

# Key Contacts

To get the address or phone number of your agency, go to [dhs.wi.gov/em/customerhelp](https://dhs.wi.gov/em/customerhelp) or call 1-800-362-3002.

**Report Public Assistance Fraud — 1-877-865-3432 (toll-free) or visit <https://www.reportfraud.wisconsin.gov/>.**

If you have a disability and need this information in a different format, need it translated to another language, or if you have any questions about your rights and responsibilities, contact your agency or Member Services at 1-800-362-3002.

## **All Applicants and Members ACCESS Online Tool —**

**[ACCESS.wi.gov](https://ACCESS.wi.gov)**

- See what health, nutrition and other programs you may be able to get
- Apply for BadgerCare Plus, Medicaid and FoodShare
- Check the status of your benefits
- Report changes (examples: new address or job)
- Replace your lost or damaged ForwardHealth card
- Renew your benefits and submit your FoodShare and/or Child Care Six-Month Report forms

## **Mail or Fax Applications and/or Proof/Verifications**

If you live in Milwaukee County:

MDPU  
PO Box 05676  
Milwaukee WI 53205  
Fax: 1-888-409-1979

If you **do not** live in Milwaukee County:

CDPU  
PO Box 5234  
Janesville, WI 53547-5234  
Fax: 1-855-293-1822

## **FoodShare, BadgerCare Plus and Medicaid — 1-800-362-3002**

- Covered Services and Copays
- Enrollment rules
- Health Insurance Premium Payments
- Find a Provider
- Replace your ForwardHealth Card

## **Your Local Agency**

- Questions about enrollment rules and premium amounts
- Why your application was approved or denied
- Why your benefits have been reduced or ended
- Your ForwardHealth card is lost, stolen or damaged.
- Report changes by phone, fax or online
- Sending proof/verification

## **FoodShare Members QUEST Customer Services — 1-877-415-5164**

- General information about your QUEST card
- If you did not get a QUEST card
- To report a lost, stolen or damaged QUEST card
- Replace your QUEST card
- To get your QUEST card account balance

## **SeniorCare Members — 1-800-657-2038**

- The name on your card is wrong
- Your SeniorCare card is lost or damaged (new card will be issued immediately)
- You have questions about the use of the card
- You have questions about your SeniorCare enrollment or level of enrollment
- You have questions about your out of pocket costs
- You have questions about covered drugs

## **Non-Emergency Transportation LogistiCare — Reservation Line (schedule trips)**

- 1-866-907-1493
- 1-866-288-3133 (TTY)

## **Where is my ride?**

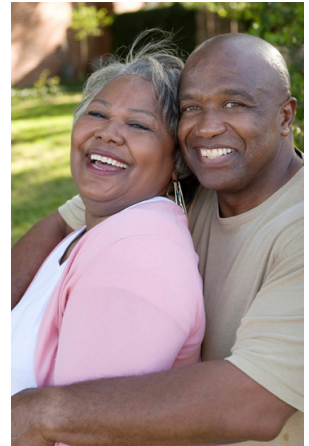
- 1-866-907-1494

## **Members Enrolled in an HMO**

- HMO Enrollment Specialist; 1-800-291-2002
- HMO Ombudsman; 1-800-760-0001
- HMO Problems; Contact your HMO and ask to speak with a Member Advocate



## **Your Connection to Health Care Coverage and Nutrition Benefits**



***Enrollment and Benefits — December 2012***

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**Please Note:** Everyone who is enrolled in any of the programs listed below are responsible for following all program rules. Program rules are listed in this handbook, for:

- FoodShare
- BadgerCare Plus Plans
- Medicaid Plans
- SeniorCare
- Medicare Savings Program

## ***Program Income and Asset Limits***

Income and asset amounts are based on Federal Poverty Level (FPL) guidelines and/or federal program rules.

Income limits can be found starting on page 36. These amounts are based on the 2012 federal guidelines which may increase by a small amount each year.

These amounts can also be found online at [dhs.wi.gov/em/customerhelp](https://dhs.wi.gov/em/customerhelp) or by calling Member Services at 1-800-362-3002.

## **ACCESS.wi.gov**

ACCESS is a free, private and easy-to-use online tool. Create your MyACCESS account today to manage your benefits. You can:

- Check to see what your benefits are. For example, what health care plan are you enrolled in or the amount of your FoodShare benefits.
- Report changes such as a change in address or a job or health care changes.
- Renew your benefits or see when your renewal is due for health care and FoodShare.
- Submit a FoodShare and/or Child Care Six-Month Report form.
- Ask for a replacement ForwardHealth card.
- Get an Explanation of Medical Benefits (EOMB).
- Check to see what BadgerCare Plus or Medicaid HMO you are enrolled in.
- Pay your BadgerCare Plus Basic Plan Premium.
- Choose your BadgerCare Plus Standard or Benchmark Plan HMO for families who live in Southeast Wisconsin.

## ***Collection and Use of Information***

The information you give in the application, including the Social Security Number (SSN) of each household member applying for benefits is authorized under the Food and Nutrition Act of 2008, as amended PL 110-246, (7 United States Code 2011-2036) and Wisconsin Statutes §49.82(2). If you do not have an SSN due to religious beliefs or because of your immigration status, you will not be required to give an SSN.

The information will be used to determine if your household can get or keep getting benefits.

Information you give will be verified through computer matching programs. This information will also be used to monitor compliance with program rules and for program management.

This information may be given to other federal and state agencies for official examination and to law enforcement officials for the purpose of apprehending people fleeing to avoid the law.

Providing this information, including the SSN of each household member, is voluntary. However, any person who is asking for benefits (FoodShare, Medicaid or BadgerCare Plus plans) but does not give an SSN will not be able to get benefits. Any SSN provided for members who are not enrolled will be used and disclosed in the same way as SSNs of enrolled household members.

Your SSN will not be shared with the United States Citizenship and Immigration Services (USCIS).

If you have a question, please read this handbook to see if your question can be answered. If you cannot find your answer, contact your agency or Member Services.

You should keep this handbook for one year or until you get a new one. You will get a new handbook once a year. If you are enrolled in a different program or ask to enroll in another program, you may get another handbook.

## **Wisconsin ForwardHealth**

The following programs are available for those who meet the program rules:

### ***Nutrition***

#### ***FoodShare Wisconsin***

### ***Health Care***

#### ***BadgerCare Plus Plans***

Health Care for Families and Pregnant Women

- Standard
- Benchmark
- Prenatal Services

Health care for adults with no dependent children

- Core Plan

#### ***Medicaid for the Elderly, Blind or Disabled***

- Medicaid Standard
- Medicaid Purchase Plan (MAPP)
- Wisconsin Well Woman Medicaid
- Long-Term Care
  - Home and Community Based Waivers (HCBW)
  - Family Care
  - Family Care Partnership
  - Institutional Medicaid (Hospital, Nursing Home, Institutions for Mental Disease)

#### ***Limited Coverage Plans***

- Family Planning Only Services
- Emergency Services
- SeniorCare Prescription Drug Assistance
- Tuberculosis-Related Services Only Benefits

#### ***Medicare Savings Program***

- Qualified Medicare Beneficiary (QMB)
- Specified Low Income Medicare Beneficiary (SLMB)
- Specified Low-Income Medicare Beneficiary Plus (SLMB+)
- Qualified Disabled and Working Individual (QDWI)

## **Who Can Enroll**

### ***FoodShare Wisconsin***

Anyone can apply for FoodShare. You may be able to enroll if:

- Your family income is at or below the monthly program limit (see page 36), and
- You are a Wisconsin resident, and
- You are a United States citizen or qualifying immigrant.

### ***BadgerCare Plus for Families (Standard and Benchmark Plans)***

You may be able to enroll if:

- Your family income is at or below 200% of the FPL,
- Children and young adults leaving out-of-home care can enroll, regardless of their family income,
- You are a Wisconsin resident, and
- You are a United States citizen or qualifying immigrant\*.

### **and**

You are one of the following:

- A child (birth to age 19), or
- A pregnant woman, or
- A parent or relative who lives with and takes care of a child, or
- A parent with a child(ren) in foster care, or
- A young adult leaving out-of-home care (foster care).

### ***BadgerCare Plus Prenatal Plan***

This plan provides pregnancy-related health care for women who cannot get BadgerCare Plus because of immigration status or who are inmates of a public institution. Even though enrollment in this plan is based on pregnancy, while enrolled, you will be able to get all BadgerCare Plus covered services.

*\*If you are not a citizen or a qualifying immigrant, you may be able to get help through Emergency Services or Prenatal Services Plan. Your immigration status will not be shared with the U.S. Citizenship and Immigration Services (USCIS).*

## ***BadgerCare Plus Core Plan***

You may be able to enroll if you:

- Are a Wisconsin resident,
- Are age 19 through 64,
- Do not have dependent children under age 19 living with you,
- Are not pregnant,
- Have family income at or below 200% of the FPL,
- Are a United States citizen or qualifying immigrant,
- Do not have health insurance now or in the last 12 months (private or through an employer),
- Have not quit your job and lost any health insurance you had through your employer,
- Do not have access to insurance in the 3 months following the date of applying,
- Pay a non-refundable application/renewal fee (if you are homeless or are eligible to get Indian Health Services, you will not have a fee),
- If required, pay a monthly premium (see BadgerCare Plus Premiums),
- Did not have access to insurance through your current employer in the last 12 months.

## ***Medicaid for the Elderly, Blind or Disabled (EBD) and Medicare Savings Programs***

You may be able to enroll if you are:

- A Wisconsin resident, and
- Age 65 or older, are blind or a person with a disability, and
- Your family income and assets are at or below the monthly program limit (see section starting on page 37), and
- You are a United States citizen or qualifying immigrant.

## ***Wisconsin Well Woman Medicaid***

Well Woman Medicaid is a standard health care plan. Women enrolled in this plan will not be enrolled in a Health Maintenance Organization (HMO).

Enrollment is limited to women who need treatment for breast or cervical cancer and are enrolled in one of the following programs at the time of diagnosis:

- Wisconsin Well Woman Program through Well Woman Program Local Coordinating Agencies, or
- BadgerCare Plus Benchmark or Core Plan, or
- Family Planning Only Services.

You may be able to enroll in Well Woman Medicaid if you:

- Are under age 65, and
- Are a United States citizen or qualifying immigrant, and
- Are a Wisconsin resident, and
- Have a diagnosis of breast or cervical cancer, or a precancerous condition of the cervix, and
- Need treatment for the breast or cervical cancer, or a precancerous condition of the cervix, as identified by the Wisconsin Well Woman Program, BadgerCare Plus Core, Benchmark, or Family Planning Only Services plans diagnosing provider, and
- Are not covered by private or other public health insurance for treatment of your breast or cervical cancer.

## **FoodShare Wisconsin**

### ***How to Apply***

You can apply online at [ACCESS.wi.gov](https://ACCESS.wi.gov), by mail, phone or in person. If you choose to apply by mail, complete the FoodShare Application (F-16019B). You can get the application from your agency, online at [dhs.wi.gov/em/customerhelp](https://dhs.wi.gov/em/customerhelp) or by calling 1-800-362-3002.

Send the signed and completed application along with any required proof (see Proof/Verification on page 37) to:

If you live in Milwaukee County:

MDPU  
PO Box 05676  
Milwaukee WI 53205  
Fax: 1-888-409-1979

If you **do not** live in Milwaukee County:

CDPU  
PO Box 5234  
Janesville, WI 53547-5234  
Fax: 1-855-293-1822

Everyone who applies for FoodShare must have an interview. The interview will be done by phone, unless you want your interview in person at the agency.

You will be notified of the status of your application, in writing, within 30 days from the day the agency gets your application, unless you qualify for Priority Services.

**Priority FoodShare Services**

You may be able to get FoodShare within 7 days of providing your application and/or registration form, if your household:

- Has \$100 or less available in cash or in the bank, and
- Expects to receive less than \$150 of income this month, or
- Has rent/mortgage or utility costs that are more than your total gross monthly income (available cash or bank accounts for this month), or
- Includes a migrant or seasonal farm worker whose income has stopped.

**Income Credits**

Certain credits for shelter, dependent care and child support are subtracted from your gross monthly income, to find your net monthly income. The FoodShare benefit amount is based on the number of people in your household and your net monthly income (see Monthly Income Table, page 36).

**How Your FoodShare Benefits are Calculated**

FoodShare benefits are based on a sliding scale. To calculate your benefit amount your agency will look at the number of people in your home, as well as your income minus any FoodShare credits and some bills.

**Household Income**

Most types of income are counted. After adding all of your household’s countable income to get your gross income, we will give you credit for some of the bills you pay.

**Credits**

For FoodShare, if you report and verify to the agency certain costs, you may be able to get up to six credits. The agency will subtract these credits from your gross monthly income, to get your net income. Some

households may not get a credit for certain expenses and not all credits will be the actual amount reported and verified.

**Your household may get the following credits:**

① Standard Credit — All households will get this credit which is based on your family size:

Family Size	Credit
1 - 3	\$149
4	\$160
5	\$187
6 or more	\$214

The Standard Credit may change by a small amount each year.

② Employment Credit — If employed we will subtract 20% of job income or wages.

Example, if your total gross job income each month is \$1,000, your employment credit is \$200 (\$1,000 x 20% = \$200).

③ Medical Expense Credit — If you are age 60 or over, blind or a person with a disability, we will give you a credit for any medical costs over \$35.

Example, you reported and verified \$100 each month in medical cost, we give you a credit for \$65 (\$100 - \$35 = \$65).

④ Dependent Care Credit — If you attend training, school or work and pay for dependent care, we will give you a credit of the amount of care you pay.

⑤ Child Support Credit — We will give you a credit for any child support you are required to pay.

⑥ Shelter Credit/Utility Credit

**Shelter Credit**

The Shelter Credit is based on your costs for rent, mortgage, property taxes and property insurance, condo fees, lot rent and certain utility costs.

**Standard Utility Credit**

All households will get a Standard Utility Credit of \$442, no matter how many utilities you pay.



Maximum Shelter/Utility Credit

**Group 1:** Households who have a member age 60 and over, blind or a person with a disability do not have a maximum Shelter Credit limit.

**Group 2:** Households who do not have a member age 60 and over, blind, or a person with a disability can only get the Shelter/Utility Credit maximum allowed of \$469.

For both groups, you will only get this credit if the shelter amount you are obligated to pay and the Standard Utility Credit (\$442) are more than 50% of your net income (after other credits have been subtracted).

**Example of Group 1 Households:** Your (adjusted) net income is \$1,000. 50% is \$500 (\$1,000 x 50% = \$500). If your reported Shelter cost is \$600, when you add the Standard Utility Credit (\$442) this totals \$1,042. Your Standard Shelter Credit will be \$542 (\$1,042 - \$500 = \$542).

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Calculating Income

To help you understand how we may count income and credits for FoodShare, we have included two examples. For the income limits and maximum allotments, please see FoodShare Monthly Income Limits/Maximum Benefit Amounts on page 36.

**Example 1:** A one or two person household with a person who is elderly, blind or has a disability has applied. The reported and verified gross monthly income of \$828.00, monthly medical costs of \$41.91, monthly shelter costs of \$343.78 and monthly utility cost of \$285.00.

The household's gross income is less than the gross income limit for two people (\$2,522), so this household passed the gross income test.

The next step is to figure the household's credits and to subtract them from the gross income (\$828) to get the household's next income.

\$ 828.00	Gross Income
- \$ 149.00	Standard Credit
- \$ 6.91	Medical Costs Over \$35.00
= \$ 672.09	Adjusted Income

To calculate the shelter/utility allowance, add the total shelter costs plus the standard \$442 utility allowance. Then subtract 1/2 of the adjusted income. (\$672.09 divided by 2 equals \$336.05). The amount left is the Shelter/Utility Credit.

\$ 343.78	Actual Shelter Cost
+\$ 442.00	Utility Credit
= \$ 785.78	Total Shelter/Utility Cost
- \$ 336.05	50% of Adjusted Income
= \$ 449.73	Shelter/Utility Credit

\$ 672.09	Adjusted Income
- \$ 449.73	Excess Shelter/Utility Credit
= \$ 222.36	Net Adjusted Income

To calculate the amount of monthly benefits, the maximum monthly benefit amount for two people (\$367) is compared to 30% of the net adjusted income. (\$222.36 x 30% = \$66.71)

\$ 367.00	Maximum Benefits Amount
- \$ 66.71	30% of Net Adjusted Income
= \$ 300.29	Household's Monthly Benefit

The monthly benefits for this household will be \$300. Please note, the amount of benefits will always be rounded down to the nearest dollar.

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**Example 2:** A household of one person applied and reported and verified monthly income of \$1,600, monthly shelter expenses of \$199 and utility expenses of \$300.

This person's gross income is less than the gross income limit for one person (\$1,862) so s/he passed the gross income test.

The next step is to figure the household's credits and to subtract these credits from the gross income (\$1,600) to get the household's net adjusted income.

\$ 1,600	Gross Income
- \$ 149	Standard Credit
= \$ 1,451	Adjusted Income

To calculate the shelter/utility allowance, add the total shelter costs plus the standard \$442 utility credit. Then subtract 1/2 of the adjusted income. (\$1,451 ÷ 2 = \$725.50) The amount left is the Shelter/Utility Credit.



\$199.00	Shelter Cost
+ \$442.00	Utility Costs
= <b>\$641.00</b>	<b>Total Shelter/Utility Costs</b>

Because 50% of the adjusted net income (\$725.50) is more than the actual shelter and utility cost (\$641) s/he will not get a shelter credit.

\$ 1,451.00	Adjusted Net Income
- 0	Excess Shelter/Utility Credit
= <b>\$1,451.00</b>	<b>Net Adjusted Income</b>
x 30%	
= <b>\$435.30</b>	<b>30% Net Adjusted Income</b>

To calculate the amount of monthly benefits, the maximum monthly benefit amount for one person (\$200) is compared to 30% of the net adjusted income.

\$ 200.00	Maximum Benefits Amount
\$ 435.30	30% of Net Adjusted Income
\$ 16.00	Household's Monthly Benefit

Because 30% of the net adjusted income (\$435.30) is more than the maximum benefit amount (\$200), and s/he passed the gross income test, s/he will get the minimum amount of benefits for a one or two person enrolled household, which is \$16.

## Using Your QUEST Card

Your Wisconsin QUEST card is a safe and easy way to use your benefits. The following sections will explain how your QUEST card works and when to contact QUEST Customer Service.



**Please Note:** You can also watch an online video that gives you information about your card and how to use it. To view this video, go to: [dhs.wi.gov/em/av/ebt-vids.htm](https://dhs.wi.gov/em/av/ebt-vids.htm).

## When You Get Your Benefits

Each month your benefits will be added to your QUEST card account automatically. The exact date you get your benefits is based on the eighth digit of your Social Security Number. (See the QUEST Card mailer you get with your QUEST card for these dates.) Each month, as your benefits are added to your QUEST account, your balance will go up. As you use your benefits, your balance goes down.

## Spending Benefits

You may use your QUEST card as often as you want and spend as much of your benefits as you want each month. At the end of each month, you can leave as many benefits in your account as you want. Keep in mind that any benefits not used after 365 days, will be removed from your account.



