



STATE OF WISCONSIN  
Division of Hearings and Appeals

In the Matter of

[Redacted]

DECISION

FCP/162467

**PRELIMINARY RECITALS**

Pursuant to a petition filed December 05, 2014, under Wis. Admin. Code § DHS 10.55, to review a decision by the Waukesha County Health and Human Services in regard to Medical Assistance, a hearing was held on January 20, 2015, at Waukesha, Wisconsin.

The issue for determination is whether the agency used the correct asset assessment date to determine the Petitioner's eligibility for Family Care.

There appeared at that time and place the following persons:

**PARTIES IN INTEREST:**

Petitioner:

[Redacted]

Petitioner's Representative:

[Redacted]

Respondent:

Department of Health Services  
1 West Wilson Street, Room 651  
Madison, Wisconsin 53703

By: Julie Miller

Waukesha County Health and Human Services  
514 Riverview Avenue  
Waukesha, WI 53188

**ADMINISTRATIVE LAW JUDGE:**

Debra Bursinger  
Division of Hearings and Appeals

**FINDINGS OF FACT**

1. Petitioner (CARES # [Redacted]) is a resident of Waukesha County. He resides in an assisted living facility.

2. The Petitioner was hospitalized from February 27, 2014 – March 1, 2014 and from March 29, 2014 – April 4, 2014.
3. On March 25, 2014, a Long Term Care Functional Screen (LTCFS) was completed for the Petitioner. The Petitioner's wife and an ADRC Specialist discussed and signed a Care Coordination Plan. It indicates that the ADRC Specialist discussed Options Counseling and Medicaid/T-19 with the Petitioner's wife and that the LTCFS was completed. The notes of the screener state: "While [Petitioner] and [Petitioner's wife] could greatly benefit from [Petitioner] receiving support of Family Care, [Petitioner's wife] is simply not sure about applying for T-19. Advised her to seek legal counsel re: spousal impoverishment and to contact our dept in the future should she decide to seek this support." The screener found that the Petitioner met the Level of Care requirements for Family Care eligibility on March 25, 2014.
4. Between March 25, 2014 and August 19, 2014, neither the Petitioner nor the ADRC contacted the income maintenance agency about financial eligibility or to request Family Care or Medicaid enrollment for the Petitioner.
5. On August 1, 2014, a Medicaid application was submitted to the agency on Petitioner's behalf.
6. On August 19, 2014, a Family Care application was submitted on Petitioner's behalf. The requested date of enrollment was August 1, 2014. A LTCFS was submitted on August 26, 2014 with a screening date of August 26, 2014. The LTCFS reported Petitioner was functionally eligible for Family Care. The March 25, 2014 LTCFS was not submitted with the application to the income maintenance agency.
7. On August 26, 2014, a Notice of Proof Needed was issued to the Petitioner's wife with a due date of September 19, 2014 for the proof. Numerous items were requested for the agency to verify the Petitioner's financial eligibility.
8. On September 19, 2014, a Notice of Decision was issued to the Petitioner's wife informing her that the Petitioner's Medicaid application was denied effective August 1, 2014 due to assets over the program limit. It also informed her that the Family Care application was denied effective September 1, 2014 due to failure to provide requested proof and assets over the program limit.
9. On October 9, 2014, the agency received all verifications that had been requested. The agency completed and issued a Community Spouse Asset Share Notice indicating that combined countable assets of Petitioner and his wife were \$96,809.12 as of August 1, 2014.
10. On October 10, 2014, numerous notices with Information about Community Spouse Asset Share Calculation were issued to Petitioner's representatives. A number of these notices were inaccurate.
11. On October 23, 2014, a second MA application was submitted. The LTCFS dated March 25, 2014 was submitted with this application. The LCTFS from March 25, 2014 expired on September 26, 2014.
12. On November 6, 2014, a Notice of Proof Needed was issued to the Petitioner's representative requesting completion of the Medicaid application. The notice also indicates that a new request for Family Care must originate with the ADRC because the original Family Care application is more than 30 days old and was denied.
13. On November 21, 2014, the agency issued a notice to the Petitioner informing him that it was unable to process his MA application received November 17, 2014 due to invalid signature date, and expiration of the Level of Care determination.
14. On December 4, 2014, the agency issued a Notice of Decision to the Petitioner's representatives informing the Petitioner that the application for Medicaid was denied on August 1, 2014 due to assets and income over the program limit. The notice also informed the Petitioner that Family Care was denied effective September 1, 2014 due to income over the program limit.

## DISCUSSION

The Family Care program, which is supervised by the Department of Health Services, is designed to provide appropriate long-term care services for elderly or disabled adults. It is authorized under Wisconsin Statute, §46.286, and is described comprehensively in the Wisconsin Administrative Code, Chapter DHS 10. See also Medicaid Eligibility Handbook (MEH), Chapter 29.

