	$~~434~~445	N/A

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