**Please Note:** You must have your QUEST card with you every time you go to the store to buy food with your benefits.

You **can** use your benefits to buy foods such as:

- Breads and cereals,
- Fruits and vegetables,
- Meats, fish and poultry,
- Dairy products, and
- Seeds and plants to grow food for your family to eat.

You **cannot** use your benefits to buy items such as:

- Nonfood items (pet foods, paper products, soaps, and household supplies, grooming items, toothpaste and cosmetics, etc.), or
- Beer, wine, liquor, cigarettes or tobacco, or
- Food that will be eaten in the store, or
- Hot foods (example; food that is purchased and cooked at the store).

If you eat at a group meal site for senior citizens or have your meals delivered to your home, you can use FoodShare benefits to pay for these meals, if the site or provider is authorized to accept the QUEST card.

You can use your benefits at one of the following, if the facility is authorized to accept the QUEST card:

- Drug and alcohol treatment center,
- Shelter for battered women,
- Shelter for the homeless, or
- Group home for people with disabilities.

FoodShare can replace food you bought with FoodShare benefits, if it is destroyed in a household disaster or misfortune. The amount of benefits the agency can replace is the actual amount of food that

was destroyed but not more than the monthly amount of benefits your household got in that month. You must ask your agency for replacement benefits within 10 days of the day your food was destroyed.

## Account Balance

Always check your account balance before you shop. If you do not know your balance, you can:

- Call QUEST Customer Service,
- Look at your last receipt, or
- Go to [ebtedge.com](http://ebtedge.com). (Click on Cardholder Login then enter your QUEST card number (See page 35 for an example of the QUEST Card.)

You should get a printed receipt when you buy food with your QUEST card. The receipt will show your account balance. If you do not get a printed receipt, ask for one. Keep all of your receipts after you shop with your QUEST card.

The receipt should have the following information. Some receipts may have more information than listed.

## Purchasing food with your FoodShare benefits

①	YOUR FOOD STORE 123 STREET ANYTOWN, WI, 53701		
②	TERM ID	12345	
③	MERCH TERM ID	234565ACB	
④	SEQ#	456	
⑤	CLERK	1	
⑥	04/02/XX	10:10	
⑦	CARD #	XXXXXXXXXXXX3456	
⑧	POST	04/02/XX	
⑨	BEG BAL	TRANS AMT	END BAL
	CASH \$0.00	\$000.00	\$000.00
⑩	FS \$175.00	\$42.50	\$129.80
FS PURCHASE \$45.20 APPROVED			
***DO NOT DISPENSE CASH***			

- ① Terminal Location: This is the store information or where the swipe card machine is located.
- ② Terminal Identification Number: This identifies the swipe card machine you used.
- ③ Merchant Identification Number: This number identifies who the merchant is or what store you shopped at.

- ④ Transaction Sequence Number: This is the number of sales made on the swipe card machine for that day.
- ⑤ Clerk Number: This number identifies the sales clerk who helped you at the check out line.
- ⑥ Transaction Date and Time: This is the date and time of your grocery purchase.
- ⑦ Card #: This shows the last 4-Digits of your QUEST card.
- ⑧ Posting Date: This is the date your transaction or purchase is posted.
- ⑨ Balance: This is your FoodShare balances. It shows your balance before you shopped, the amount of benefits you are using for this purchase and the amount of benefits you have left on your QUEST card.
- ⑩ Transaction Amount/Results: This shows the amount of your transaction or purchase and if your purchase was approved.

## QUEST CUSTOMER SERVICE



**1-877-415-5164** (voice)  
**711** (TTY)



**[ebtedge.com](http://ebtedge.com)**

This contact information is available  
24 hours a day — 7 days a week.

If you buy groceries that are more than the amount in your account, tell the clerk what amount you want to subtract from your QUEST card account. You will have to pay for the rest with your own money.

Keep in mind that you cannot get cash from your Wisconsin QUEST card. The Wisconsin QUEST card does not have this option.

You can find out what your last 10 purchases or deposits were online at [ebtedge.com](http://ebtedge.com) or by calling QUEST Customer Service. You may also ask for a written history of the purchases and deposits to your account for the past three calendar months, by calling QUEST Customer Service.

If you find a mistake in your account balance, call QUEST Customer Service right away. When you

speak with someone in Customer Service, make sure to ask for the name of the person you speak to and also ask for a “ticket number.” The ticket number is a code that will help you prove that you called and reported the mistake.

If a computer problem occurs that takes away or adds benefits to your account in error, a correction may be made to your balance. The correction could affect your current or future month’s balance.

You will get a letter in the mail if it will lower your balance. If you do not agree that the correction is right, you may ask for a fair hearing. See the Fair Hearing section on page 33, for more details.

## **Personal Identification Number (PIN)**

### **Selecting a PIN**

You will be asked to select a PIN. You will need your PIN to access your benefits when using your QUEST card. The following will give you step by step directions to select a PIN. If you are deaf or hearing impaired see “Instructions For People Who Are Hearing Impaired” following this section.

- ① Select four numbers that are easy for you to remember but hard for someone else to figure out.
- ② Have your QUEST card number, the four digits you have selected for a PIN, your date of birth and the last four digits of your Social Security Number (SSN) ready.
- ③ Call Customer Service at 1-877-415-5164.
- ④ The system will give you several options: Pick the option to select a PIN.
- ⑤ Then say or press the numbers for:
  - Your date of birth.
  - The last four digits of your SSN.
  - The four digit PIN you have selected. You will be asked to enter your PIN twice.

### **Instructions For People Who Are Hearing Impaired**

- ① Select four numbers that are easy for you to remember but hard for someone else to figure out.

- ② Have your QUEST card number, the four digits you have selected for a PIN, your date of birth and the last four digits of your Social Security Number ready.
- ③ Call 711 and have the TTY operator call 1-877-415-5164.
- ④ There are a couple options to choose from. Have the operator choose the option to select a PIN.
- ⑤ Instruct the operator to say or press:
  - Your birth date.
  - The last four digits of your SSN.
  - The four digit PIN you have selected. The operator will need to do this step twice.

### **Keep Your PIN Safe**

Never give your PIN to anyone, including your worker, family members, the grocery clerk, store manager or other store personnel. Anyone who knows your PIN will have access to your benefits. Be careful about sharing your card and PIN.

Benefits will not be replaced if your card is used by an authorized buyer, authorized representative or any other person you give your QUEST card and PIN to.



**Please Note:** Do not write your PIN on your card or on anything you keep in your wallet or purse. You should call QUEST Customer Service and select a new PIN if you think someone else knows your PIN.

### **If You Forget Your PIN**

If you are in the grocery store and enter the wrong PIN three times, a “lock” is put on your card and you will not be able to use your card until the next day.

### **Problems with your QUEST Card**

If your QUEST card does not work, call QUEST Customer Service. If you still need help, contact your agency. You should also call QUEST Customer Service, if you get an error message at the grocery store that you do not understand.

### **Error Messages**

Examples of error messages you could get are:

- **Card not on file** — Contact QUEST Customer Service.
- **Insufficient balance** — You have tried to spend more than you have in your account. You can put back some of your groceries or pay for the rest with your own money.
- **Invalid PIN** — You have entered the PIN wrong. If you enter the wrong PIN three times on the same day, a “lock” is put on your card until the next day.
- **Inactive card** — If this is your first card, you must select a PIN before it can be used. Call QUEST Customer Service to select a PIN.

## Taking Care Of Your Card

### DO

- ⇒ Keep your card safe.
- ⇒ Keep your card clean.
- ⇒ Take care of your card like you would a credit card.
- ⇒ Keep the magnetic stripe clean and free from scratches.
- ⇒ Store your card in a wallet or purse.
- ⇒ Keep your card away from magnets such as purse or handbag clasps, televisions, etc.

### DON'T

- ⇒ Bend or twist your card.
- ⇒ Use your card to scrape windshields, etc.
- ⇒ Tell anyone your PIN, including the store clerk.

## If Your Card is Lost or Stolen

As soon as you know you have lost your QUEST card or it has been stolen, call QUEST Customer Service. Your card will be cancelled when you call. If someone uses it before you call to cancel your card, your benefits will not be replaced. Once your card is reported lost or stolen, no one will be able to use your card. A new card will be mailed to you on the next business day.

## If Your Card is Damaged

If your card is damaged or the store must type in your card number, call QUEST Customer Service and ask for a new card.

## Using Your Card

If your store does not have a swipe card terminal, you may not be able to use your QUEST card there (see page 35 for an example of the QUEST card). Ask the store manager or clerk if the store accepts the QUEST card. Most stores that take part in the FoodShare program will have a QUEST® sign on the door.



If the swipe card terminal is not working, the store may choose to handle the purchase by using a paper form and calling QUEST Customer Service.

If your store chooses to complete a paper form, the following is required:

1. The clerk will fill out the paper form with the following information:
  - QUEST card number
  - Your name (or FoodShare member's name)
  - Merchant identification number
  - Type of transaction (purchase or refund)
  - Amount of purchase or refund
  - Store name and address
2. The clerk will call QUEST at the number used by the merchant or store number for an authorization. If the authorization is for a purchase, the clerk will be told whether or not you have enough benefits in your FoodShare account to purchase your groceries. Once the clerk receives authorization, the clerk will write in the date and time of call, the amount authorized and an authorization approval number.
3. You will be required to approve and sign the paper form. You will get a copy of the form for your records.



**Please Note:** A hold for the amount of purchase will be placed on your account to make sure the store is able to complete the transaction and receive payment.

Some small stores, farmers markets or route vendors may also use a paper form that you will need to sign.



## **Returning a Purchase**

If you need to return an item to the store, take the item, store receipt and your QUEST card to the store where you bought the item. The store will put your benefits back into your account. You will be able to use these benefits right away. You will not get cash back.

## **If You Move**

If you plan to move, give the agency your new address before you move. If a card is mailed to your old address, it will not be forwarded to your new address.

## **If You Move Out of State**

If you move out of state, report it to the agency. You should still be able to use any benefits you have on your Wisconsin QUEST card in your new state. If you cannot find a store in your new state that accepts the Wisconsin QUEST card, contact the Wisconsin agency that issued the FoodShare benefits. To keep getting benefits in your new state, you must apply there.

## **Keep Your QUEST Card**

Do not throw away your QUEST card unless you are told to do so or you are sent a new card. You can use the same card if you get benefits in the future.



**Please Note:** If you get a new card in the mail, you must call QUEST Customer Service, within 15 days to activate your new card. Your old card will be deactivated or closed 15 days from when your new card was issued.

## **FoodShare Rules**

If you are getting benefits you must comply with program rules to keep getting benefits.

## **Overpayments**

Overpayments are benefits you received but should not have. You must repay benefits you get in error even if it is the agency's fault and not your own. If federal and state law require you to repay benefits and you do not do so, it could result in collection actions such as:

- Federal or state tax refund interceptions: Tax refund interceptions mean that the State of Wisconsin can

take any FoodShare overpayment from any tax refunds you are owed.

- Credits or lien and levy against any real property: If a lien is placed on your home, you can not sell or trade your home until the over-payment is paid. A levy gives the State of Wisconsin the legal right to keep or sell your property as security for a debt.
- Wage assignment: Wage assignment takes any FoodShare overpayment from job income or wages before you are paid.

## **Quality Control Review**

Your FoodShare case may be randomly selected by the Wisconsin Department of Health Services for a quality assurance review. These reviews are to make sure that members are getting the right benefits.

You will need to meet with the reviewer to continue to receive benefits.

## **Reporting Changes**

If everyone in your household:

- Is age 60 and over, or
- Blind, or
- Has a disability, and
- The household had no income from self-employment or wages.

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

- A new job,
- An increase in total Other Income of more than \$50 each month, (Example, Social Security, Veterans Benefits, Retirement, Child Support, etc.)
- If a person moves in or out of your home,
- Any change in your address and shelter cost,
- An increase in total Child Support income of more than \$100 per month, and/or
- Any change in the legal obligation to pay child support.

All other people must report to the agency by the 10th of the month if the family income goes over the 130% income limit for the reported household size. The amount you are to report will also be listed on your latest Letter of Enrollment.

Household Size	Income Limit
1	\$1,211
2	\$1,640
3	\$2,068
4	\$2,498
5	\$2,927
6	\$3,356
7	\$3,785
8	\$4,214

For each additional member add: \$429.

The amounts listed are based on the October 1, 2012, federal guidelines which may increase each year.

Changes can be reported at [ACCESS.wi.gov](http://ACCESS.wi.gov), by using the FoodShare Change Report (F-16006), or to report income only, the FoodShare Income Change Report form (F-16066), or by contacting your agency by phone, in writing or in person. You can get these forms by calling your agency or online at [dhs.wi.gov/em/customerhelp](http://dhs.wi.gov/em/customerhelp).

### **FoodShare Six-Month Reporting**

You may be required to complete a Six-Month Report form. If you are, you will get a reminder letter that will tell you when the report is due.

You will also be asked to save check stubs for every person in your home who has a new job or a change in job income or wages.

There are different ways to submit your Six-Month Report form. Your letter will tell you how.

You will need to send proof of the information you report on the form. The agency will use the information on your completed form and the proof you provide to update your information. See Proof on on page 37, to learn more.



**Please Note:** If you do not complete the Six-Month Report and provide proof of your answers by the due date, you may lose your benefits.

### **Renewals**

Once enrolled in FoodShare, you must complete a renewal at least once per year. The renewal is to make

sure you still meet all program rules and the amount of benefits you get are correct. If you do not complete your renewal, your benefits will end.

You will be notified by mail the month before your renewal is due. This letter will also tell you how you can do your renewal.

For example, if your renewal is due in April, your letter will be sent in March. This letter will also give you options on how you can do your renewal — Online at [ACCESS.wi.gov](http://ACCESS.wi.gov), by mail, phone or in person.

An interview is also required. The interview will be done by phone, unless you prefer to have your interview at the agency.

### **Fraud/Intentional Program Violation**

- If any information you give is found to be incorrect, you may be denied benefits and/or be subject to criminal prosecution for knowingly providing false information.
- You must repay any benefits you got because you gave false information.
- If a FoodShare claim is filed against your household, the information on your application, including all Social Security Numbers, may be referred to federal and state agencies, as well as private claims and collection agencies for claims collection action.

Fraud or intentional program violations by anyone in your household may result in disqualification from FoodShare. This means you will not be able to get FoodShare benefits for:

- One year after the first violation.
- Two years after the second violation.
- Permanently for the third violation.

Depending upon the value of misused benefits, the individual can also be fined up to \$250,000, and/or imprisoned up to 20 years. A court can also bar an individual from the program for an additional 18 months. You will also be permanently barred if you are convicted of trafficking benefits of \$500 or more.

You will not be able to get benefits for 10 years, if you are found to have made a false statement about your identity and where you live in order to receive multiple benefits at the same time.

Fleeing felons and probation or parole violators cannot get FoodShare benefits. The individual may also be subject to further prosecution under other applicable federal laws.

Individuals who trade (buy or sell) benefits for a controlled substance/illegal drug(s), will be barred from receiving FoodShare benefits for a period of two years for the first offense and permanently for the second offense.

Individuals who trade (buy or sell) benefits for firearms, ammunition or explosives, will be barred from receiving FoodShare benefits permanently.

## **BadgerCare Plus for Families**

### **How to Apply**

You can apply online at [ACCESS.wi.gov](https://ACCESS.wi.gov), by mail, phone or in person with the agency.

If you choose to apply by mail, complete the BadgerCare Plus Application Packet (F-10182).

You can get the application:

- At [dhs.wi.gov/em/customerhelp](https://dhs.wi.gov/em/customerhelp),
- By calling 1-800-362-3002, or
- From your agency.

To get the address and phone number of your agency, go to [dhs.wi.gov/em/customerhelp](https://dhs.wi.gov/em/customerhelp) or call 1-800-362-3002.

Your completed and signed application, along with any required proof (see Proof/Verification on page 37) should be sent to:

If you live in Milwaukee County:

Milwaukee Document Processing Unit  
PO Box 05676  
Milwaukee WI 53205  
Fax: 1-888-409-1979

If you **do not** live in Milwaukee County:

Central Document Processing Unit  
PO Box 7190  
Madison WI 53707-7190  
Fax Number: 1-855-293-1822

You will be notified about your enrollment, in writing, within 30 days from the day the agency gets your application.

### **Enrollment Date**

You cannot get benefits until the agency gets your application (either online at [ACCESS.wi.gov](https://ACCESS.wi.gov), by mail, in person or phone) and you have met all program rules. The earliest enrollment day will be the first of the month that a completed and signed application is received by the agency. In some cases, you may be able to get backdated coverage.

### **Backdated Coverage**



**Please Note:** The Federal Poverty Level (FPL) income guidelines can be found on page 37.

If you have medical bills in any of the three months prior to your application date, you may be able to get coverage for those months, if you are:

- Blind or disabled, or
- A pregnant woman, except those enrolled in the Prenatal Services Plan, or
- A young adult leaving out-of-home care (foster care), or
- A parent or relative who cares for a child with family income at or below 133% of the FPL, or
- A child under age 1 with family income at or below 300% of the FPL, or
- A child ages 1 through 5, with family income at or below 185% of the FPL, or
- A child over age 6 with family income at or below 150% of the FPL.

### **How Income Is Counted**

To determine which plan is available to you and if there is a cost, we look at your gross family income (before any deductions or taxes). For BadgerCare Plus for Families, you are allowed to deduct any court-ordered child support you are obligated to pay. Your gross income minus any child support obligation is your net income.



**Please Note:** Earnings of children under age 18 are not counted.

**Example:** A family of four has gross monthly income of \$2,999.25 and a court-ordered child support obligation of \$350 each month. This family's net income is \$2,649.25. This is below the monthly income limit for a family of four (currently \$3,841.67).

\$2,999.25	Gross Income
- \$ 350.00	Court-Ordered Child Support
<b>= \$2,649.25</b>	<b>Net Income</b>

### How Income from Self-Employment is Counted

For families with self-employment income, we determine your average monthly net income from your business. This is usually based on your previous year's tax return. When there has been a change in your circumstances, we will base the monthly average on your net income from the business since the change. Under BadgerCare Plus for Families, we allow most business expenses except depreciation, mortgage principal of business loans, purchase of capital assets or durable goods.

If your family income, including self-employment income is at or below 200% of the FPL without deducting depreciation expenses, you will be enrolled in the Standard Plan. If your family income is over 200% of the FPL, a second calculation is done to deduct any depreciation expenses from the business income. If the depreciation deduction reduces your family income below the monthly income limit, the family will be enrolled in the Benchmark Plan.

**Example:** A family of four, whose income is from self-employment, has a gross monthly income of \$4,200 and allowed expenses of \$200.

\$ 4,200	Gross Business Income
- \$ 200	Allowed Business Expense
<b>= \$4,000</b>	<b>Net Income</b>

Since the net income of \$4,000 is more than the monthly income limit of \$3,841.67 for a family of four, a second calculation is done subtracting the monthly depreciation expenses. This family reported \$400.

\$ 4,200	Gross Business Income
- \$200	Allowed Business Expense
- \$400	Depreciation Expenses
<b>= \$3,600</b>	<b>Net Income</b>

Since the amount after depreciation expenses is below \$3,841.67, this family is enrolled in the Benchmark Plan.