The issue in this case is whether the agency properly determined the Petitioner was over the asset limit for purposes of eligibility. Specifically, the agency determined the Petitioner's assets using a date of August 18, 2014 after the agency received the Petitioner's application and Level of Care determination dated August 26, 2014. The Petitioner argues that the agency should have used March 25, 2014 as the asset assessment date based on the Petitioner's Level of Care determination completed that day. The Petitioner relies on the following language in MEH, §18.4.2:

“The IM Agency must make an assessment of the total countable assets of the couple at the:

1. Beginning of the person's first continuous period of institutionalization of 30 days or more, or
2. Date of the first request for community waivers, whichever is earlier.”

The Petitioner contends that the Level of Care determination done on March 25, 2014 was a request for community waivers. Therefore, he argues the agency do an asset assessment on March 25, 2014 because this was the date of his first request for community waivers. I note that the Petitioner did not dispute the accuracy of the asset assessment done for August, 2014; rather, the issue was presented as a dispute regarding the proper date of the asset assessment.

The agency asserts that a Level of Care determination is done by the ADRC to determine whether a particular individual meets the Level of Care requirements for the Family Care program but the Level of Care assessment is not, by itself, a request by an individual for community waivers. It argues that the application the agency received in August, 2014 with the Level of Care determination dated August 26, 2014 was the Petitioner's first request for community waivers. Though the agency received a second application on October 23, 2014 with the Level of Care determination from March 25, 2014, the Level of Care determination had expired on September 26, 2014. Also, the agency asserts that the first request for waivers remained as August 26, 2014 when the original FC application was received.

DHS explains the process for requesting Family Care as follows:

There are three steps to determine eligibility and enrollment in a Family Care MCO. The ADRC helps people with each step.

1. The ADRC will visit the person and complete the Long-Term Care Functional Screen to assess the person's level of need for services and functional eligibility for the Family Care benefit. ***Once the individual's particular needs for long-term care are determined, the ADRC will provide advice about the options available to him or her.*** Options may include enrollment in Family Care, Partnership, IRIS or a different long-term care program. Or the person could choose to receive services through the Medicaid fee-for-service system, or to privately pay for services.

*2. If the person is interested in Family Care or another Medicaid program, the ADRC will help the person contact an income maintenance agency to determine financial eligibility.*

3. Once functional and financial eligibility is established, the ADRC notifies an "enrollment consultant" to contact the person, either by phone or in person. The enrollment consultant makes sure the person understands what it means to become a member of the MCO, and that he or she understands all the options for long-term care available. If the person decides on Family Care, the resource center finishes the enrollment process and notifies the MCO of the enrollment date.

<https://www.dhs.wisconsin.gov/familycare/apply.htm> (Emphasis added).

On March 25, 2014, the ADRC completed Step #1 above by visiting the Petitioner and completing the LTCFS. The ADRC also advised the Petitioner's wife of her options. The evidence establishes that, at that time, the Petitioner's wife was unsure about what option to pursue. The notes from the ADRC Specialist indicate that she advised the Petitioner's wife that while she and her husband could "greatly benefit from [Petitioner] receiving support of Family Care, [Petitioner's wife] is simply not sure about applying to T-19." The specialist advised her to seek legal counsel "and contact our dept in the future should she decide to seek this support." The testimony of the Petitioner's wife at the hearing is consistent with these notes. She testified that she was told at the time of the LTCFS that the Petitioner was functionally eligible and she could apply but she wanted to wait. She waited until August, 2014 to indicate an interest by submitting an application to the income maintenance agency.

The agency representative testified that the income maintenance agency receives a referral from the ADRC when an individual completes an application. The Level of Care determination accompanies the referral and application. In this case, a Level of Care determination dated August 26, 2014 accompanied the referral and application. Therefore, the agency completed the asset assessment based on the August, 2014 referral, application and level of care determination. In October, 2014, the Petitioner submitted a second MA application with the March 25, 2014 Level of Care determination. However, there still was no request made or application submitted to the income maintenance agency until August, 2014.

Based on the evidence, I conclude there was no request by Petitioner or his wife for Family Care or Medicaid on March 25, 2014. The Petitioner's wife specifically indicated on March 25, 2014 that she was unsure about whether she wanted to apply for Family Care or Medicaid. No referral or information or request or application was submitted to the income maintenance agency at that time. A level of care determination, by itself, is insufficient to constitute a request for enrollment in a waiver program.

I further note that although an asset assessment may be completed at any time it is requested, it must also be completed when the institutionalized person or his/her spouse applies for MA in order to get the most current asset share. See Wis. Stats. §49.455(5)(a)2, MEH, §§18.4.2 and 18.4.4. There was no specific request by the Petitioner or his wife on March 25, 2014 or at any time before the application was submitted in August, 2014 for an asset assessment.

### **CONCLUSIONS OF LAW**

The agency properly used an asset assessment date of August 19, 2014 in determining the Petitioner's eligibility.

**THEREFORE, it is**

**ORDERED**

That the Petitioner's appeal is 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, 5005 University Avenue, Suite 201, 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, 1 West Wilson Street, Room 651, Madison, Wisconsin 53703, **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 Milwaukee,  
Wisconsin, this 23rd day of February, 2015

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\sDebra Bursinger  
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 23, 2015.

Waukesha County Health and Human Services  
Office of Family Care Expansion  
Attorney Patrick Schultz