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[REDACTED]

**STATE OF WISCONSIN**  
**Division of Hearings and Appeals**

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In the Matter of

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

**DECISION**  
Case #: CWA - 220703

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**PRELIMINARY RECITALS**

A petition was filed on November 3, 2025, under Wis. Admin. Code § HA 3.03, to review a decision by the Milwaukee Enrollment Services regarding Medical Assistance (MA). The hearing was initially scheduled for December 3, 2025, but was rescheduled at the request of the petitioner's representative. The hearing was then held on December 17, 2025, by telephone.

The issue for determination is whether the agency correctly denied the petitioner's application for Medicaid community waivers on September 25 and October 4, 2025.

There appeared at that time the following persons:

**PARTIES IN INTEREST:**

Petitioner:

[REDACTED]  
[REDACTED]  
[REDACTED]  
[REDACTED]

Respondent:

Department of Health Services  
201 E. Washington Ave.  
Madison, WI 53703

By: Stacy Green  
Milwaukee Enrollment Services  
6055 N. 64th Street  
Milwaukee, WI 53218

**ADMINISTRATIVE LAW JUDGE:**

Kate J. Schilling  
Division of Hearings and Appeals

**FINDINGS OF FACT**

1. Petitioner (CARES # [REDACTED]) is a 94 year old resident of Milwaukee County who lives in a CBRF.
2. On August 8, 2025, the petitioner applied for Medicaid community waivers. Her application indicated that she had 5 sources of income which totaled \$5,631.75 net income per month ([REDACTED] \$175, [REDACTED] [REDACTED] \$92.50, Social Security \$1,793, [REDACTED] \$546, [REDACTED] \$185.25, Employee Trust Fund \$2,840). In addition, the petitioner listed that she had bank accounts and a burial fund.
3. On August 21, 2025, the agency requested verification of the income from the 5 pensions, checking accounts, and burial assets, with a due date of September 8, 2025.
4. On September 2, 2025, the agency extended the due date for verifications to September 15, 2025. A notice reflecting the extended due date was sent out on September 3, 2025.
5. On September 13, 2025, the petitioner's representative requested an extension of time to obtain verifications. The agency agreed to extend the verification deadline to September 30, 2025.
6. On September 15, 2025, the agency processed verification documents from the petitioner's representative. These documents referred to a new, additional bank account that the agency was not previously aware of, as well as a letter from the petitioner's representative explaining that the petitioner had purchased 6 burial assets for her adult children (\$5,500 each).
7. On September 16, 2025, the agency sent out a request for verification of the new bank account, burial assets, and the 5 sources of pension income. The verifications were due September 30, 2025.
8. On September 24, 2025, the petitioner's representative submitted verification documents to the agency. The agency worker reviewed the bank statements, burial asset statements of goods and services, and proof of payments made from the petitioner's bank account that were for her room and board. The agency determined that the petitioner was over the \$2,000 asset limit for Medicaid, and had not sent in verification of the 5 sources of pension income.
9. On September 25, 2025, the agency denied the petitioner's Medicaid application due to lack of verification of pension income and being over the \$2,000 asset limit.
10. On September 26, 2025, the agency sent a request for verification notice to the petitioner requesting verification of signed funeral documents, copies of contracts with [REDACTED] and [REDACTED], and verification of the 5 income pensions.
11. On September 30, 2025, the agency received verification of burial assets, updated bank account information, and verification of a payment by the petitioner to the IRS for a \$10,000 tax penalty. However, no verifications of the pension income were received.
12. On October 4, 2025, the agency sent a notice to the petitioner stating that her application for Medicaid community waivers was denied for failure to verify her pension income.

## DISCUSSION

The petitioner applied for Medicaid community waivers. Given that she is living in a CBRF, the only long-term care program the petitioner is eligible for is FamilyCare. (Institutional Medicaid requires a person to be living in a skilled nursing facility/nursing home; individuals living in an assisted living facility or community based residential facility are not eligible for IRIS.) The Family Care Program is a Medical Assistance home and community based waiver program designed to provide long-term care services for individuals with physical and developmental disabilities and older adults individuals through a managed care service delivery model. See Wis. Stat. §46.286, Wis. Admin. Code ch. DHS 10, Family Care 1915(b) Waiver, and Family Care 1915(c) Home and Community-Based Services Waiver. The Department of Health Services (“the Department”) contracts with managed care organizations (MCOs) throughout the state to provide services to Family Care members. See the Family Care / Partnership 2025 Contract (available online at <https://www.dhs.wisconsin.gov/familycare/mcos/contract.htm>).

To be eligible for Family Care, a person must apply for benefits and meet the program’s financial, non-financial, and functional criteria. Wis. Stat. §46.286(1); Wis. Admin. Code §§ DHS 10.32(1)(d) and (e). The Aging and Disability Resource Centers (ADRCs) complete the functional screen, and the Income Maintenance (“IM”) agencies determine financial and non-financial eligibility. Wis. Admin. Code §10.31(4)(a). However, a person who meets all of the program eligibility criteria is not entitled to receive benefits until he is enrolled in a managed care organization (MCO). See Wis. Stat. §46.286 (“A person is eligible for, but not necessarily entitled to, the FamilyCare benefit if [the person satisfies all eligibility criteria]”), Wis. Admin. Code § DHS 10.36(1), and Wis. Admin. Code § DHS 10.41(1). In other words, an individual cannot begin to actually receive FamilyCare benefits until s/he is enrolled in a managed care organization and s/he cannot be enrolled in a managed care organization until s/he is found eligible for Medicaid. If a person loses Medicaid financial eligibility, they will consequently be disenrolled from FamilyCare.