### BadgerCare Plus Standard and Benchmark Plans, Premiums and Copays

You may have to pay a monthly premium to enroll in a BadgerCare Plus Standard or Benchmark plan. If you do, your first premium payment(s) must be paid to the agency before you can enroll. More information about premiums is on page 42.

Some services require you to pay a part of the cost of that service. This is called a copayment or copay. More information about copays is on page 46.

To see what Plan you may be enrolled in, if you will have to pay a monthly premium, copays or a deductible\*, or if you can get backdated coverage, see the charts on page 40.

### \*Deductible

The amount of the deductible is the difference between the family income and 150% of the FPL over a six month period. At the time the family has medical expenses that add up to the deductible amount, the child(ren) will be enrolled and will not have a premium.

### Enrollment in a BadgerCare Plus Health Maintenance Organization

One of the many benefits for families enrolled in BadgerCare Plus Standard and Benchmark plans is that you and your family will also be enrolled in a BadgerCare Plus Health Maintenance Organization (HMO).

Where there are two or more HMOs available to you and your family, you will have a choice of which HMO to enroll in.

If you and your family are required to enroll in a BadgerCare Plus HMO, you will receive an HMO Enrollment packet.



## **BadgerCare Plus Limited Coverage Plans Family Planning Only Services**

Certain individuals, with family income under 300% of the FPL may be able to get family planning services.

You can apply online at [ACCESS.wi.gov](https://ACCESS.wi.gov) or by calling your agency.

If you want more information or have questions, go to [dhs.wi.gov/em/customerhelp](https://dhs.wi.gov/em/customerhelp) or call Member Services at 1-800-362-3002.



**Please Note:** The following services could change. Ask your provider to see if the service you need is covered.

Through an initial or routine family planning related office visit, the following services may be covered:

- Contraceptive services and supplies (birth control supplies such as birth control pills, condoms, IUDs, etc.),
- Family planning prescriptions,
- Tests and treatment for certain STD/STIs (Sexually Transmitted Diseases/Infections) including chlamydia, herpes, gonorrhea and syphilis as well as certain other lab tests,
- Natural family planning supplies,
- Pap tests,
- Tubal ligation,
- Routine preventive primary services related to family planning.



**Note:** Only certain services are covered under Family Planning Only Services. For example, mammograms and hysterectomies are not covered.

You should tell your health care provider you have this plan, before you get services. Your provider must tell you if a service is not covered.

If a service is not covered and you still want and get the service, you will have to pay for it. You may also call the number on the back of your card and ask if a service is covered.

Please keep in mind, this is a limited plan and you may be able to enroll in the BadgerCare Plus Standard or Benchmark Plans which are full-benefit plans.

Federal law allows members to choose their provider, including physicians and family planning clinics, for family planning services and supplies.

This means you can also go to any family planning clinic that will accept your ForwardHealth ID card, even if the clinic is not part of your HMO.

## **Emergency Services Plan**

This plan provides short term coverage for people who have an emergency medical condition and cannot get BadgerCare Plus only because of their immigration status. Emergency Services will only pay for health care you get for an emergency medical condition. A medical emergency is a medical problem which could put your health at risk if you do not get medical care right away.



**Please Note:** The Emergency Services plan does not guarantee the care you get will be paid. You will have to pay the cost of health care you get, if it is not considered an emergency.

## **BadgerCare Plus Core Plan**

### **Waitlist Information**

The Department of Health Services (DHS) has suspended enrollment in the BadgerCare Plus Core Plan, due to the total number of applications being greater than the number of slots available. The DHS created a waitlist and will be able to enroll people in the Core Plan as space becomes available. To learn more about the waitlist, go to [badgercareplus.org/core](https://badgercareplus.org/core).

While you are on the waitlist, you should let us know if you have any changes in your contact information such as address and phone number so that we can reach you when there is an opening in the program.

### **How To Get Your Name on the Waitlist**

If you are an adult with no dependent children, you must apply for health care online at [ACCESS.wi.gov](https://ACCESS.wi.gov) or by calling your agency.

If you meet the Core Plan rules, you will have your name placed on the waitlist. You will not need to provide proof/verification of your answers or complete the Health Survey until a slot opens and you are able to enroll in the Core Plan.

## ***Rules for BadgerCare Plus Core Plan Core Plan Premiums***

Depending on your income you may be required to pay a premium. The amount of your premium will be based on family income. The premium will cover all adults in your family.

If you do not pay your premium, your benefits could end. You will not be able to receive health care benefits through BadgerCare Plus Core Plan for 12 months. For more information about premiums, see page 42.

### ***Non-refundable Processing Fee/Premiums***

People applying for, or renewing their Core Plan benefits are required to pay a \$60 non-refundable processing fee.

You will not have a processing fee, if you are:

- A Tribal member, or
- Alaskan Native, or
- Eligible for Indian Health Services, or
- Homeless.

If you have a premium, your \$60 processing fee will be used to pay your next monthly premium. If your premium is less than \$60, you will receive a refund of the difference between your premium and the fee. Example: If your monthly premium is \$45, you would get a \$15 refund. If your premium is more than \$60, your premium will be adjusted to \$60 for that month.

You can pay the fee online with a credit card, debit card or electronic check. To pay online go to [ACCESS.wi.gov](https://ACCESS.wi.gov).

To pay by mail using a credit card, debit card, personal check, money order, cashier's or certified check, use a payment slip (you will get a slip online when you submit your renewal) and send payment to:

State of Wisconsin  
P.O. Box 93735  
Milwaukee, WI 53293-0735

## ***Medicaid for the Elderly, Blind or Disabled***

Medicaid provides health care coverage to people who are age 65 and older, blind, or who have a disability.

Disability and blindness determinations are made by the Disability Determination Bureau (DDB) in the Department of Health Services.

### ***How to Apply***

You can apply for all plans listed below by mail, phone, in person or online at [ACCESS.wi.gov](https://ACCESS.wi.gov).

- Institutional Medicaid (Hospital, Nursing Home, Institutions for Mental Disease)
- Medicaid Standard
- Medicaid Purchase Plan (MAPP)
- Emergency Services
- Tuberculosis-Related Services Only Benefit
- Medicare Savings Program

To apply for Long-Term Care services through Home and Community Based Waivers, Family Care, Partnership or PACE you must contact your local Aging and Disability Resource Center (ARDC). To get the address and phone number of your ARDC, go to [dhs.wisconsin.gov/LTCare/adrc/](https://dhs.wisconsin.gov/LTCare/adrc/) or call 1-800-362-3002. If your county does not have an ADRC, contact your local Social or Human Services Department for information on requesting these services.

If you choose to apply by mail, fill out the Medicaid for the Elderly, Blind or Disabled Application Packet (F-10101). You can get the application from your agency, by calling Member Services at 1-800-362-3002 or online at [dhs.wi.gov/em/customerhelp](https://dhs.wi.gov/em/customerhelp).

Send the signed and completed application along with any required proof (see Proof/Verification on page 37) to:

If you live in Milwaukee County:

MDPU  
PO Box 05676  
Milwaukee WI 53205  
Fax: 1-888-409-1979

If you **do not** live in Milwaukee County:

CDPU  
PO Box 5234  
Janesville, WI 53547-5234  
Fax: 1-855-293-1822

You will be notified about your enrollment, in writing, within 30 days from the day the agency gets your application.

Enrollment Date


You cannot get benefits until the agency gets your application (either online at ACCESS.wi.gov, by mail, in person or phone) and you have met all program rules. The earliest enrollment day will be the first of the month that a completed and signed application is received by the agency. In some cases, you may be able to get backdated coverage.

Income Credits

The Medicaid plan you are enrolled in is based on your “countable income”. Countable income is your gross income minus allowed credits. The credits subtracted from your income will vary depending on the plan you are enrolled in.

The credit needs to meet the rules of the Medicaid plan you are enrolled in. You must provide proof/ verification of the expense to get the credit.

The credits you receive will determine if you are able to enroll in Medicaid and what plan. It will also determine if you will have a cost share. The following pages will list which of the following credits you may be able to get and how it is calculated.

 **Please Note:** Income and asset amounts may change each year. You can get current amounts by contacting your agency or by calling Member Services at 1-800-362-3002.

The credits you may be able to get are:

- 1. **\$65 and ½ (one half) Earned Income Credit —**  
This credit is only available to people with job income or wages. The \$65 and ½ credit is calculated by subtracting \$65 from your monthly gross job income and wages, then dividing the remaining amount by two, then adding back the \$65.

**For example:** If your monthly gross income from employment is \$500, your credit would be \$ 282.50.

\$ 500.00	\$ 435.00	\$ 217.50
– 65.00	÷ 2	+ 65.00
= \$435.00	= \$217.50	= \$ 282.50

- 2. **Community Waivers (Group B) Basic Needs Credit —** As of 2012, this allowance is \$878.
- 3. **Community Waivers Personal Maintenance Credit —** This allowance is for room, board, and personal expenses, and it consists of three components.  

\$ 878.00	Waivers Basic Needs Credit
+	65 and ½ Earned Income Credit
+ _____	Special Housing Credit
=	<b>Maintenance Credit</b>
- 4. **Cost Associated with Real Property Credit —** If you are residing in a nursing home and own property that is listed for sale, you can use some of your income to pay for minimal heat and electricity costs to avoid damage to the home while it is listed for sale.
- 5. **Depreciation —** If self-employed, you may be able to deduct depreciation from your self-employment income. The amount of the depreciation credit is the same as the amount you claim on your tax forms.
- 6. **Excess Self-Employment Expenses Credit —**  
When there is more than one self-employment business the losses of one can offset the profits of another.
- 7. **Fees to Guardians or Attorneys Credit —**  
Court-ordered guardian and/or attorney fees paid directly out of your monthly income. Costs paid by you for establishing and maintaining a court-ordered guardianship or protective placement for yourself.
- 8. **Health Insurance Premiums Credit —** The cost of health insurance premiums you are obligated to pay for your or your spouse may be subtracted.

If you and a spouse apply, but only one pays the premium, divide the premium equally. Prorate premiums over the months the payments cover.



**Please Note:** For Institutional cases, the member does not get credit for a premium deduction if they are not responsible for the premium payment.

## 9. Impairment Related Work Expenses (IRWE)

**Credit** — These are costs you may expect to incur due to your impairment and employment.

Examples of IRWE related work expenses are:

- Modified audio/visual equipment,
- Typing aides,
- Specialized keyboards,
- Prostheses,
- Reading aids,
- Vehicle modification (plus installation, maintenance, and associated repair costs),
- Wheelchairs.

**10. Maintaining Home/Apartment Credit** — If you are in a medical institution and you have an apartment or house, you may be able to get a credit for the cost of maintaining the home, if:

- Your doctor certifies (verbally or in writing) that you are likely to return to the home or apartment within six months, and
- Your spouse is not living in the apartment or home.

## 11. Medical/Remedial Expenses (MRE) Credit —

These costs are used in the home and community based waiver programs (HCBW) for cost share and premium calculations for the Medicaid Purchase Plan. They are also used to see if you may be able to enroll in the Medicaid Deductible plan.

**Medical expenses** are services or goods prescribed or provided by a licensed professional medical practitioner. The amount of the credit are expenses for diagnosis, cure, treatment, prevention of disease or for treatment affecting any part of the body.

**Remedial expenses** are costs for goods or services that are provided for the purpose of remedying, relieving, or reducing a medical condition. You will only get

a credit for the costs that you are required to pay and not paid by any other source, such as Medicaid, private insurance or your employer.

Your care manager or an agency worker can help you in calculating your medical/remedial expenses.

## 12. Personal Needs Credit for Institutional Medicaid

— This credit is \$45.

## 13. Special Exempt Income

- Income used for supporting others
- Court-ordered attorney fees
- Court-ordered guardian and guardian ad litem fees
- Legal Expenses Credit: The expense for establishing and maintaining a court-ordered guardianship or protective placements, including court-ordered attorney or guardian fees.
- Expenses associated with a Self-Support Plan (see 16)
- Impairment Related Work Expenses (IRWE) (see number 9)

**14. Standard Credit** — This credit is \$20.

**15. Support Payments Credit** — Support payments are payments which a Medicaid EBD member makes to another person outside of the home for the purpose of supporting and maintaining that person. These payments can be either court-ordered or non-court-ordered.

**16. Self-Support Plan Credit** — A member whose enrollment is based on blindness or disability may get a credit for an approved self-support plan.

To qualify for this credit, the member must perform in accordance with a plan that is:

- Specific, current, and in writing, and
- Approved by the county or tribal agency.

## Program Income and Asset Limits

The following sections will explain how income and assets are counted for each Medicaid plan.

**Job Income and Wages:** This is earned income that you get from a job or employment. Usually this is



the gross income that you earn in the form of wages or salary. It also includes net earnings from self-employment.

**Other Income:** This is income that you get from sources other than active employment. Examples include but are not limited to Social Security Income, annuity or trust, alimony/maintenance, pension or retirement, Veterans Benefits, etc.

**Counted Income:** This is your gross income minus allowed credits. Each Medicaid plan will describe what credits are allowed and how it is calculated.

**Income Not Counted:** Some of your income may not be counted when comparing your income to the Medicaid income limits.

Examples of income which is not counted include:

- Veterans Administration Allowances
  - Aid and Attendance
  - Unusual Medical Expenses
- Some payments to Native Americans.

**Assets**

Some Medicaid plans have different asset limits. The asset limits will be listed in each individual plan description. You must include assets you own owned jointly with any other person. Do not include the value of personal household belongings (televisions, furniture, appliances).

Examples of assets are cash, property or other holdings which can be converted to cash. The following are some examples of assets.

- Cash
- Savings or checking accounts
- Certificates of Deposit
- Life insurance policies
- Trust funds
- Stocks, bonds
- Retirement accounts
- Interest in annuities
- U.S. Savings Bonds
- Property agreements, contracts for deeds, time-shares, rental property, life estates, livestock, tools, farm machinery

- Keogh plans or other tax shelters, personal property being held for investment purposes, etc. For a complete list of counted assets, contact your agency.

Medicaid does not count some assets. Those not counted may include:

- One vehicle,
- Certain burial assets (including insurance, trusts funds, and plots),
- Tribal property,
- Clothing, and
- Other personal items.

**Medicaid Standard Plan**

The Medicaid Standard Plan is a full-benefits plan.

**Asset Limit**

The asset limit for the Medicaid Standard Plan is \$2,000 for one person or \$3,000 for a married couple.

**Income Test**

There are two ways to qualify for the Medicaid Standard Plan.

**Step 1**

Subtract certain credits from your monthly gross income to calculate the “counted income”. The credits included in the example below are allowed in this income calculation.

\$	Gross Income
-	\$65 and ½ Earned Income
-	Credit for Court-Ordered Guardian or Attorney Fees
-	Credit for Court-Ordered Support Payments
-	Self Support Plan Credit
-	Impairment Related Work Expenses
-	Standard Medicaid Credit
= \$	<b>Counted Income</b>

**Step 2**

Compare your counted income with the Medicaid income limit. The income limits are based on whether you are single or married. The Medicaid Standard plan income limit has two parts: an income amount plus a shelter cost allowance.

**Medicaid Standard Plan Income Limit**

Group Size 1	Group Size 2	
\$ 549.11	\$830.72	Income Amount
<u>+\$232.67</u>	<u>+\$349.33</u>	Actual Shelter Cost
(\$781.78)	(\$1,180.05)	(up to maximum)

An individual/couple with counted income above \$591.67, can qualify for the Standard Plan by meeting a Medicaid deductible.

**Medicaid Deductible**

Income Test: If your counted income is higher than the Medicaid Standard Plan income limit, your Medicaid Deductible is calculated for a six-month period based on the difference between your monthly counted income and \$591.67.

Your deductible amount will be listed on the Letter of Enrollment you get after your application is processed.

**Calculating your Deductible**

\$	Counted income
- \$591.67	Monthly Income Limit
= _____	Monthly amount over income limit
	X 6 Six Month period
=	<b>Deductible Amount</b>

You can use the cost of unpaid and recently paid bills for medical or remedial expenses to meet your deductible. You will need to provide proof of the expenses to your local agency. Once your deductible has been met, Medicaid will pay for covered services until the end of the six-month period. Examples of medical costs include:

- Health insurance premiums, and
- The portion of medical bills you must pay for yourself, your spouse or your minor children after Medicare and private insurance has paid.

Once you have met your deductible, you will have a copay for certain Medicaid covered services. See the “Covered Services and Copay” section (page 46) of this handbook for more information about covered services.

**Institutional Medicaid**

Institutional Medicaid provides medical services for those who reside in a medical care facility such as skilled nursing facilities (SNF), intermediate care facilities (ICF), institutions for mental disease (IMD), and hospitals.

In order to receive Institutional Medicaid, your assets must be lower than the asset limit. The asset limit for one person is \$2,000. The asset limit for married couples is described in the Spousal Impoverishment Section (page 22). The income limit is \$2,094.

There are two ways to qualify for Institutional Medicaid. Your monthly gross income (job income and wages and other income) is first compared with the Level 1 Income Limit (see Income Test). If your gross income is less than the Level 1 Income Limit you may be able to enroll in Institutional Medicaid.

If your gross income is greater than the Level 1 Income Limit, your gross income is compared to the cost of your medical needs. If your gross income is less than your medical needs, you may be able to enroll in Institutional Medicaid.

**Medical Need**

The following expenses are used when determining your medical needs for Institutional Medicaid.

	\$45.00 Personal Needs Allowance
+	*Cost of Institutional Care (private care rate, as of 2012, this is \$6,554)
+	Cost of Health Insurance
+	Support Payments Credit
+	Other Medical Costs
+	Impairment Related Work Expenses (IRWE)
+	Self-Support Plan
+ _____	Credit for Court-Ordered Guardian or Attorney Fees
=	<b>Medical Need</b>

\*This is the actual cost of the institutional care.

**Institutional Medicaid Cost Share Calculation**

There may be a monthly cost share for someone enrolled in Institutional Medicaid.

## Cost Share

Depending on your income and marital status, you may have to pay toward your cost of care. This is called your cost share. Medicaid will pay for the rest of the Medicaid covered services.

Your cost share calculation will differ depending on your marital status and the Long-Term Care program you are enrolled in. (See the description and calculations for your specific Long-Term Care program in this handbook).

The cost share is calculated as follows:

\$	Gross Income
-	65 ½ Earned Income Credit
-	Cost of the Institutionalized Person's Health Insurance Premium
-	Court-Ordered Support Payments
-	Personal Needs Allowance
-	Home Maintenance Costs
-	Credit for Court-Ordered Guardian or Attorney Fees
-	Income Allocation to a Community Spouse or Dependents (see page 22)
=	<b>Cost Share</b>

## Long-Term Care Services (LTC)

Many people who are elderly, blind or disabled need help accomplishing activities of daily living and caring for their health. This help, referred to as long-term care, includes many different services such as personal care, housekeeping or nursing. Long-term care is provided in people's homes, in residential care facilities or group homes, in nursing facilities and in the workplace.

Long-Term Care (LTC) includes any service or support that a person needs due to age, disability or chronic illness which limits his/her ability to perform everyday tasks. LTC services go beyond the Medicaid Standard Plan covered services and are designed to meet the special needs of elderly and/or people with disabilities.

LTC services and supports include:

- Nursing Facility Services
- Personal Care Services

- Home Health Services
- Therapies
- Disposable Medical Supplies (DMS)
- Durable Medical Equipment (DME)

LTC settings include a:

- Person's Own Home
- Nursing Home
- Residential Facility
- Community Setting
- Hospital
- Institutions for Mental Disease

LTC programs include Institutional Services, Home and Community Based Waivers, Family Care and Wisconsin Partnership Program.

## Asset Limit

The asset limit for a person applying for a LTC plan is \$2,000. If the person applying for the LTC plan has a spouse living in the community, the spouse will be able to keep some assets above the \$2,000 limit without affecting the LTC applicant's enrollment. See the section on Spousal Impoverishment Protections (page 22) for the asset limit when there is a spouse living in the community.

## Income Test

The monthly income limits for the specific LTC plans are explained in the following sections:

Community Waiver/Family Care Medicaid Level 1, Income Limit, \$2,094

Community Waiver/Family Care Medicaid Level 2, Income Limit, \$591.67

Institutional Medicaid Level 1, Income Limit, \$2,094

## Home and Community Based Waivers (HCBW)

These plans enable people who are elderly, blind, or disabled to live in community settings rather than in state institutions or nursing homes. They pay for community services which normally are not covered by Medicaid. To receive long-term care services through these programs, you must:

- Meet level of care requirements as determined by your care manager.
- Meet all program rules.
- Reside in a setting allowed by HCBW policies.
- Have a disability determination, if you are under the age of 65.
- Contribute toward the cost of your waiver services if required.
- Have assets at or below the asset limit. (The assets limit for one person is \$2,000. The asset limit for married couples is described in the Spousal Impoverishment Section on page 22).

There are three different HCBW groups (A, B and C). You cannot be in more than one group at the same time. You may have a cost share that must be paid each month to keep getting HCBW benefits. Your Letter of Decision will let you know if you have a cost share and how much it is. In addition to a cost share, certain services you get will require a copay.

### Group A Waivers

Group A members must meet the HCBW functional eligibility and also meet the income/asset and all other rules for the Medicaid, BadgerCare Plus Standard or Medicaid Purchase Plans, so no additional financial test is required.

As a Group A member, you are not required to pay a monthly cost share, but still need to pay any monthly amount associated with the Medicaid, BadgerCare Plus Standard and Medicaid Purchase Plans.

### Group B Waivers

Group B members must meet all the HCBW rules and have monthly gross income less than the Community Waiver/Family Care Medicaid Level 1 income limit.

If you are a Group B member you may have to pay a cost share. The Group B cost share is based on your income and allowable credits. The Group B cost share is calculated by subtracting the following credits from your monthly gross income:

\$	Gross Income
-	Community Waivers Personal Maintenance Credit
-	Family Maintenance Allowance
-	Support Payments Credit

-	Credit for Court-Ordered Guardian or Attorney Fees
-	Self-Support Plan
-	Impairment Related Work Expenses
-	Health Insurance Premiums Credit
-	Medical Remedial Expenses Credit
=	<b>Cost Share</b>

### Special Housing Credit

This amount is the total of housing costs (listed) minus \$350.

\$	Rent
+	Insurance (renter/homeowner)
+	Mortgage
+	Property tax
+	Utilities (heat, water, sewer, electric)
-	\$350
=	<b>Special Housing Credit</b>

### Group C Waivers

Group C members must meet all HCBW rules but have monthly gross income over the Institutions Medicaid Level 1 income limit (See Income Test page 18.)

To meet the income test for Group C, the applicant's income must be below the Medicaid Level 2 income limit after all credits have been applied. To determine your countable income, subtract the following credits from your Gross Income.

\$	Gross income
-	\$65 and ½ Earned Income Credit
-	Standard Medicaid Credit
-	Health Insurance Premiums Credit
-	Excess Self-Employment Expense
-	Support Payments Credit
-	Credit for Court-Ordered Guardian or Attorney Fees
-	Self-Support Plan
-	Impairment Related Work Expenses
=	<b>Adjusted net income</b>
\$	Adjusted net income
-	Monthly medical/remedial expenses*
-	Costs that would have been covered by Medicaid if enrolled*
=	<b>Counted Income</b>

\*Information provided by care manager.



If the counted income is below \$591.67, you are able to enroll in the HCBW in the Group C category. You may also have to meet a monthly spenddown amount to remain enrolled.

**Determining the Group C Spenddown Amount**

The spenddown is the amount of expenses a Group C member must incur and/or pay monthly to remain enrolled in Medicaid under the Group C plan. If you do not have a community spouse, you must pay the spenddown amount each month to stay enrolled. Your care manager monitors and documents this monthly.

**Group C Cost Sharing Calculation for Member with a Community Spouse**

Once the eligibility determination is made, you can give some of your monthly income to your community spouse, if you are married and your spouse does not reside in an institution. The cost sharing calculation for members with a community spouse or a community spouse with dependent children (or other dependent relatives) is calculated as follows:

\$	Enrolled spouse’s gross income
-	Community Waiver Personal Maintenance Allowance
-	Community Spouse Income Allocation
-	Total Dependent Family Member(s) Allocation
-	Support Payments Credit
-	Credit for Court-Ordered Guardian or Attorney Fees
-	Self-Support Plan
-	Impairment Related Work Expenses
-	Cost of Community Waiver’s Enrollee Health Insurance Premiums
- _____	Medical Remedial Expenses
=	<b>Cost Share</b>

**Family Care**

Family Care provides long-term care services for people who are elderly, blind or disabled. Family Care is not yet offered in every county. The Family Care income rules are the same as the income rules for HCBW. Family Care also provides long-term care services for people who do not need nursing home level of care but need help to accomplish activities of daily living and caring for their health if:

- The member meets the program rules for any non-HCBW plan, and
- Long-term care services are requested.

To enroll in Family Care, you must be able to enroll in one of the previously listed Medicaid plans or the BadgerCare Plus Standard Plan.

**Family Care Partnership**

Family Care Partnership is a full-benefit plan which covers health care and long-term support services for people who are elderly or disabled. Services are provided in the member’s home or in a setting of his or her choice. The services this plan covers are similar to Family Care and HCBWs except Partnership also covers acute and primary care services.

Like Family Care, the Family Care Partnership is not yet available in all counties.

Family Care Partnership enrollment rules are similar to either HCBW or Institutional Long-Term Care (ILTC), depending on your circumstances.

**Spousal Impoverishment Protections**

Special financial protections are allowed for the spouse and dependent children of a LTC member to keep assets and income that are above Medicaid financial limits.

**Asset Limit for Spousal Impoverishment**

For LTC cases where one spouse is still living in the community, special asset protection rules apply at application.

**Asset Assessment**

An Asset Assessment is done by your agency to establish the asset limit for your Medicaid LTC (Institutions, HCBW, Family Care) application.

During the asset assessment you will be required to provide proof of assets that you and your spouse owned on the date of the first continuous period of institutionalization 30 days or longer or the date of initial request for community waivers, Family Care or Partnership, whichever occurs earlier.

Based on the proof you provide, the agency will determine “the total countable assets of the couple” and the Community Spouse Asset Share (CSAS).

The asset limit for the applicant is \$2,000 plus the CSAS. The CSAS is the amount of countable assets above \$2,000 that the community spouse, the institutionalized person, or both, can have at the time the institutionalized person wants to enroll in Medicaid LTC. Once the spouse in the institution is enrolled, the assets of the community spouse are considered unavailable to the institutionalized spouse.

If the total countable assets of the couple are \$227,280, or more, then the CSAS is \$113,640; the Medicaid LTC asset limit at the time of application in LTC is \$115,640 (\$113,640 + \$2,000).

If the total countable assets of the couple are less than \$227,280 but greater than \$100,000, then the CSAS is ½ of the total countable assets; the Medicaid LTC asset limit is ½ of the total countable assets + \$2,000.

If the total countable assets of the couple are \$100,000 or less, then the CSAS is \$50,000; the Medicaid LTC asset limit is \$52,000 (\$50,000 + \$2,000).

The institutional spouse cannot be enrolled in Medicaid LTC, as long as the total assets of the community spouse and institutional spouse are above the combined asset limit of \$2,000 plus the CSAS amount.

Excess assets (assets which are above the asset limit) can be reduced to allowable limits if they are used to pay for nursing home or home care costs, or other things such as home repairs or improvements, vehicle repair or replacement, clothing or other household expenses.

**Calculation for Spousal Impoverishment**

The LTC income limit is the same whether or not the institutionalized person has a spouse or dependent relative(s) in the community. However, for the person who does have a spouse in the community, the person applying for or enrolled in the LTC program is allowed to give some of his/her income back to the community spouse and dependent relative(s) living with the

community spouse. This is referred to as an income allocation.

**Community Spouse Income Allocation**

The community spouse income allocation is calculated by subtracting the gross income of the community spouse from the Maximum Community Spouse Income Allocation.

\$	Maximum Community Spouse Allocation (see allocation below)
-	Gross Income of Community Spouse
=	<b>Community Spouse Income Allocation</b>

**The maximum allocation is the lesser of:**

- The Maximum Community Spouse Income Allocation of \$2,841.00, or
- \$2,521.67 plus excess shelter allowance.

**Community Spouse Excess Shelter Cost Limit —**

As of 2012, the allowance is any shelter expense over \$756.50. This amount may be updated each year. (Spousal Impoverishment)

**Excess Shelter Allowance:**

\$	Rent
+	Mortgage (principal and interest)
+	Property Taxes
+	Homeowners or renters insurance
+	Condominium fee
+ \$469	Standard utility amount of \$469
=	Total Shelter
- \$756.50	(Amount as of 2012)
=	<b>Excess Shelter allowance</b>

**Maximum Community Spouse Income Allocation**

— As of 2012, this amount is \$2,841. This amount may be updated each year.

**Dependent Relative Income Allocation —** The dependent relative income allocation is calculated by subtracting the dependent relative’s income from the Maximum Dependent Family Member Income Allocation.

$$\begin{array}{rcl}
 \$ & \text{Maximum Dependent Family} & \\
 & \text{Member Income Credit } (\$630.42 \text{ as} & \\
 & \text{of 2012)} & \\
 - & \text{Dependent Family Member's Income} & \\
 = & \text{Dependent Relative Income Credit} & 
 \end{array}$$

**Family Maintenance Allowance Credit** (Community Waiver/Family Care) — The Family Maintenance Allowance is for the support of the family members when spousal impoverishment protections do not apply. If the member is a disabled child, the Family Maintenance Allowance is not included.

When the waiver member is the custodial parent of minor children living in the home, and there is no spouse in the home, the Family Maintenance Allowance is calculated using the following steps:

$$\begin{array}{rcl}
 \$ & \text{Minor children's gross earned} & \\
 & \text{income} & \\
 - & \$65 \text{ and } \frac{1}{2} \text{ of gross earned income} & \\
 & \text{credit} & \\
 + & \text{Minor Children's total other income} & \\
 = & \text{Minor Children's Adjusted Income} & 
 \end{array}$$

Compare the Minor Children's Adjusted Income total with the Medicaid Level 1 Income Limit for the number of individuals in the household. (Do not include the waiver applicant in the group size.)

Group Size	Medicaid Level 1 Income Limit
1	\$ 591.67
2	\$ 591.67

If the Minor Children's Adjusted Income is greater than Medicaid Level 1 Income Limit, there is no Family Maintenance allowance. If Minor Children's Adjusted Income is less than Medicaid Level 1 Income Limit, the Family Maintenance Allowance is the difference between Minor Child's Adjusted Income and the Medicaid Level 1 Income Limit.

$$\begin{array}{rcl}
 \$ & \text{Medicaid Level 1 Income Limit} & \\
 - & \text{Minor Children's Adjusted Income} & \\
 = & \text{Family Maintenance Allowance} & 
 \end{array}$$

If there are no minor children in the home, and spousal impoverishment policies do not apply, the Family Maintenance Allowance is then calculated as follows:

$$\begin{array}{rcl}
 \$ & \text{Spouse's Gross earned Income} & \\
 - & \$65 \text{ and } \frac{1}{2} \text{ of Total Gross Earned} & \\
 & \text{Income Credit} & \\
 + & \text{Spouse's Total Other Income} & \\
 - & \$20 \text{ Standard Medicaid Credit} & \\
 = & \text{Spouse's Adjusted Income} & 
 \end{array}$$

SSI Payment Level Plus the E Supplement for one person (\$877.77).

If the Spouse's Adjusted Income is greater than the SSI Payment Level Plus the E Supplement for one person there is no Family Maintenance Allowance.

If Spouse's Adjusted Income is less than SSI Payment Level Plus the E Supplement for one, the Family Maintenance Allowance is calculated as follows:

$$\begin{array}{rcl}
 \$877.77 & \text{SSI Payment Level Plus the E} & \\
 & \text{Supplement for one person} & \\
 - & \text{Spouse's Adjusted Income} & \\
 = & \text{Family Maintenance Allowance} & 
 \end{array}$$

## Divestment

Divestment is giving away resources, such as income, non-exempt assets and property for less than fair market value to be able to enroll in Medicaid. Fair market value is an estimate of the price an asset could have been sold for on the open market at the time it was given away or sold below value. Divestment is also an action taken to avoid receiving income or assets that you are entitled to receive.

Divesting financial resources 60 months before your application, institutionalization or after you are enrolled may result in a divestment penalty period.

Medicaid will not pay for long-term care benefits through Community Waivers, Institutional Medicaid or Family Care plans, during a divestment penalty period.

**The divestment penalty period is calculated as follows:**

$$\begin{array}{rcl}
 \$ & \text{Divested amount} & \\
 \div & \text{Average nursing home cost per month*} & \\
 = & \text{Length of the divestment penalty} & \\
 & \text{period (in months)*} & 
 \end{array}$$

\*For divestments that occurred on or after January 1, 2009, the penalty period includes partial months of ineligibility.

**Medicaid Purchase Plan (MAPP)**

This plan is a full-benefit plan that provides health care coverage for people with disabilities who are working or are enrolled in the Health and Employment Counseling Program (HEC).

**Assets** — The total countable assets of a MAPP applicant or member must be \$15,000 or less. Assets owned by the applicant’s spouse do not count towards this limit.

**Income** — The income limit is 250% of the federal poverty level (see page 37).

**Independence Accounts** — If you are enrolled in MAPP, you can set up Independence Accounts. These accounts will not affect your enrollment.

There is no limit to the number of accounts you may set up and there is no restriction on how you use the money. Any income you deposit while you are enrolled in MAPP will not be counted as an asset. Deposits (earned or other income) in your independence account may total up to 50% of gross earnings over a 12-month period without penalty. If the deposits exceed 50% of your actual gross earnings, a penalty may be assessed.

**Income Test** — The income limit for MAPP is 250% of the FPL (see page 37). You and your spouse’s monthly income, if you are living together, are counted for the MAPP Income test.

\$	Gross Earned Income
-	\$65 and ½ Earned Income Credit
-	Impairment Related Work Expenses
-	Gross Other Income
- \$20	Standard Medicaid Credit
-	Court-ordered Support Payments
-	Self-Support Plan Credit
-	Credit for Court-Ordered Guardian or Attorney Fees
=	<b>Counted Income for MAPP</b>

Compare your Counted Income to the FPL table on page 37. If your counted income is less than 250% of the FPL for your group size, you may be enrolled in MAPP. When determining your group size, include you, your spouse and your minor dependent children (natural or adopted) living with you. Do not include your stepchildren in the group size.

**MAPP Premiums and Copays**

If your gross income exceeds 150% of the FPL for your group size, you will need to pay a premium to enroll in MAPP. (See the FPL chart on page 45) In addition to a monthly premium, you may also have copays (see Covered Services and Copays on page 46).

If you do not pay the monthly premium on time, you may be subject to a specific period of time during which you cannot be enrolled in MAPP, unless there is good cause.

For more information about premiums, see page 45 or the MAPP Consumer Guide. You will get your guide when you enroll in MAPP.

**Limited Coverage Medicaid Plans**

**Medicare Savings Program**

Wisconsin Medicaid may be able to help pay for certain Medicare costs, if you request and qualify for the Medicare Savings Program (also called Premium Assistance). This program is for those who are eligible to take part in Medicare and who have low income and limited assets. The asset limits for the following plans are:

Group Size	Asset Limit
1	\$ 6,940
2	\$10,410

Not all of your income and assets will be counted when determining if you are able to enroll in the Medicare Savings Program. Income and asset limits may change each year. For current amounts, call 1-800-362-3002 or go to [dhs.wi.gov/em/customerhelp](https://dhs.wi.gov/em/customerhelp).



**Qualified Medicare Beneficiary (QMB)**

Medicaid will pay any Medicare Parts A and B premiums, Medicare co-insurance and Medicare deductibles if you meet all of the following:

- Are entitled to Medicare Part A, and
- Have assets at or below the program limit, and
- Have monthly income at or below 100% of the FPL after subtracting certain credits.

**Specified Low Income Medicare Beneficiary (SLMB)**

Medicaid will pay Medicare Part B premiums, if you meet all of the following:

- Currently getting Medicare Part A, and
- Have assets at or below the program limit, and
- Have monthly income between 100% and 120% of the FPL, after subtracting certain credits.

**Qualified Individual Group 1 (also called Specified Low-Income Beneficiary Plus (SLMB+))**

Medicaid will pay your Medicare Part B premiums, if you meet all of the following:

- Currently getting Medicare Part A, and
- Have assets at or below the program limit, and
- Are not enrolled in Medicaid, and
- Have monthly income between 120% and 135% of the FPL after subtracting certain credits.

**Qualified Disabled and Working Individual (QDWI)**

The asset limits for Qualified Disabled and Working Individuals are:

Group Size	Asset Limit
1	\$4,000
2	\$6,000

Medicaid will pay for Part A premiums, if you meet all of the following:

- You have a disability, and
- You are employed, and
- You are entitled to Medicare Part A, and
- You have assets at or below the program limit,
- You have monthly income less than 200% of the FPL, after subtracting certain credits, and
- Are not enrolled in Medicaid.

**When Will Payments Begin?**

If you are enrolled in any of the Medicare Savings Program plans, you will need to allow at least two months for payments to begin. This is the time that is needed for payments to be adjusted by Wisconsin Medicaid, Medicare and the Social Security Administration.

When Medicaid starts paying your Medicare premiums, your Social Security check will increase. If payments do not begin immediately you may get a refund from the Social Security Administration.

**Medicare Saving Program Calculations**

Calculate your counted income for the Medicare Savings Program as follows.

\$	Earned income
-	65 and ½ earned income credit
-	Other income
-	Court-ordered Support payment credit
-	Court-ordered Legal expenses credit
-	Self support plan credit
- \$20	Standard Medicaid credit
=	<b>Counted Income</b>

**SeniorCare Prescription Drug Assistance**

SeniorCare is for Wisconsin residents who are 65 years of age or older and who meet enrollment rules.

Enrollment rules include:

- Must be a Wisconsin resident, and
- Must be 65 years of age or older, and
- Must pay a \$30 annual enrollment fee per person, and
- Only income is counted. Assets such as bank accounts, insurance policies, home property, etc., are not counted.