At the hearing, the agency representative testified that eligibility was initially denied on September 25, 2025, due to lack of verification of income as well as being over the \$2,000 asset limit. The petitioner’s representative subsequently provided additional verification documents reflecting that the bank account had been further spent down by paying the petitioner’s outstanding room and board balance to her CBRF, paying her \$10,000 tax bill to the IRS, and setting up prepaid burial funds for her adult children. On October 4, 2025, the agency sent out a notice of denial indicating that the petitioner was no longer over the asset limit; however, her application for Medicaid community waivers was being denied due to the lack of verification of her gross income from her 5 pensions.

The facts of this case are largely undisputed. The petitioner’s representative and power of attorney had provided a significant amount of documentation to the agency regarding the petitioner’s assets and expenditures. However, the petitioner had not submitted verification of her 5 sources of income.

The agency is required to verify certain components of a Medicaid application.

### 20.3.1 Mandatory Verification Items Introduction

The following items must be verified for Medicaid:

- SSN (see [Section 10.1 SSN Requirements](#))
- U.S. citizenship (see [Section 7.2 Verifying U.S. Citizenship](#))
- Immigrant status (see [Section 7.3.2 Verification](#))
- Disability (see [Section 5.2 Determination of Disability](#))
- **Income** (see [Section 15.1 Income Introduction](#))
- **Assets** (see [Section 16.1 Assets Introduction](#))

- **Divestment, for Medicaid long-term care programs** (see [Chapter 17 Divestment](#))

\* \* \*

(Emphasis added.) *MA Handbook* §20.3.1. A person's income and assets, including burial assets, are mandatory verification items at the time of a Medicaid application and at annual renewals. Additionally, non-routine expenditures from a bank account that may signify a divestment are mandatory verification items as well. The Medicaid program requires that agencies use gross income for eligibility determinations.

15.1.6 Countable Income

Countable income is the prospective gross monthly amount used in the eligibility determination and post-eligibility calculations.

*MA Handbook* § 15.1.6. The gross monthly income must be verified before deductions such as taxes, garnishments, or Medicare premiums are taken out. For this reason, bank statements reflecting monthly income deposits are insufficient verification.

In this case, the petitioner had income from 5 different sources. The agency requested verification of these pensions on multiple occasions. The petitioner's representative provided verifications of assets to the agency on multiple occasions; however, none of those documents provided verifications of the petitioner's income. For that reason, the IM agency could not complete processing the petitioner's Medicaid community waivers application, and properly denied it on September 25, 2025, and October 4, 2025.

The decisions relating to the petitioner's application for a Medicare Savings Program and Medicaid are in MQB 220702 and CWA 220701, respectively.

**CONCLUSIONS OF LAW**

The agency correctly denied the petitioner's application for Medicaid community waivers due to failure to provide gross income verification.

**THEREFORE, it is**

**ORDERED**

That this appeal is hereby dismissed.

**REQUEST FOR A REHEARING**

You may request a rehearing if you think this decision is based on a serious mistake in the facts or the law or if you have found new evidence that would change the decision. Your request must be **received within 20 days after the date of this decision**. Late requests cannot be granted.

Send your request for rehearing in writing to the Division of Hearings and Appeals, 4822 Madison Yards Way, 5<sup>th</sup> Floor North, Madison, WI 53705-5400 **and** to those identified in this decision as "PARTIES IN INTEREST." Your rehearing request must explain what mistake the Administrative Law Judge made and why it is important or you must describe your new evidence and explain why you did not have it at your first hearing. If your request does not explain these things, it will be denied.

The process for requesting a rehearing may be found at Wis. Stat. § 227.49. A copy of the statutes may be found online or at your local library or courthouse.

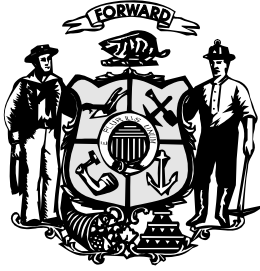
### **APPEAL TO COURT**

You may also appeal this decision to Circuit Court in the county where you live. Appeals must be filed with the Court **and** served either personally or by certified mail on the Secretary of the Department of Health Services, 201 E. Washington Ave., **and** on those identified in this decision as “PARTIES IN INTEREST” **no more than 30 days after the date of this decision** or 30 days after a denial of a timely rehearing (if you request one).

The process for Circuit Court Appeals may be found at Wis. Stat. §§ 227.52 and 227.53. A copy of the statutes may be found online or at your local library or courthouse.

Given under my hand at the City of Madison,  
Wisconsin, this 3rd day of February, 2026

\s \_\_\_\_\_  
Kate J. Schilling  
Administrative Law Judge  
Division of Hearings and Appeals



**State of Wisconsin\DIVISION OF HEARINGS AND APPEALS**

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The preceding decision was sent to the following parties on February 3, 2026.

Milwaukee Enrollment Services  
Bureau of Long-Term Support