There are four levels of enrollment based on income limits (as of 02/01/2012):

**Level 1** — At or below \$17,872 per individual or \$24,208 per couple annually.

**Level 2a** — At \$17,873 - \$22,340 per individual and \$24,209 - \$30,260 per couple annually.

**Level 2b** — \$22,341 - \$26,808 per individual and \$30,261 - \$36,312 per couple annually.

**Level 3** — \$26,809 or higher per individual and \$36,313 or higher per couple annually.



**Please Note:** There is not an asset limit for the SeniorCare Program.

SeniorCare members are subject to certain annual out-of-pocket expense requirements depending on their annual income. Drug coverage may vary by level of enrollment.

You can apply for SeniorCare by completing the SeniorCare application (F-10076). To get an application, contact SeniorCare Customer Services at 1-800-657-2038 or you can get an application at [dhs.wi.gov/em/customerhelp](https://dhs.wi.gov/em/customerhelp).

### ***Tuberculosis Related Services Only***

Tuberculosis (TB)-Related Services Only benefits helps pay some medical costs for the care of TB infection or disease.

To get this benefit, a person must meet income and asset rules and have been infected with TB. For one person, the gross monthly income limit is \$1,481 and the asset limit is \$2,000. Only the income and assets of the applicant are counted. For a minor, age 18 or younger living at home, some of the parents' income and assets are counted.

TB-Related Medicaid will only cover services directly related to the care of TB. These include:

- ✓ Physician services,
- ✓ Prescription drugs,
- ✓ Laboratory tests and x-rays,
- ✓ Clinic services,
- ✓ Services designed to encourage completion of treatment,
- ✓ Services needed due to side effects of prescribed drugs for TB care.



**Note:** TB-Related Services does not pay for hospital stays or room and board.

### ***Emergency Services Plan***

This plan provides short term coverage for people who have an emergency medical condition and meet all program rules except for their immigration status.

A medical emergency is a problem which could put your health at risk if you did not get medical care right away. Emergency Services will only pay for health care you get for an emergency medical condition.



**Please Note:** The Emergency Services plan does not guarantee the care you get will be paid. You will have to pay the cost of health care you get, if it is not considered an emergency.

### ***Medicaid SSI HMO Enrollment***

The Medicaid SSI HMO program is a group of health plans that provide health care services for people who get Medicaid SSI or SSI-related Medicaid because of a disability determined by the Disability Determination Bureau. An HMO is a group of doctors, hospitals and clinics that work together to help you manage your health care in one location.

### ***Enrolling in an HMO***

Once you are enrolled in Medicaid, you will get information in the mail about the HMOs in your area and how to choose an HMO.

You will get all your health care from providers who are part of that HMO. If you do not choose an HMO, you may be enrolled in an HMO by the Medicaid program.

You may only get care outside your HMO, if:

- It is an emergency.
- Your HMO says you may see another doctor.
- The service is a Medicaid covered service, but is not covered by your HMO (for example, dental or chiropractic services).

## ***Important Information for all Health Care Plans***

### ***Limits for Emergency Services***

All plans have limits on when you use emergency room and ambulance services. These services can only be used in an emergency situation. This will allow Medicaid and BadgerCare Plus providers to be able to provide services to more people. It also helps to keep Medicaid and BadgerCare Plus costs down.

Emergencies require medical attention right away to prevent death or serious damage to your health. Non-emergencies are illnesses, injuries or medical needs that are usually taken care of at a doctor's office.

Examples of non-emergency conditions are (but not limited to):

- × Prescription refills
- × Minor cuts or burns
- × Skin rash
- × Sprains or strains
- × Back pain
- × Toothache
- × Cold or flu symptoms
- × Common headache
- × Check-ups
- × Pregnancy test, medical or other lab tests
- × An ongoing condition that has not suddenly changed or worsened



**Please Note:** You cannot use the emergency room or ambulance rides because it is easier for you to use these services. To avoid using emergency rooms and ambulance services:

- Have a regular doctor,
- Keep your appointments,
- Call your doctor or nurse help line about your medical needs, if one is available to you.

### **Prior Authorization for Services**

Some services must be approved before you can get them. This is called "Prior Authorization."

Your provider asks for the approval for these services from ForwardHealth. If your provider does not get the services approved, ForwardHealth will not pay for the service. The provider will then be responsible for the cost of care provided. If you choose to get a service after you know the approval was denied, the provider can bill you for the service.

### **If You Get A Bill**

ForwardHealth pays your provider for covered services. A provider should not ask you, your family or others to pay anything other than a copay for covered services. If you get something that looks like a bill, contact the provider who is billing you.

Providers know the ForwardHealth coverage limits. The provider must tell you if ForwardHealth does not cover a service before the service is provided.

### **Other Providers**

If you are not enrolled in an HMO, you should check with your health care provider to see if your provider takes Medicaid and/or BadgerCare Plus. If not, call Member Services and ask for help finding a provider who does take Medicaid and/or BadgerCare Plus. All services must be provided by your HMO or a Medicaid/BadgerCare Plus provider. If you get services from someone who is not, you will be responsible for paying the cost of the service.

If there is an emergency and you do not have your card with you when you get services, give your ForwardHealth card number to all providers as soon as possible.

### **Reporting Changes**

#### **Report your Changes — BadgerCare Plus for Families and Medicaid**

You must report changes within 10 days, of the change, if:

- You have a change in where you live or where you are staying, or if someone moves in or out of your home, or
- Your household relationships change (someone gets married or divorced, or adopted), or
- Your family's monthly income (before taxes) goes over a certain monthly income limit for your family. Your Enrollment Letters (see Letters on page 35) will give you the monthly income limit for your family size and other reporting rules, or
- For Medicaid, you must also report changes in your households assets or expenses.

If you do not report a change and you get coverage when you should not, you may have to repay the cost of that coverage.

If you move out of Wisconsin and do not report this move, you will be required to repay any payments made to your HMO or other health care providers, even if you did not use your ForwardHealth card.

**Example — BadgerCare Plus for Families:**

BadgerCare Plus paid your HMO \$475 each month for your family, you would have to repay the State of Wisconsin \$475, for each month the HMO was paid after you moved out of Wisconsin.

**Example — Medicaid:**

You were enrolled in Medicaid with a cost share of \$200, in January. When you enrolled, you were given a \$75 credit for a health insurance expense. At the end of March you cancelled the health insurance but you did not report it until June. Your overpayment would be the difference between your new cost share and the old cost share for May and June.

**Report Your Changes — Family Planning Only Services**

If you are enrolled in Family Planning Only Services, changes in your income will not affect your enrollment. However, you need to report within 10 days, the following:

- You move to a new address, or
- You move out of Wisconsin, or
- Where you live changes (example, you go to a nursing home or other institution).

**Report Your Changes — BadgerCare Plus Core Plan**

You must report, within 10 days, the following changes:

- A change in your address, or
- If you move out of the state of Wisconsin, or
- Have a change in where you are staying, or
- Your family's monthly income (before taxes) goes over a certain monthly income limit for your family. Your Enrollment Letters (see Letters on page 35) will give you the monthly income limit for your family size and other reporting rules, or
- Have a child under age 19, who is under your care and moves into your home for more than 40% of the time, or
- You get other health insurance or access to other insurance, or
- You become pregnant.

**Report Your Changes — Well Woman Medicaid**

If you are enrolled in Well Woman Medicaid you must report the following changes to the agency, if you:

- Reach 65 years of age,
- Change your address,
- Move out of Wisconsin,
- Receive Medicare Part A, Part B or both,
- Enroll in private insurance that covers your cancer treatment.

**How To Report Changes**

- Online: You can report changes at [ACCESS.wi.gov](https://ACCESS.wi.gov).
- Phone: Contact your agency to report changes.
- Mail:
  - For Medicaid, you can use the Medicaid Change Report form (F-10137).
  - For BadgerCare Plus for Families and Family Planning Only Services, you can use the BadgerCare Plus Change Report form (F-10183).

To get these forms go to [dhs.wi.gov/em/customerhelp](https://dhs.wi.gov/em/customerhelp) or contact your agency.



**Please Note:** If you receive SSI benefits, your changes should be reported to the Social Security Administration.

If you do not report a change, you may be required to pay for services you received after your cost share or enrollment status should have changed.

You will be required to verify (give proof) of some of these changes (see Proof on page 37).

**Renew Your Benefits**

Once you are enrolled in Medicaid or BadgerCare Plus, you must complete a renewal at least once each year. The renewal is to make sure you still meet all program rules and you are getting the correct benefit. If the renewal is not done, your benefits will end.

**BadgerCare Plus for Families and Medicaid**

**Renewals:** There are many ways to do a renewal. Your renewal can be done online at [ACCESS.wi.gov](https://ACCESS.wi.gov), by phone, mail or in person. You will be notified by mail the month before your renewal is due.



For example, if your renewal is due in April, your letter will be sent in March. This letter will also tell you how you can do your renewal.

**Core Plan Renewal:** You will be required to pay a non-refundable processing fee of \$60 and to complete a Health Survey. If you are homeless, a tribal member or are eligible to get Indian Health Services, you will not have a fee.

If you owe a premium, the \$60 fee will be used to pay your next premium.

In order to avoid a delay in your enrollment and/or a gap in coverage, you must start the renewal process by the 5th of the month. For example, if your enrollment ends October 31st, you must submit the renewal by phone or online at [ACCESS.wi.gov](https://ACCESS.wi.gov) by October 5th.

**Monthly Premiums**

Adults enrolled in BadgerCare Plus and have income above 133% of the FPL will be required to pay a premium. The monthly premium will cover all adults over 18 in your house. If you are one of the following, you will not be required to pay a premium:

- Tribal members, children and grandchildren of tribal members.
- Tribal members and any children of tribal members who are eligible to get Indian Health Services.
- Pregnant women.
- Adults who are blind or disabled, as determined by the Disability Determination Bureau.
- Young adults leaving out-of-home care (example: foster care).

Premiums are between 3% and 9.5% of your family's gross income. If your family's income is between 133% and 140% of the federal poverty level (FPL) your premiums would start at 3%. The most your premium could be is 9.5% of your family's income. The premium will be calculated based on your actual income and rounded to the nearest dollar (premiums will not be rounded if income is at 300% of the FPL).

Example: If there are two adults (mother and father) and one child (under age 19) living in your home and

your family is 135% of the FPL, (\$2,147.63 for a family of 3) your premium would be 3% of your family income.

\$2,147.63	Gross Family Income
x 3%	Percent of Income
= \$ 64.43 (\$64)	Premium Amount

Because premiums are rounded to the nearest dollar, this family's premium would be \$64. See page 42 for more information on premium amounts.

**Self-Employed Adults**

If you are a self-employed parent or relative who takes care of a child and you are required to pay a premium, your premium will be based on your income after your depreciation expenses are added back to your net self-employment income (see How Income from Self-Employment is Counted on page 13). If that income amount exceeds 200% of the FPL, the premium is 5% of the family's income.

**Children**

If you have children who are required to pay a premium, their premiums are set at specific amounts depending on the family's income and will not be more than 5% of the family's income. See page 37 for more information on premium amounts.

**Premium Payment Methods**

If you are required to pay a monthly premium, you will have choices on how you can to pay your premium.

You may pay by check or money order, electronic funds transfer (EFT) or wage withholding. To learn more about your options or for help, contact the Premium Payment Unit at 1-888-907-4455.

**Non-Payment of Premiums**

If you are required to pay a monthly premium and you do not pay your premium, your benefits may end. If your BadgerCare Plus benefits end because you didn't pay your monthly premium, adults will not be able to enroll in BadgerCare Plus for 12 months and children for 6 months.

## **Fraud**

Fraud means to get coverage or payments you know you should not get. It also means to help someone else get coverage or payments you know that person should not get. Anyone who commits fraud can be prosecuted. If a court decides that someone got health care benefits by committing fraud, the court will require you to pay back the state for those services in addition to other penalties.

You may be fined up to \$10,000 and jailed for up to one year in a county jail, if you:

- Intentionally give false or incomplete information on your application for health care.
- Do not report a change that causes you to get more benefits than you should.
- Use another person's card to get services for yourself.
- Let someone else use your ForwardHealth card to get health care services or prescription drugs.

## **Other Health Insurance**

If you or anyone in your family has any other health insurance coverage, you must tell the agency. If you do not inform the agency about any other health insurance your benefits may be denied or ended. Anyone requesting BadgerCare Plus is required to make an assignment of Medical Support Liability. Medical Support Liability means that applicants and members must sign over to the State of Wisconsin all rights to payments from court-ordered medical support or from other third party payers of your medical expenses. Examples of third party payers are:

- Health insurance (other than BadgerCare Plus or Medicaid), or
- Payments from an accident or injury if Medicaid or BadgerCare Plus paid for any services due to the accident (see Accident and Injury Claims on page 31).

In some situations, you must cooperate with the Child Support Agency to establish paternity. This means that if you were not married at the time of the child's birth, the Child Support Agency will help you to legally name the parent.

If your child does not have health insurance and has an absent parent, you must help the Child Support

Agency to get insurance information from the absent parent. The Child Support Agency will also help you get and to keep getting health insurance (medical support) for your child through court-orders.

You must cooperate with the Child Support agency, unless you:

- Are a pregnant woman, or
- Are under age 18, or
- Have good cause for not cooperating.

There are different Good Cause reasons. If you think you may have a good reason for not cooperating with the Child Support Agency, tell your local agency.

If you have questions about your other insurance coverage, ask your insurance company. If you have questions or complaints regarding that insurance company, contact:

Office of the Commissioner of Insurance  
Bureau of Market Regulation  
PO Box 7873  
Madison WI 53707-7873  
1-800-236-8517

## **Access to Affordable Employer-Sponsored Health Insurance**

If you are able to enroll or have been able to sign up for health insurance through an employer, you may not be able to stay enrolled in BadgerCare Plus.

If you have any access to health insurance, you cannot enroll in the BadgerCare Plus Core Plan.

For parents or relatives who care for a child, employer-sponsored health insurance is considered affordable, if the premium for an individual plan is not more than 9.5% of the family's income.

Your agency will check to see if you have access to employer-sponsored health insurance.

## **Accident and Injury Claims**

If you are in an accident or injured and you get a cash award or settlement due to the accident or injury and ForwardHealth paid for part or all of your care, you must report this to your local agency. If you have

hired an attorney or are working with an insurance agency to settle your claim, you must report this information.

If you are getting Supplemental Security Income (SSI), or you live in Clark, Douglas, Eau Claire, Fond du Lac, Green Lake, Juneau, LaCrosse, Lincoln, Marinette, Milwaukee, Rock, Sheboygan, Trempealeau, Vilas, Walworth, Waushara or Winnebago County, you must report your accident or injury case to:

Wisconsin Casualty Recovery – HMS  
5615 Highpoint Drive  
Irving, TX 75308-9984  
Toll Free Telephone: 1-877-391-7471  
Fax Number: (469) 359-4319

All other members, not receiving SSI or in one of the counties listed above, should report your accident or injury to the agency before the case is settled.

## **Important Information for FoodShare and Health Care Proof/Verification**

You are required to provide proof of your answers for FoodShare, BadgerCare Plus and Medicaid, when applying for benefits, renewing benefits or reporting changes. The Proof table on page 37, describe what is required and items you can use to provide proof.



**Please Note:** If you need help getting any proof, contact your agency. They can help you.

If you have already given proof of citizenship and identity to the agency in the past, you will not have to provide this information again. You will not have to provide proof of citizenship or identity if you are:

- Currently getting Social Security Disability Insurance (SSDI).
- Currently getting Supplemental Security Income (SSI) benefits.
- Currently receiving Medicare.
- Applying for/enrolled in Emergency Services
- Applying for or enrolled in the BadgerCare Plus Prenatal plan.

For FoodShare and Medicaid, you are given credit for some costs. For BadgerCare Plus Standard and Benchmark Plans you are given credit for child support you are court-ordered to pay to someone else. To get these credits, you must report and provide proof of the cost.

There are no credits for the BadgerCare Plus Core Plan.

## **Your Rights**

Everyone applying for or getting BadgerCare Plus, Medicaid, Family Planning Only Services and FoodShare has the right to:

- Be treated with respect by agency staff.
- Have your civil rights upheld. (To learn more see Civil Rights Protection.)
- Have your private information kept private.
- Get an application or have the application mailed on the same day you ask for it.
- Have an application accepted right away by the agency.
- Ask the agency to explain anything in this handbook you do not understand.
- Get a decision about your application within 30 days of the day the agency gets your application.



**Please Note:** If your application is received at the agency after 4:30 p.m. or on a weekend or holiday, the date of receipt will be the next business day. This includes paper and online applications.

- Get FoodShare benefits within 7 days of applying, if you are in immediate need and qualify for faster service.
- Be told in advance if your benefits are going to be reduced or ended and the reason for the change.
- Ask for a fair hearing if you do not agree with any action of the agency.
- See agency records and files relating to you, except information obtained from a confidential source.

## **Civil Rights Protections**

All people applying for or getting benefits are protected from discrimination on the basis of race, color, national origin, sex, age, or disability. Under the Food and Nutrition Act and USDA policy, discrimination is also

prohibited on the basis of religion or political beliefs. State and federal laws require all benefits to be provided on a nondiscriminatory basis.

## **Fair Hearings**

Anytime your benefits are denied, reduced or ended, and you think the agency made a mistake, contact the agency. If the agency does not agree, you can ask the agency worker to help you in asking for a prehearing conference and a fair hearing.

### **Prehearing Conference**

You may be able to come to an agreement with the agency through a prehearing conference without having to wait for a fair hearing to take place. At a conference you get to tell your side of the story. The agency will explain why s/he feels that the action was taken. If the agency finds that it has made a mistake, it will change its decision and will take corrective action. If the agency decides that its initial decision is correct, and you still feel that the agency is still wrong, you have the right to go through the fair hearing process.



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**Please Note:** To agree to have a prehearing conference does not affect your right to have a fair hearing. You can ask for a fair hearing and if you are satisfied with the action of the prehearing conference you can cancel your fair hearing.

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### **Fair Hearing**

A fair hearing gives you the chance to tell a hearing officer why you think the decision about your application or benefits was wrong. At the hearing, a hearing officer will hear from you and the agency to find out if the decision was right or wrong. You may bring a friend or family member with you to the hearing. You may also be able to get free legal help. See Legal Help on page 34 to learn more.

### **When to Use The Fair Hearing Process**

Examples of when to ask for a Fair Hearing include:

- You believe your application was denied unfairly or in error.
- Your benefits were suspended, reduced or ended and you think it was a mistake.
- You do not agree with the amount of benefits you are getting.
- Your application was not acted on within 30 days.

Read each letter you get carefully to help you understand the action taken. If the reason for the change in your benefits is a federal or state rule change, the Division of Hearings and Appeals is not required to give you a fair hearing.

### **How to Ask for a Fair Hearing**

Ask your agency to help you file for a fair hearing, or write directly to:

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

You can get the Fair Hearing Request form online at [dhs.wi.gov/em/customerhelp](https://dhs.wi.gov/em/customerhelp) or by calling (608) 266-3096.

If you chose to write a letter in place of the form, you must include the following:

- Your name,
- Your mailing address,
- A brief description of the problem,
- The name of the agency that took the action or denied the service,
- Your social security number, and
- Your signature.

For FoodShare, your agency can take your request verbally.



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**Please Note:** A request must be made no later than 45 days for health care or 90 days for FoodShare after the date of the action being appealed. You can request a hearing at any time while you are getting FoodShare benefits if you do not agree with the benefit amount. Your latest Enrollment Letter will have the date by which you must request a hearing.

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You, your chosen representative (if you have one), and the agency will all get written notice at least 10 days before the fair hearing with the time, date and place of the hearing.

### **Preparing for a Fair Hearing**

You have the right to bring witnesses, your own lawyer or other advisor to the fair hearing. The



Department of Health Services will not pay for legal help to represent you, but, they may be able to help you find free legal help for questions or fair hearing representation.

You have the right to review any information in your case file that was used to determine your enrollment.

You, or your representative, have the right to:

- Question anyone who testifies at the fair hearing
- Present your own arguments and written materials that show why you think you are right.

If the fair hearing is about whether or not you are disabled or unable to work due to illness or injury, you have the right to present medical evidence for proof. The agency will pay these medical costs.

If you cannot speak English, you have the right to have an interpreter present at the hearing. The Division of Hearings and Appeals may pay for translation or interpreters, if you ask.

### ***Continuation of Benefits***

If you are getting benefits and you ask for a hearing before your benefits change, you can keep getting the same benefits until the hearing officer makes a decision. If the hearing officer decides that the agency was right, you may need to return or repay the extra benefits that you get between the time you asked for your fair hearing and the time that the hearing officer decides about your case.

If you have asked for a fair hearing, you will still need to complete any scheduled renewals. If the agency tells you, before the fair hearing has taken place, that your enrollment period has ended, you must reapply and meet all program rules for your benefits to be continued. If the renewal shows that there have been changes in your circumstances, your benefits may change or end because of these changes.

### ***Effects of the Fair Hearing***

If the fair hearing decision is in your favor:

- No action will be taken against you by the agency.
- If your benefits have been ended, you will start receiving them again (the date you will start getting

benefits will be listed in the letter of the Fair Hearing decision you get).

If the fair hearing is decided against you:

- The action will stand and you will have to pay back any benefits you should not have received.

Ask the agency about any limitations on the recovery of overpayments.

No other action will be taken against you for filing a fair hearing request.

### ***Rehearings***

If you do not agree with the fair hearing decision, you have the right to ask for a “Rehearing”, if:

- You have new evidence that was not known or available to you before the hearing that could change the decision, or
- You feel that there was a mistake in the facts of the decision, or
- You feel that there was a mistake in the legal basis of the decision.

A written request for a rehearing must be received within 20 days after the date of the written decision from the fair hearing. The Division of Hearings and Appeals will then decide within 30 days of getting the written request if you will get a rehearing. If the agency does not issue a written response to your request within 30 days, your request is denied.

### ***Appealing a Hearing or Rehearing Decision***

If you do not agree with the fair hearing or rehearing decision, it is still possible for you to appeal this decision to the Circuit Court in your county. This must be done within 30 days after you get the written decision about the fair hearing or within 30 days of the denial of the rehearing request. An appeal to the Circuit Court must be done by filing a petition with the Clerk of Courts in your county. It is best to have legal help if you decide to appeal a fair hearing decision in Circuit Court.

### ***Legal Help***

You may be able to get legal help from Wisconsin Judicare, Inc. or Legal Action of Wisconsin, Inc (LAW).

Find the office closest to you, call:

- Judicare at 1-800-472-1638 or [www.judicare.org](http://www.judicare.org) or
- LAW at 1-888-278-0633 or [www.badgerlaw.net](http://www.badgerlaw.net)

## **Letters**

You will get letters about your benefits. These letters tell you the status of your benefits.

A letter will be sent to you before any change in your FoodShare or health care benefits. It is important that you read each letter you get.

These letters will tell you if:

- Your benefits are being reduced or ended, or
- Your worker is waiting for anything from you, or
- You need to do a renewal to keep getting benefits.

### **Enrollment Letters**

Enrollment letters you get for FoodShare and health care will be in the same format. The following is what will be on these letters:

**Summary:** This page gives a short review of your case as well as what benefits you will get. You can also find the contact information for your agency.

**Benefit Details:** This page will give you details about your benefits such as:

- Who is enrolled
- Dates enrolled
- Who is not enrolled
- If you are not enrolled, the reason(s) you are not

If you are able to enroll in several programs such as FoodShare and a health care plan, you will get a separate Benefit Details section for each program.

**Household Income and Bills:** This section has two parts, a list of the income and a list of the bills on file for your household. You should check your letters to make sure all income and bills are listed.

**How We Counted Your Income:** This section has the amounts and limits that were used to decide whether you could enroll. Your Gross Income is the

total income you reported. Your Counted Income is your income after certain credits are subtracted. The Counted Income Limit is the most income you can have for your family size and still be enrolled without having a deductible or premium.

**Your Reporting Rules:** This page has your reporting rules, which tell you what changes need to be reported to your agency.

**Key Contacts:** This page has your key contacts. The key contacts give you information about who to contact with questions. You can also get this information in the Key Contacts section (inside cover) of this handbook.

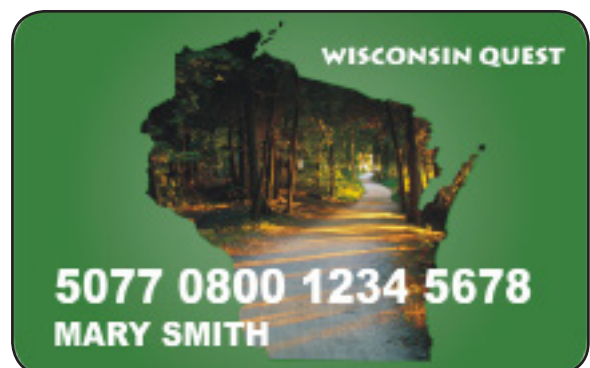
**Fair Hearing:** The last page of your letter has information about fair hearings. The date by which a hearing must be requested and how to ask for a fair hearing. See the Fair Hearing section of this handbook for more information on fair hearings.

## **Identification Cards**

If you already have an Identification card, you should keep it unless you are sent a new card or your agency tells you to throw it away. You will not get a new card each month.

### **QUEST Card**

Your FoodShare benefits will be put into your Wisconsin QUEST card account using an Electronic Benefits Transfer (EBT) system. You can spend your benefits by using your QUEST card.



You must have your QUEST card with you every time you go to the store to buy food using your FoodShare benefits.

### ForwardHealth Card

Each person enrolled in a BadgerCare Plus or Medicaid Plan will get a ForwardHealth card.



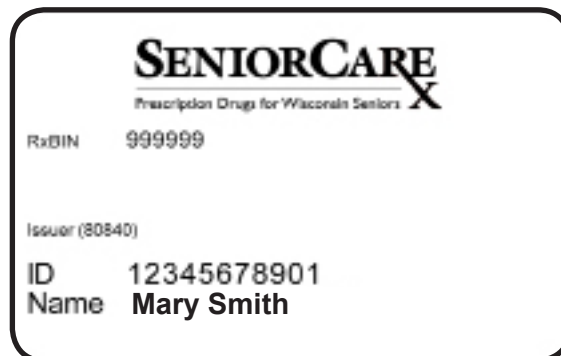
Your ForwardHealth card does not show the dates that you are enrolled. You will get an Enrollment Letter in the mail from the agency with your dates of enrollment.

If you are not sure if you are enrolled, or the plan you are enrolled in, call the number on the back of your card or go to [ACCESS.wi.gov](http://ACCESS.wi.gov).

If there is an emergency and you do not have your card with you when you get services, give your ID card number to all providers as soon as possible.

### SeniorCare Card


Everyone who is enrolled in SeniorCare will get a SeniorCare card. When going to a SeniorCare pharmacy provider, be sure to take your card with you. The SeniorCare card will be used to verify your enrollment at each visit.



Keep your card. You will not get a new card each month.

If you have questions about your card, contact SeniorCare Customer Service.

## Program Income Limits

 **Please Note:** Program income amounts are based on federal guidelines which may increase by a small amount each year. The following tables will list the dates these amounts are effective. For current guidelines, call 1-800-362-3002 or go to: [dhs.wi.gov/em/customerhelp](http://dhs.wi.gov/em/customerhelp).

### FoodShare Monthly Income Limits/Maximum Benefit Amounts — Effective October 1, 2012.

People in Household	Gross Monthly Income Limit	Net Monthly Income Limit	Maximum Benefit Amount
1	\$1,862	\$ 931	\$200
2	\$2,522	\$1,261	\$367
3	\$3,182	\$1,591	\$526
4	\$3,842	\$1,921	\$668
5	\$4,502	\$2,251	\$793
6	\$5,162	\$2,581	\$952
7	\$5,822	\$2,911	\$1,052
8	\$6,482	\$3,241	\$1,202
For each additional person add:			
	\$660	\$330	\$150

## Health Care Monthly Income Limits — Effective February 1, 2012

Group Size	100% FPL	120% FPL	133% FPL	135% FPL	150% FPL	185% FPL	200% FPL	250% FPL	300% FPL
1	\$930.83	\$1,117.00	\$1,238.01	\$1,256.63	\$1,396.25	\$1,722.04	\$1,861.67	\$2,327.08	\$2,792.50
2	\$1,260.83	\$1,513.00	\$1,676.91	\$1,702.13	\$1,891.25	\$2,332.54	\$2,521.67	\$3,152.08	\$3,782.50
3	\$1,590.83	\$1,909.00	\$2,115.81	\$2,147.63	\$2,386.25	\$2,943.04	\$3,181.67	\$3,977.08	\$4,772.50
4	\$1,920.83	\$2,305.00	\$2,554.71	\$2,593.13	\$2,881.25	\$3,553.54	\$3,841.67	\$4,802.08	\$5,762.50
5	\$2,250.83	\$2,701.00	\$2,993.61	\$3,038.63	\$3,376.25	\$4,164.04	\$4,501.67	\$5,627.08	\$6,752.50
6	\$2,580.83	\$3,097.00	\$3,432.51	\$3,484.13	\$3,871.25	\$4,774.54	\$5,161.67	\$6,452.08	\$7,742.50
7	\$2,910.83	\$3,493.00	\$3,871.41	\$3,929.63	\$4,366.25	\$5,385.04	\$5,821.67	\$7,277.08	\$8,732.50
8	\$3,240.83	\$3,889.00	\$4,310.31	\$4,375.13	\$4,861.25	\$5,995.54	\$6,481.67	\$8,102.08	\$9,722.50
9	\$3,570.83	\$4,285.00	\$4,749.21	\$4,820.63	\$5,356.25	\$6,606.04	\$7,141.67	\$8,927.08	\$10,712.50
10	\$3,900.83	\$4,681.00	\$5,188.11	\$5,266.13	\$5,851.25	\$7,216.54	\$7,801.67	\$9,752.08	\$11,702.50
<i>For each additional person, add:</i>									
	\$330.00	\$396.00	\$438.90	\$445.50	\$495.00	\$610.50	\$660.00	\$825.00	\$990.00

## Proof/Verification

The following tables list what you are required to provide as proof of your answers and items you can use. If you need help getting any items of proof, call your agency and ask for help.

Proof Needed and Items You Can Use	BadgerCare Plus	Medicaid	FoodShare
<b>Identity</b> — Items you can use: <ul style="list-style-type: none"> <li>• U.S. passport</li> <li>• Military dependent ID card</li> <li>• State driver license</li> <li>• Military ID or draft record</li> <li>• School picture ID</li> <li>• Native American Tribal Enrollment document</li> <li>• For children under 18, applying for BadgerCare Plus or Medicaid, a signed Statement of Identity form. To get this form, contact your agency</li> </ul>	Yes	Yes	Yes
<b>U.S. Citizenship</b> <ul style="list-style-type: none"> <li>• U.S. passport</li> <li>• U.S. birth certificate</li> <li>• Citizenship ID card</li> <li>• Adoption papers</li> <li>• Military record</li> <li>• Hospital record of U.S. birth</li> <li>• Insurance record with U.S. birth</li> <li>• Nursing home admission papers showing U.S. birth</li> </ul>	Yes	Yes	Yes



<b>Proof Needed and Items You Can Use</b>	<b>Badger-Care Plus</b>	<b>Medicaid</b>	<b>FoodShare</b>
<b>Immigration Status</b> — Anyone who is not a U.S. citizen can use a copy of his or her: <ul style="list-style-type: none"> <li>• Alien Registration card</li> <li>• Naturalization certificate</li> </ul>	Yes	Yes	No
<b>Tribal Membership and/or Native American or Alaskan Native Descent</b> — Items you can use are: <ul style="list-style-type: none"> <li>• Tribal Enrollment card</li> <li>• Written verification or document issued by the Tribe indicating Tribal affiliation</li> <li>• Certificate of Degree of Indian blood issued by the Bureau of Indian Affairs</li> <li>• Tribal Census document</li> <li>• Medical Record card or similar documentation that specifies Indian descent issued by an Indian care giver</li> </ul>	Yes	Yes	No
<b>Pregnancy</b> — You can use a note or letter from your health care provider that confirms a medically verified pregnancy and includes the due date.	Yes	Yes	Yes
<b>Health Insurance</b> — The State of Wisconsin will check for you to see if employer health insurance is available to you and/or your family members.	Yes	Yes	No
<b>Disability</b> — You may be asked to provide proof of disability or blindness if the state is not able to get this information. If so, you may provide an approval letter from the State Disability Determination Bureau or award letter from the Social Security Administration.	No	Yes	Yes
<b>Child Support Paid or Received</b> — You can use: <ul style="list-style-type: none"> <li>• Court order</li> <li>• Payment record from other state</li> </ul> <p>If you pay or get child support in Wisconsin, the agency may be able to get this proof. If not, you will need to provide proof.</p>	Yes	Yes	Yes
<b>Assets</b> <ul style="list-style-type: none"> <li>• Bank statements</li> <li>• Titles</li> <li>• Contracts</li> <li>• Deeds</li> <li>• Life insurance policies, etc.</li> </ul>	No	Yes	Yes

<b>Proof Needed and Items You Can Use</b>	<b>BadgerCare Plus</b>	<b>Medicaid</b>	<b>FoodShare</b>
<b>Income</b> — Proof of all job income and wages for any family members who have a job. <ul style="list-style-type: none"> <li>• Check stubs (for the last 30 days)</li> <li>• An Employer Verification of Earnings (EVF-E) form</li> <li>• A letter from the employer</li> </ul> <p>If you choose a letter, it must have the same information as the EVF-E form. Note: If you want to use an EVF-E form, ask the agency to send one to you. Your employer must complete and sign this form. Return the form to the agency.</p>	Yes	Yes	Yes
<b>Self-Employment Income</b> — Proof of income for all family members who are self-employed. <ul style="list-style-type: none"> <li>• Copies of tax forms</li> <li>• A Self-Employment Income Report. Contact the agency for this form</li> </ul>	Yes	Yes	Yes
<b>Other Income</b> — You must provide proof of all other income for anyone in your home such as alimony, child support, disability or sick pay, interest or dividends, Veterans Benefits, workers compensation, unemployment insurance, etc. You can use: <ul style="list-style-type: none"> <li>• Pension statement</li> <li>• Current award letter</li> <li>• Copy of current check</li> </ul>	Yes	Yes	Yes

<b>Proof and Items You Can Use, If You Want to Get a Credit</b>	<b>BadgerCare Plus</b>	<b>Medicaid</b>	<b>FoodShare</b>
<b>Rent or House Payments</b> — Some items you can use: <ul style="list-style-type: none"> <li>• Lease, rental agreement or receipt/letter from landlord</li> <li>• Mortgage payment record</li> </ul>	No	Yes	No
<b>Utility Cost</b> — Some items you can use are: <ul style="list-style-type: none"> <li>• Utility and/or phone bill</li> <li>• Letter from utility company</li> <li>• Firewood receipt</li> </ul>	No	Yes	No
<b>Medical Cost</b> — Some items you can use: <ul style="list-style-type: none"> <li>• Billing statement/itemized receipts</li> <li>• Medicare card showing Part “B” coverage</li> <li>• Health insurance policy showing premium, coinsurance, copay or deductible</li> <li>• Medicine or pill bottle with price on label</li> </ul>	Yes	Yes	Yes

## BadgerCare Plus Standard and Benchmark Plans — Enrollment Information

The following will tell you what plan is available under each BadgerCare Plus income level for families. It will also list whether or not you:

- Will have copays.
- Will be required to pay a monthly premium.
- Can get backdated coverage.
- Will have a deductible.

**Young adults leaving out-of-home care** (foster care)  
— If you are a young adult leaving out-of-home care, you may enroll in the Standard Plan. If you qualify as a BadgerCare Plus youth, you will not pay copays or premiums, regardless of your income.

Please keep in mind, there is no income limit for young adults leaving out-of-home care.

**Self-employed parents and caretakers** — If your family income is at or below 200% of the FPL without deducting depreciation, you will be enrolled in the Standard Plan.

If your income is at or below 200% only by deducting depreciation expense, you will be enrolled in the Benchmark Plan. If your family income is over 150% of the FPL, you will have to pay premiums. You will also have to pay copays regardless of your income.

<b>Income Limit</b> (See page 37 for amounts)	<b>Pregnant Women</b>	<b>Children</b>	<b>Children with access to employer health insurance</b>
At or below 100% FPL	Standard Plan Premium - No Copay - No Backdated Coverage Yes	Standard Plan Premium - No Copay - No Backdated Coverage	Standard Plan Premium - No Copay - No Backdated Coverage
From 100% to 150% FPL	Standard Plan Premium - No Copay - No Backdated Coverage	Standard Plan Premium - No Copay - Yes* Backdated Coverage	Standard Plan Premium - No Copay - Yes* Backdated Coverage
Over 150% FPL			Standard Plan Premium - No Copay - Yes Spenddown
150% to 200% FPL	Standard Plan Premium - No Copay - No	Standard Plan Premium - No Copay - Yes	
From 200% to 300% FPL	Benchmark Plan Premium - No Copay - No	Benchmark Plan Premium - Yes Copay - Yes	
300% FPL and over	Benchmark Plan Premium - No Copay - No Spenddown	Benchmark Plan Premium - Yes Copay - Yes	

\*Children under age 6 with family income of 100% up to 150% of the FPL do not have copays.

## BadgerCare Plus Standard and Benchmark Plans — Enrollment Information

### Parents and Relatives Who Care For a Child (See the table on page 37 for amounts.)

Income Limit	Plan	Premium	Copay	Backdated Coverage
At or below 100% FPL	Standard	No	Yes	Yes
From 100% to 133% FPL	Standard	No	Yes	Yes
133% to 200% FPL	Standard	Yes	Yes	No
From 200% to 300% FPL and over	Benchmark*	Yes	Yes	No

\*Only self-employed parents and/or relatives who care for a child can be enrolled at this income level.

Income Limit (See page 37 for amounts)	Children age 1 to 6 who are tribal members	Children age 6 to 18 who are tribal members
At or below 100% FPL	Standard Plan Premium - No Copay - No Backdated Coverage	Standard Plan Premium - No Copay - No Backdated Coverage
From 100% to 150% FPL	Standard Plan Premium - No Copay - Yes Backdated Coverage	Standard Plan Premium - No Copay - Yes Backdated Coverage
150% to 185% FPL	Standard Plan Premium - No Copay - Yes	Standard Plan Premium - No Copay - No
From 185% to 200% FPL	Standard Plan Premium - No Copay - No	Benchmark Plan Premium - No Copay - No
From 200% to 300% FPL	Benchmark Plan Premium - No Copay - No	Benchmark Plan Premium - No Copay - No
300% FPL and over	Benchmark Plan Premium - Yes Copay - Yes	Benchmark Plan Premium - Yes Copay - Yes



## BadgerCare Plus Standard and Benchmark Plans — Enrollment Information

<b>Individual(s)</b> — Income Limit (See page 37 for amounts)	<b>Premium</b>	<b>Copay</b>	<b>Copay for Indian Health Services</b>
Tribal Members and Children of Tribal Members <ul style="list-style-type: none"> <li>Adults</li> <li>Age birth to 1, income at 300% FPL and over</li> <li>Age 1 to 5 years, income at or below 185% FPL</li> <li>Age 6 to 18 years, income at or below 150% FPL</li> </ul>	No	Yes	No
Tribal Members and Children of Tribal Members <ul style="list-style-type: none"> <li>Age 6 to 18 years, income at 150 to 300% FPL</li> <li>Age 1 to 5 years, income at 185 to 300% FPL</li> </ul>	No	No	No
Other people who are eligible to get services from an Indian Health Center <ul style="list-style-type: none"> <li>Adults</li> <li>Age birth to 1, income at 300% FPL and over</li> <li>Age 1 to 5 years, income at or below 185% FPL</li> <li>Age 6 to 18 years, income at or below 150% FPL</li> </ul>	No	Yes	No
Other people who are eligible to get services from an Indian Health Center <ul style="list-style-type: none"> <li>Age 6 to 18 years, income at 150 to 300% FPL</li> <li>Age 1 to 5 years, income at 185 to 300% FPL</li> </ul>	Yes	Yes	Yes

## BadgerCare Plus Monthly Premiums Amounts

BadgerCare Plus monthly premiums are based on family size, income and Federal Poverty Level (FPL) guidelines. The premium amount listed for your family size and income amount will cover all adults in the family. If you have children in the family, with income over 200% of the FPL, you will also be required to pay a premium for that child. To see what percent of the FPL your family's income is at, see the table on page 37.

The following tables lists the BadgerCare Plus monthly premium amounts for:

- Children (age 18 and under) with family income over 200% of the FPL
- Adults with family income over 133% of the FPL
- Self-employed parents or an adults who cares for a related child

### BadgerCare Plus Monthly Premiums for Children

<b>Family Income</b>	<b>200% to 230%</b>	<b>230% to 240%</b>	<b>240% to 250%</b>	<b>250% to 260%</b>	<b>260% to 270%</b>	<b>270% to 280%</b>	<b>280% to 290%</b>	<b>290% to 300%</b>	<b>300% and Over</b>
<b>Monthly Premium Amount for Each Child</b>	\$10	\$15	\$23	\$34	\$44	\$55	\$68	\$82	\$97.53

## BadgerCare Plus Monthly Premiums for Adults

Family Size of 1 Person	
Monthly Family Income	Monthly Premium
\$0.00 - \$1,238.01	No Premium
\$1,238.02 - 1,396.24	\$37 - 49
\$1,396.25 - 1,582.41	\$56 - 71
\$1,582.42 - 1,861.66	\$78 - 108
\$1,861.67 - 2,327.07	\$117 - 179
\$2,327.08 - 2,792.49	\$188 - 257
\$2,792.50 and over	\$265 and up

Family Size of 2 People	
Monthly Family Income	Monthly Premium
\$0.00 - \$1,676.91	No Premium
\$1,676.92 - 1,891.24	\$50 - 66
\$1,891.25 - 2,143.41	\$76 - 96
\$2,143.42 - 2,521.66	\$105 - 146
\$2,521.67 - 3,152.07	\$159 - 243
\$3,152.08 - 3,782.49	\$255 - 348
\$3,782.50 and over	\$359 and up

Family Size of 3 People	
Monthly Family Income	Monthly Premium
\$0.00 - \$2,115.81	No Premium
\$2,115.82 - 2,386.24	\$63 - 84
\$2,386.25 - 2,704.41	\$95 - 122
\$2,704.42 - 3,181.66	\$133 - 185
\$3,181.67 - 3,977.07	\$200 - 306
\$3,977.08 - 4,772.49	\$322 - 439
\$4,772.50 and over	\$453 and up

Family Size of 4 People	
Monthly Family Income	Monthly Premium
\$0.00 - \$2,554.71	No Premium
\$2,554.72 - 2,881.24	\$77 - 101
\$2,881.25 - 3,265.41	\$115 - 147
\$3,265.42 - 3,841.66	\$160 - 223
\$3,841.67 - 4,802.07	\$242 - 370
\$4,802.08 - 5,762.49	\$389 - 530
\$5,762.50 and over	\$547 and up

Family Size of 5 People	
Monthly Family Income	Monthly Premium
\$0.00 - \$2,993.61	No Premium
\$2,993.62 - 3,376.24	\$90 - 118
\$3,376.25 - 3,826.41	\$135 - 172
\$3,826.42 - 4,501.66	\$187 - 261
\$4,501.67 - 5,627.07	\$284 - 433
\$5,627.08 - 6,752.49	\$456 - 621
\$6,752.50 and over	\$641 and up

Family Size of 6 People	
Monthly Family Income	Monthly Premium
\$0.00 - \$3,432.51	No Premium
\$3,432.52 - 3,871.24	\$103 - 135
\$3,871.25 - 4,387.41	\$155 - 197
\$4,387.42 - 5,161.66	\$215 - 299
\$5,161.67 - 6,452.07	\$325 - 497
\$6,452.08 - 7,742.49	\$523 - 712
\$7,742.50 and over	\$736 and up

Family Size of 7 People	
Monthly Family Income	Monthly Premium
\$0.00 - \$3,871.41	No Premium
\$3,871.42 - 4,366.24	\$116 - 153
\$4,366.25 - 4,948.41	\$175 - 223
\$4,948.42 - 5,821.66	\$242 - 338
\$5,821.67 - 7,277.07	\$367 - 560
\$7,277.08 - 8,732.49	\$589 - 803
\$8,732.50 and over	\$830 and up

Family Size of 8 People	
Monthly Family Income	Monthly Premium
\$0.00 - \$4,310.31	No Premium
\$4,310.32 - 4,861.24	\$129 - 170
\$4,861.25 - 5,509.41	\$194 - 248
\$5,509.42 - 6,481.66	\$270 - 376
\$6,481.67 - 8,102.07	\$408 - 624
\$8,102.08 - 9,722.49	\$656 - 894
\$9,722.50 and over	\$924 and up

## BadgerCare Plus Monthly Premiums for Adults (continued)

Family Size of 9 People	
Monthly Family Income	Monthly Premium
\$0.00 - \$4,749.21	No Premium
\$4,749.22 - 5,356.24	\$142 - 187
\$5,356.25 - 6,070.41	\$214 - 273
\$6,070.42 - 7,141.66	\$297 - 414
\$7,141.67 - 8,927.07	\$450 - 687
\$8,927.08 - 10,712.49	\$723 - 986
\$10,712.50 and over	\$1,018 and up

Family Size of 10 People	
Monthly Family Income	Monthly Premium
\$0.00 - \$5,188.11	No Premium
\$5,188.12 - 5,851.24	\$156 - 205
\$5,851.25 - 6,631.41	\$234 - 298
\$6,631.42 - 7,801.66	\$325 - 452
\$7,801.67 - 9,752.07	\$492 - 751
\$9,752.08 - 11,702.49	\$790 - 1,077
\$11,702.50 and over	\$1,112 and up

## Self-Employed Parents and Relative Caretakers Premiums

Family Size	200 to 210%	210 to 220%	220 to 230%	230 to 240%	240 to 250%	250 to 260%
1	\$93	\$97	\$102	\$107	\$111	\$116
2	\$126	\$132	\$138	\$144	\$151	\$157
3	\$159	\$167	\$174	\$182	\$190	\$198
4	\$192	\$201	\$211	\$220	\$230	\$240
5	\$225	\$236	\$247	\$258	\$270	\$281
6	\$258	\$270	\$283	\$296	\$309	\$322
7	\$291	\$305	\$320	\$334	\$349	\$363
8	\$324	\$340	\$356	\$372	\$388	\$405
9	\$357	\$374	\$392	\$410	\$428	\$446
10	\$390	\$409	\$429	\$448	\$468	\$487

Family Size	260 to 270%	270 to 280%	280 to 290%	290 to 300%	300%
1	\$121	\$125	\$130	\$134	\$139.63
2	\$163	\$170	\$176	\$182	\$189.13
3	\$206	\$214	\$222	\$230	\$238.63
4	\$249	\$259	\$268	\$278	\$288.13
5	\$292	\$303	\$315	\$326	\$337.63
6	\$335	\$348	\$361	\$374	\$387.13
7	\$378	\$392	\$407	\$422	\$436.63
8	\$421	\$437	\$453	\$469	\$486.13
9	\$464	\$482	\$499	\$517	\$535.63
10	\$507	\$526	\$546	\$565	\$585.13



**Please Note:** If you have a premium, you will get a BadgerCare Plus Premiums slip each month. You should mail your premium to the address on the slip. If you do not have your slip, mail your premium to the following address:

BadgerCare Plus  
C/O Wisconsin Department of Health Services  
PO Box 93187  
Milwaukee, WI 53293-0187

If you are required to pay a BadgerCare Plus monthly premium and you fail to pay it, you will not be able to enroll in BadgerCare Plus for 12 months if you are age 19 and over or 6 months if you are age 18 and under.

## Medicaid Purchase Plan Premium Table

Net monthly income amount:		The premium is:	Net monthly income amount:		The premium is:
From:	To:	Premium	From:	To:	Premium
\$0	\$25.00	\$0.00	\$500.01	\$525.00	\$500.00
\$25.01	\$50.00	\$25.00	\$525.01	\$550.00	\$525.00
\$50.01	\$75.00	\$50.00	\$550.01	\$575.00	\$550.00
\$75.01	\$100.00	\$75.00	\$575.01	\$600.00	\$575.00
\$100.01	\$125.00	\$100.00	\$625.01	\$650.00	\$625.00
\$125.01	\$150.00	\$125.00	\$650.01	\$675.00	\$650.00
\$150.01	\$175.00	\$150.00	\$675.01	\$700.00	\$675.00
\$175.01	\$200.00	\$175.00	\$700.01	\$725.00	\$700.00
\$200.01	\$225.00	\$200.00	\$725.01	\$750.00	\$725.00
\$225.01	\$250.00	\$225.00	\$750.01	\$775.00	\$750.00
\$250.01	\$275.00	\$250.00	\$775.01	\$800.00	\$775.00
\$275.01	\$300.00	\$275.00	\$800.01	\$825.00	\$800.00
\$300.01	\$325.00	\$300.00	\$825.01	\$850.00	\$825.00
\$325.01	\$350.00	\$325.00	\$850.01	\$875.00	\$850.00
\$350.01	\$375.00	\$350.00	\$875.01	\$900.00	\$875.00
\$375.01	\$400.00	\$375.00	\$900.01	\$925.00	\$900.00
\$400.01	\$425.00	\$400.00	\$925.01	\$950.00	\$925.00
\$425.01	\$450.00	\$425.00	\$950.01	\$975.00	\$950.00
\$450.01	\$475.00	\$450.00	\$975.01	\$1,000.00	\$975.00
\$475.01	\$500.00	\$475.00			



## Core Plan — Covered Services and Copays



**Please Note:** Core Plan covered services and copays can change. To see if the service you need is covered or if there are any limits, you should ask your health care provider.

You may be required to pay a copay. You may have more than one copay if you get more than one service.

**Example:** If you saw your doctor and you also had an X-ray, you would have two copays — one for the doctor's visit and one for the X-ray. Members covered under the Core Plan may be refused services if the copay is not paid at the time the service is provided.

<b>Core Plan Covered Services/Copays/Limits</b>
<b>Ambulatory Surgical Centers (ASC)</b>
Coverage of certain surgical procedures and related lab services. \$3 copay per service.
<b>Chiropractic Services</b>
Full coverage — \$0.50 to \$3 copay per service.
<b>Dental Services</b>
Coverage limited to certain emergency services. No copay.
<b>Disposable Medical Supplies (DMS)</b>
Coverage of certain diabetic supplies, ostomy supplies, and other DMS that are required with the use of durable medical equipment. \$0.50 to \$3 copay per service and \$0.50 per prescription for diabetic supplies.
<b>Drugs - Prescription</b>
Generic-only formulary drug benefit with a limited number of over-the-counter drugs. Some brand name drugs are covered. Up to \$4 copay for generic drugs and up to \$8 for brand name drugs with a \$24 copay limit per month, per provider.
Members will be automatically enrolled in BadgerRx Gold. This is a separate program administered by Navitus Health Solutions. More information about Rx Gold can be found at <a href="http://badgerxgold.com">badgerxgold.com</a> .
<b>Durable Medical Equipment (DME)</b>
Full coverage up to \$2,500 per enrollment year — \$0.50 to \$3 copay per item.
Rental items are not subject to copay but count toward the \$2,500 annual limit.
<b>End Stage Renal Disease (ESRD)</b>
Full coverage — No copay.
<b>Home Care Services (Home Health, Private Duty Nursing [PDN], and Personal Care)</b>
Coverage of home health services for 30 days following an inpatient stay if discharge from the hospital is contingent on the provision of follow-up home health services. Coverage is limited to 100 visits within the 30-day post-hospitalization period. No copay.
<b>Hospice</b>
Full coverage — No copay

## **Core Plan Covered Services/Copays/Limits**

### **Hospital — Emergency Room**

Full coverage. \$3 copay for members with income up to 100 % of the FPL. \$60 copay per visit for members with income from 100 % to 200 % of the FPL (waived if the member is admitted to a hospital).

### **Hospital — Outpatient**

Full coverage — \$3 copay per visit for members with income up to 100% of the FPL. \$15 copay per visit for members with income from 100% to 200% of the FPL.

\$300 total copay cap per enrollment year for inpatient and outpatient hospital services for all income levels.

Outpatient mental health and substance abuse treatment services are not covered.

### **Hospital — Inpatient**

Full coverage (not including inpatient psychiatric stays in either an Institute for Mental Disease [IMD] or the psychiatric ward of an acute care hospital and inpatient substance abuse treatment).

\$3 copay per day for members with income up to 100 % of the Federal Poverty Level (FPL) with a \$75 cap per stay.

\$100 copay per stay for members with income from 100 % to 200 % of the FPL.

There is a \$300 total copay cap per enrollment year for inpatient and outpatient hospital services for all income levels.

### **Mental Health and Substance Abuse Treatment**

Coverage limited to services provided by a psychiatrist under the physician services benefit. \$0.50 to \$3 copay per service, limited \$30 per provider, per enrollment year.

### **Physical Therapy (PT), Occupational Therapy (OT), and Speech and Language Pathology (SLP)**

Full coverage, limited to 20 visits per therapy discipline, per enrollment year. \$0.50 to \$3 copay per service. Copay obligation limited to the first 30 hours or \$1,500, whichever occurs first, during one enrollment year (copay limits calculated separately for each discipline). Cardiac rehabilitation visits count towards the 20-visit limit for PT.

### **Physician (Doctors)**

Full coverage, including laboratory and radiology. \$0.50 to \$3 copay per service, limited to \$30 per provider per enrollment year.

No copay for emergency services, anesthesia, or clozapine management.

### **Podiatry**

Full coverage — \$0.50 to \$3 copay per service, limited to \$30 per provider per enrollment year.

### **Reproductive Health (Family Planning)**

Family planning services provided by family planning clinics will be covered separately under Family Planning Only Services. More information about Family Planning Only Services is on page 14.

**The following services are not covered;** infertility treatments, reversal of voluntary sterilization, surrogate parenting (including, but not limited to obstetric care, pharmacy services, labor and delivery due to surrogacy).

### **Transportation — Ambulance**

Coverage limited to emergency transportation by ambulance. No copay.

**BadgerCare Plus Standard,  
Benchmark and Medicaid Plans**

**Covered Services and Copays**

You may be required to pay a part of the cost of a service. This payment is called a copay. The following tables list what services are covered and what the copay will be for that services.

**BadgerCare Plus Standard/Medicaid Plans**

Providers are required to make a reasonable effort to collect the copay but cannot refuse services to a member who fails to make that payment.

**BadgerCare Plus Benchmark Plans**

Members covered under the Benchmark plan may be refused services, if the copay is not paid at the time of your appointment.



**Please Note:** Because copays could change, you should ask your provider what your copay amount will be. If you get more than one service during the same appointment, you may be asked for more than one copay.

A provider can charge you for services that are not covered by BadgerCare Plus or Medicaid, if:

- The provider told you before providing the service that the service was not covered, and
- You agreed to pay for the service.



**Please Note:** Not all plans cover the same services. The covered services listed may change. To see if the service you need is covered, ask your health care provider.

<b>BadgerCare Plus Standard Plan/Medicaid/Well Woman Medicaid</b>	<b>Benchmark Plan</b>
<b>Ambulatory Surgical Centers</b>	
Coverage of certain surgical procedures and related lab services.  \$3 copay per service.	Coverage of certain surgical procedures and related lab services.  \$15 copay per visit.
<b>Chiropractic Services</b>	
Full coverage — \$.50 to \$3 copay per service.	Full coverage — \$15 copay per visit.
<b>Dental Services</b>	
Full coverage — \$.50 to \$3 copay per service.	Limited coverage of preventive, diagnostic, simple restorative, periodontics, and extractions for pregnant women and children.  Coverage limited to \$750 per enrollment year.  A \$200 deductible applies to all services except preventive and diagnostic.  Cost-sharing equal to 50% of allowable fee on all services.  Pregnant women are exempt from deductible and cost-sharing requirements for dental services.

<b>BadgerCare Plus Standard Plan/Medicaid/Well Woman Medicaid</b>	<b>Benchmark Plan</b>
<b>Disposable Medical Supplies (DMS)</b>	
Full coverage.  \$0.50 to \$3 copay per service and \$0.50 per prescription for diabetic supplies.	Coverage of diabetic supplies, ostomy supplies, and other DMS that are required with the use of durable medical equipment (DME).  \$0.50 copay per prescription for diabetic supplies.  No copay for other DMS.
<b>Drugs (Prescription)</b>	
Coverage of generic and brand name prescription drugs, and some over-the-counter (OTC) drugs.  Copay: <ul style="list-style-type: none"> <li>• \$0.50 for OTC drugs</li> <li>• \$1 for generic drugs</li> <li>• \$3 for brand</li> </ul> Copays are limited to \$12 per member per provider, per month. OTCs are excluded from this \$12 maximum.	Generic drug-only formulary with a few generic over-the-counter (OTC) drugs.  Members will be automatically enrolled in the Badger Rx Gold plan. This is a separate program administered by Navitus, which provides for a discount on the cost of drugs.  \$5 copay with no upper limits.
<b>Durable Medical Equipment (DME)</b>	
Full coverage — \$0.50 to \$3 copay per item.  Rental items are not subject to copay.	Full coverage up to \$2,500 per enrollment year.  \$5 copay per item.  Rental items are not subject to copay but count toward the \$2,500 annual limit.  Hearing aid repairs are subject to the \$2,500 enrollment year limit.
<b>End-Stage Renal Disease (ESRD)</b>	
Full coverage. No copay.	Full coverage. No copay.
<b>HealthCheck Screenings for Children</b>	
Full coverage of HealthCheck screenings and other services for individuals under age 21 years.  \$1 copay per screening for 18, 19 and 20 year olds.	Full coverage of HealthCheck screenings and other services for individuals under age 21 years.  \$1 copay per screening for 18, 19 and 20 year olds.
<b>Hearing Services</b>	
Full coverage — \$.50 to \$3 copay per procedure.  No copay for hearing aid batteries.	Full coverage for members 17 years of age and younger.  \$15 per visit, regardless of the number or type of procedures administered during one visit.



**Please Note:** BadgerCare Plus services can change. Your health care provider can tell you if a service is covered and what your copay will be. You may have more than one copay if you get more than one service.  
**Example:** If you saw your doctor and you also had an X-ray, you would have two copays — one for the doctor's visit and one for the X-ray.



<b>BadgerCare Plus Standard Plan/Medicaid/Well Woman Medicaid</b>	<b>Benchmark Plan</b>
<b>Home Care Services (Home Health, Private Duty Nursing and Personal Care)</b>	
Full coverage of private duty nursing, home health services, and personal care.  No copay.	Full coverage of home health services. Coverage limited to 60 visits per enrollment year.  Private duty nursing and personal care are not covered.  \$15 copay per visit.
<b>Hospice</b>	
Full coverage. No copay.	Full coverage, up to 360 days per lifetime. No copay.
<b>Hospital Services — Inpatient</b>	
Full coverage — \$3 copay per day with a \$75 cap per stay.	Full coverage — Copays are as follows: <ul style="list-style-type: none"> <li>• \$100 stay for medical stays.</li> <li>• \$50 copay per stay for mental health and/or substance abuse treatment.</li> </ul>
<b>Hospital — Outpatient</b>	
Full coverage. \$3 copay per visit.	Full coverage. \$15 copay per visit.
<b>Hospital Services — Outpatient Emergency Room</b>	
Full coverage. No copay.	Full coverage — \$60 copay per visit (waived if admitted to hospital).
<b>Mental Health and Substance Abuse Treatment</b>	
Full coverage (not including room and board).  \$0.50 to \$3 copay per service, limited to the first 15 hours or \$825 of services, whichever comes first, provided per calendar year.  Copays are not required when services are provided in a hospital setting.	Covered services include outpatient mental health, outpatient substance abuse (including narcotic treatment), mental health day treatment for adults, substance abuse day treatment for adults and children, and child/adolescent mental health day treatment and inpatient hospital stays for mental health and substance abuse.  \$10 to \$15 copay per visit for all outpatient services: <ul style="list-style-type: none"> <li>• \$10 per day for all day treatment services.</li> <li>• \$15 per visit for narcotic treatment services (no copay for lab tests).</li> <li>• \$15 per visit for outpatient mental health diagnostic interview exam, psychotherapy — individual or group (no copay for electro-convulsive therapy and pharmacological management).</li> <li>• \$15 per visit for outpatient substance abuse services.</li> </ul>

<b>BadgerCare Plus Standard Plan/Medicaid/Well Woman Medicaid</b>	<b>Benchmark Plan</b>
<b>Nursing Home Services</b>	
Full coverage — No copay.	Full coverage for stays at skilled nursing homes limited to 30 days per enrollment year.  No copay.
<b>Physician Services</b>	
Full coverage, including laboratory and radiology.  \$.50 to \$3 copay per service limited to \$30 per provider per calendar year.  No copay for emergency services, anesthesia or clozapine management.	Full coverage, including laboratory and radiology.  \$15 copay per visit.  No copay for emergency services, preventive care, anesthesia or clozapine management.
<b>Podiatry Services</b>	
Full coverage — \$.50 to \$3.00 copay per service; limited to \$30 per provider per calendar year.	Full coverage. \$15 copay per visit.
<b>Prenatal/Maternity Care</b>	
Full coverage, including prenatal care coordination, and preventive mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems.  No copay.	Full coverage, including prenatal care coordination, and preventive mental health and substance abuse screening and counseling for women at risk of mental health or substance abuse problems.  No copay.
<b>Reproductive Health Services — Family Planning Services</b>	
Full coverage with the exceptions listed below (No copay for services provided by a family planning provider.)  Does not cover: <ul style="list-style-type: none"> <li>• Reversal of voluntary sterilization</li> <li>• Infertility treatments</li> <li>• Surrogate parenting and related services, including but not limited to: <ul style="list-style-type: none"> <li>◦ Artificial insemination</li> <li>◦ Obstetrical care</li> <li>◦ Labor or delivery</li> <li>◦ Prescription or over-the-counter drugs</li> </ul> </li> </ul>	Full coverage with the exceptions listed below (No copay for services provided by a family planning provider.)  Does not cover: <ul style="list-style-type: none"> <li>• Reversal of voluntary sterilization</li> <li>• Infertility treatments</li> <li>• Surrogate parenting and related services, including but not limited to: <ul style="list-style-type: none"> <li>◦ Artificial insemination</li> <li>◦ Obstetrical care</li> <li>◦ Labor or delivery</li> <li>◦ Prescription or over-the-counter drugs</li> </ul> </li> </ul>
<b>Routine Vision</b>	
Full coverage including eyeglasses — \$.50 to \$3 copay per service.	One eye exam every two years, with refraction — \$15 copay per visit.

<b>BadgerCare Plus Standard Plan/Medicaid/Well Woman Medicaid</b>	<b>Benchmark Plan</b>
<b>Therapy — Physical Therapy, Occupational Therapy and Speech and Language Pathology</b>	
Full coverage — \$.50 to \$3 copay per service. Copay obligation limited to the first 30 hours or \$1,500, whichever occurs first, during one calendar year (copay limits calculated separately for each discipline).	Coverage limited to 20 visits per therapy type per enrollment year. Covers up to 36 visits per enrollment year for cardiac rehabilitation provided by a physical therapist. Covers up to a maximum of 60 Speech Language Pathology (SLP) visits over a 20-week period following a bone anchored hearing aid or cochlear implant surgeries (members 17 years of age and younger). These SLP services do not count towards the 20-visit limit for SLP.  \$15 copay per visit, per provider.  There are no monthly or annual copay limits.
<b>*Transportation – Ambulance, Specialized Medical Vehicle (SMV), Common Carrier</b>	
Full coverage of emergency and non-emergency transportation to and from a certified provider for a BadgerCare Plus covered service.  <ul style="list-style-type: none"> <li>• \$2 copay for non-emergency ambulance trips.</li> <li>• \$1 copay per trip for transportation by SMV (Specialized Medical Vehicle).</li> <li>• No copay for transportation by common carrier or emergency ambulance.</li> </ul>	Full coverage of emergency and non-emergency transportation to and from a certified provider for a BadgerCare Plus covered service.  <ul style="list-style-type: none"> <li>• \$50 copay per trip for emergency transportation by ambulance.</li> <li>• \$1 copay per trip for transportation by SMV (Specialized Medical Vehicle).</li> <li>• No copay for transportation by common carrier or emergency ambulance.</li> </ul>

## Services Not Covered Under Any Plan

Services or items not covered include (but are not limited to):

- Items such as televisions, radios, lift chairs, air conditioners, and exercise equipment (even if prescribed by a physician),
- Procedures considered experimental or cosmetic in nature, and
- Services that need approval (prior authorization) before you get them.

## \*Non-Emergency Transportation

(to medical services)



**Please Note:** The following is about non-emergency medical transportation. If you have a medical emergency you should call 911.

Non-emergency medical transportation are rides to covered medical appointments such as a doctor or dental appointment.

If you have no other way to get a ride, you can get a ride to services covered for the program you are enrolled in such as Medicaid or BadgerCare Plus.

If neighbors, friends, relatives or voluntary organizations can give you a ride to your appointment, you will not be able to get rides through LogistiCare.

## Who Must Schedule Rides with LogistiCare

LogistiCare will schedule rides to appointment for members enrolled the following programs:

- Wisconsin Medicaid
- BadgerCare Plus Standard
- BadgerCare Plus Benchmark

- Family Planning Only Services
- Tuberculosis-Related Services-Only Benefit
- BadgerCare Plus Express Enrollment for Pregnant Women

If you are enrolled in one of the following programs, non-emergency medical transportation is not covered:

- BadgerCare Plus Core Plan
- BadgerCare Plus Basic Plan
- SeniorCare

You will continue to receive rides as you do now, if you are:

- Enrolled in Family Care, Family Care Partnership or Program of All-Inclusive Care for the Elderly (PACE).
- Residing in a nursing home.



**Please Note:** If you are enrolled in the Core Plan or the Basic Plan **and** Family Planning Only Services, you can get a ride only to services covered under Family Planning Only Services.

### **How to Schedule a Ride**

LogistiCare is available to schedule appointment from 7:00 a.m. and 6:00 p.m. Monday through Friday.

- Call LogistiCare — 1-866-907-1493 or 1-866-288-3133 (TTY)
- Call at least two days before a routine appointment to schedule a ride. If you do not call two days before an appointment, LogistiCare may not be able to provide you a ride and you may have to reschedule your appointment.

If you have an urgent appointment and cannot wait two days to go to an appointment, a ride may be scheduled within three hours.

If you have regularly scheduled appointments three or more times a week, talk with your doctor. Your doctor can work with LogistiCare to schedule these rides.

### **What You Will Need When Asking for a Ride**

You will need the following when you call:

- Your name, street address and phone number.
- Your ForwardHealth member number. (This is the 10-digit number listed on your ForwardHealth card.)

- The street address and the telephone number where you want to be picked up.
- The name, phone number, address and ZIP Code of the doctor or other health care provider with whom you have the appointment.
- The date and time of your appointment.
- Any special transportation needs.
- General reason for the appointment (doctor's visit, check-up, eye appointment, etc.)

If you do not have all of this information when you call, you may not be able to schedule your ride and will have to call LogistiCare back.

At the end of the call, LogistiCare will give you a confirmation number for your ride and tell you when your ride will pick you up.

### **Day of Your Appointment**

You should be ready for your ride at the time you were told your the ride was coming. If you are more than 10 minutes late, you may miss your ride. If you have been waiting for your ride for more than 15 minutes, you should call LogistiCare's "Where's My Ride" number at 1-866-907-1494 or 1-866-288-3133 (TTY). They can tell you when your ride will arrive. You should also call your doctor to let them know you are running late.

You will be asked by the driver to sign a driver log for the trip to your appointment and for the trip home. **Do not** sign the driver log for the trip home until you are returning home.

### **After your Appointment**

Your ride should arrive within 15 minutes, if you scheduled a pick-up time. If you did not schedule a pick up time because you were not sure when your appointment will be over, you can call LogistiCare after the appointment is over and a ride will come to pick you up within one hour.

You will be asked by the driver to sign a driver log for your trip home.

### **Copay for Rides**

If your ride is by special medical vehicle, you will have a \$1 copay, unless you are exempt from copays. You



should not pay for anything else for the ride such as a tip or gas money.

### ***Can I, or My Relative, Get Paid to Drive to me to an Appointment?***

Members will not be paid for driving themselves to a covered medical appointment. Also, friend or family members will not be paid for giving rides to members going to a covered medical appointment.

LogistiCare is required to follow federal and state law and only pay for rides after all other options for free transportation such as family and friends have been exhausted.

### ***Do I Need a Car Seat for My Child?***

Parents/guardians are responsible for providing any car seats or booster seats for the ride. State law require car seats for any children under the age of 4 or for any children who weighs less than 40 pounds. Booster seats are required for children who are under 8 years old, weighs less than 80 pounds, or under 4 feet 9 inches tall. LogistiCare will not provide any car seats or booster seats. If you do not have a car seat or booster seat at the time of your ride for any children that need them, LogistiCare will deny your ride.

### ***What If Someone Else Needs to Come Along?***

No one besides a medically required attendant or a parent accompanying a minor child to the child's appointment is allowed to go along on the ride to an appointment. You can take your own car and request gas money and then you may take an additional passenger. You may also request a bus pass from LogistiCare and the additional rider may purchase their own bus pass and ride along.

### ***Meals and Overnight Stays***

Wisconsin Medicaid and BadgerCare Plus have rules for when members can get payment for meals and overnight stays when you travel by non-emergency medical transportation to covered appointments.

### ***Rules for Meals and Overnight Stays***

- You may be paid for one meal if you are going to a covered service and have to be away from home for at least four hours and are traveling at least 100 miles one way.

- You may be paid for two meals if you are going to a covered service and have to be away from home for at least eight hours and are traveling at least 100 miles one way.
- You may be paid for two meals and one overnight stay if you are going to a covered service and have to be away from home for at least eight hours and are traveling at least 200 miles one way.

If you are going to a covered appointment and need to be away from home for more than one night, you should talk with LogistiCare about what meals and overnight stays you can get paid for.

Medically required attendants may be allowed the same meal and overnight stay payment as you are. An attendant could be someone in your family.

### ***Asking for Meals and Overnight Stays***

While you are scheduling your ride, ask if you meet the rules for payment of your meals or overnight stays.

LogistiCare will pay you up to \$10 per meal if you meet the payment rules. You need to keep receipts for all your meals and mail them to LogistiCare with a form. Once LogistiCare receives your receipts and form, they will send you a check for the amount you spent on your meal or up to \$10 per meal, whichever is less. LogistiCare will arrange any required overnight stays. LogistiCare will not pay for any alcohol or recreational activities.

If you are cannot pay for your overnight stay at the time of your appointment, LogistiCare will arrange and pay for it for you. If you are unable to pay for your meals at the time of your appointment, LogistiCare will pre-pay for your meal at locations where this is possible, such as a hospital cafeteria.

### ***Payment for Meals and Overnight Stays***

You will need to work with LogistiCare, if you are enrolled in any of the following Wisconsin health care programs:

- Medicaid
- BadgerCare Plus Standard Plan
- BadgerCare Plus Benchmark Plan
- Family Planning Only Services

- Tuberculosis-Related Services-Only Benefit
- BadgerCare Plus Express Enrollment for Pregnant Women.


The rules about meals and overnight stay limits does not apply to the following members and you can receive your rides as you do now:

- Members who live in a nursing home.
- Members enrolled in Family Care, Family Care Partnership or Program of the All-Inclusive Care for the Elderly (PACE).

If you are enrolled in one of the following programs, non-emergency medical transportation as well as meals and overnight stays are not covered:

- BadgerCare Plus Core Plan.
- BadgerCare Plus Basic Plan.
- SeniorCare.

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 **Please Note:** If you are enrolled in the Core Plan or the Basic Plan and Family Planning Only Services, you can get a ride only to services and get payment for meals and overnight stays to services covered by Family Planning Only Services.

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### **Complaint Process**

If you have a complaint about the service provided to you by LogistiCare, you may file a complaint. Complaints may be about, but is not limited to:

- Having a hard time getting a ride,
- Long waiting times, or
- Rude drivers.

You can call LogistiCare at 1-866-907-1494 or 1-866-288-3133 (TTY). You may also write to LogistiCare at:

LogistiCare Solutions, LLC  
2335 City View Dr Ste 200  
Madison WI 53718

LogistiCare will get back to you with an initial response within 10 business days. A final response will be sent to you in writing within 30 business days of receiving a complaint.

If you do not agree with the decision you get from LogistiCare, you may appeal to the LogistiCare Ombudsmen.



**Please Note:** You have the right to appeal denials of rides by LogistiCare to the Department of Health Services.

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If you have filed a complaint with LogistiCare and the LogistiCare Ombudsman but you are still not satisfied with their decision, you may file a complaint with the State of Wisconsin, by writing to:

Department of Health Services  
Attn: Medicaid Transportation Analyst  
P.O. Box 309  
Madison WI, 53701-0309

Or, by calling Member Services at 1-800-362-3002.

### **HealthCheck**

HealthCheck is a preventive health check-up plan for anyone under the age of 21 who is currently enrolled in BadgerCare Plus or Medicaid.

HealthCheck providers will teach you and your child how to lower the risk of serious illness and help find health problems early, before they get worse. HealthCheck meets the physical exam rules for Head Start, Child Care, WIC and school physicals. Your child may also be able to get certain services not normally paid for by BadgerCare Plus through a HealthCheck exam.

Call 1-800-722-2295 (toll free) to find your HealthCheck provider. If you are enrolled in a Medicaid or BadgerCare Plus HMO, call them for information on HealthCheck services.

### **Other Programs**

#### **FoodShare Employment and Training Program (FSET)**

FSET offers FoodShare members free services to build job skills and find employment. If you need help finding a job or if you are currently working and want to increase your skills, FSET may be able to help you.

You can get help with your resume, interview skills and job leads through the FSET program. You may also be able to get help with taking classes needed for a GED

or ESL, transportation and child care while you look for a job, go to training or go to school may be covered through FSET.

Ask your agency about the FSET services available in your area. FSET is a voluntary program. You can keep your FoodShare benefits even if you decide to end FSET services.

### ***Caretaker Supplement (CTS)***

This program is a cash benefit for parents who are eligible for Supplemental Security Income (SSI) payments and who are living with and caring for their minor children. The Caretaker Supplement benefit amounts are \$250 per month for the first eligible child and \$150 per month for each additional eligible child.

### ***Women, Infant and Children Program (WIC)***

If you are able to enroll in FoodShare, you may also be able to get WIC (a special supplemental food program for Women, Infants and Children). Young children and pregnant women may get nutritious food and nutrition and health counseling.

To find out more about WIC and other programs, go to [dhs.wi.gov/wic](https://dhs.wi.gov/wic) or [ACCESS.wi.gov](https://ACCESS.wi.gov) or call 1-800-722-2295.

### ***Job Center of Wisconsin***

Job Center of Wisconsin is available to you. Job Center is the largest source of job openings in Wisconsin. You can visit the Job Center website at [jobcenterofwisconsin.com](https://jobcenterofwisconsin.com). Or, you can use touch-screen computers at your local Job Center.

To find a Job Center near you, call 1-888-258-9966.

## **Discrimination**

In accordance with Federal law and U.S. Department of Agriculture (USDA) and U.S. Department of Health and Human Services (HHS) policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, or disability. Under the Food Stamp Act and USDA policy, discrimination is prohibited also on the basis of religion or political beliefs.

To file a complaint of discrimination, for health care or FoodShare, contact:

Wisconsin Department of Health Services  
Affirmative Action/Civil Rights Compliance  
1 W. Wilson, Room 555  
Madison, WI 53707-7850  
Phone: (608) 266-9372 (voice)  
1-888-701-1251 (TTY)

Or, for FoodShare,

USDA, Director,  
Office of Adjudication  
1400 Independence Avenue, SW  
Washington, D.C. 20250-9410  
Phone: 1-800-795-3272 or  
1-866-632-9992 (toll free, voice)

Individuals who are hearing impaired or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339 or (800) 845-6136 (Spanish).

Or, for health care,

HHS, Director, Office for Civil Rights,  
Room 506-F  
200 Independence Avenue, S.W.  
Washington, D.C. 20201  
Phone: (202) 619-0403 (voice) or  
(202) 619-3257 (TTY).

USDA, HHS and DHS are equal opportunity providers and employers. For civil rights questions, call (608) 266-9372 (voice) or 1-888-701-1251 (TTY).

If you have a disability and need this information in a different format, or need it translated to another language, please contact (608) 266-3356.



State of Wisconsin  
Department of Health Services  
Division of Health Care Access and Accountability

P-00079 (12/12)