Who can get coverage?

BadgerCare is a Wisconsin Medicaid Program that provides affordable health care for Wisconsin’s low- to moderate-income families with children. BadgerCare provides coverage for:

- families who do not have health insurance;
- families who can’t afford to purchase health insurance;
- families who are working in a job where family health insurance coverage is not offered; or
- families who experience a temporary job layoff or job loss.

**Note:** Parents in BadgerCare families do not have to be employed to qualify for coverage.

The following is a list of people that can get coverage through BadgerCare:

- children under the age of 19 (marital status does not affect eligibility);
- a natural or adoptive parent with a child under age 19 living in the household;
- spouses of parents with a child under 19 living in the household (stepparent);
- a non-marital co-parent with a child under 19 living in the household; and
- a family who is not currently covered by a comprehensive healthcare plan.

**Note:** You must be a U.S. citizen to qualify for BadgerCare.

Insurance coverage and access to health care coverage have very complicated rules that can affect BadgerCare eligibility. Please call ABC for Health at 1-800-585-4222 to talk with a Health Benefits Counselor about what effect private insurance may have on eligibility.

Are there income limits?

To qualify for BadgerCare, a family must be below 185% Federal Poverty Level (FPL). There are specific deductions that a family is allowed to take from household income that will lower a family’s countable income and increase the chance that they will be found eligible for BadgerCare. Once a family is in the BadgerCare program, they can keep coverage until their income goes over 200% FPL (see chart). There is no asset test for BadgerCare.

<table>
<thead>
<tr>
<th>Family Size</th>
<th>150%</th>
<th>185%</th>
<th>200%</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>$1492</td>
<td>$1840</td>
<td>$1990</td>
</tr>
<tr>
<td>3</td>
<td>$1877</td>
<td>$2315</td>
<td>$2503</td>
</tr>
<tr>
<td>4</td>
<td>$2262</td>
<td>$2790</td>
<td>$3016</td>
</tr>
<tr>
<td>5</td>
<td>$2647</td>
<td>$3265</td>
<td>$3530</td>
</tr>
<tr>
<td>6</td>
<td>$3032</td>
<td>$3740</td>
<td>$4043</td>
</tr>
</tbody>
</table>
There is no three-month backdated coverage in the BadgerCare program. Therefore, it is very important that a family submit a BadgerCare application as soon as possible. Always turn in the application before the end of the current month. Eligibility for BadgerCare coverage will begin the first day of the month that the family is found eligible for coverage.

If a BadgerCare family has an income between 150-200% FPL, they will be required to pay a modest premium for BadgerCare. Premiums for many families range from $30-45 per month.

Applying for coverage
Applicants must be prepared to provide information about his or her and the children’s:

- Social Security Numbers;
- dates of birth;
- monthly income and sources of this income; and
- recent or current private health insurance coverage.

Steps for applying
- Complete the Family Medicaid/BadgerCare Application. Mail, fax or deliver the application (applications can be taken over the phone, but the date of eligibility will be determined based on when the signed application is received at the county human or social service department, not the date of the phone request).
- An individual or family can also apply in person at their county/tribal human or social service department, W-2 agency or Medicaid outstation site. Contact your local human or social service department for details.

What services are covered?
BadgerCare provides comprehensive coverage for a wide range of medical services. Some examples include: doctor visits, hospitalization costs, prescription drugs, ambulance charges, emergency medical care, dental and vision care, therapies, and counseling services.

For help with coverage questions, call 1-800-585-4222 statewide / 261-6939 in Madison
ABC for Health provides free health benefits counseling to families anywhere in Wisconsin. Benefits advocates will talk with you about health coverage options.
Who can get coverage?
Healthy Start provides payment of health care costs for:

- pregnant women;
- newborns (a child born to a mother on Healthy Start or any other Medicaid category will be continuously eligible for his or her first 12 months regardless of income; however, parents must report the birth of the child to their economic support worker);
- children up to age six; and
- children age 6 to 19 (children in this category must meet stricter income eligibility requirements. For more coverage options for children in this age group see the BadgerCare fact sheet).

Are there income limits?
- Pregnant women and children under age 6 must have an income at or below 185% FPL.
- Children ages 6 to 19 must have an income at or below 100% FPL (see chart).

For pregnant women, the fetus is counted for the purpose of income eligibility. For example, a pregnant woman with no other children is a family of two and must have a monthly income at or below $1,789.

Additional methods of income eligibility calculations exist that make these income guidelines more generous. For more information see the Medicaid Deductible and Family Fiscal Unit fact sheets.

There is no asset test for Healthy Start and eligibility may be backdated to include up to three months preceding the month of application.

Applying for coverage
Applicants must be prepared to provide information about his or her and the children’s:

- monthly income;
- Social Security Number;
- date of birth; and
- verification of pregnancy (a woman must provide written verification, signed by a medical provider that includes the expected due date and the number of fetuses).

Steps for applying
- Complete the Family Medicaid/BadgerCare Application.
Mail, fax or deliver the application (applications can be taken over the phone, but the date of eligibility will be determined based on when the signed application is received at the county human or social service department, not the date of the phone request).

An individual or family can also apply in person at their county/tribal human or social service department, W-2 agency or Medicaid outstation site. Contact your local human or social service department for details.

Advocacy Tip: Always apply before the end of the month to gain the most benefits possible.

Waiver provisions for pregnant women and children

Pregnant women applying for Healthy Start will be asked to provide contact information for the baby’s father. There are specific circumstances under which the pregnant woman does not have to answer these questions.

- Coverage for a pregnant woman or child cannot be denied if the applicant does not provide the contact information for the absent parent to the county child support office. A pregnant woman will remain covered until the last day of the month 60 days after the birth of the baby. After the Healthy Start coverage ends, the woman will not be eligible for any other Medicaid program if she does not provide the contact information for the absent parent, however, her child will remain eligible.

- If the pregnant woman does not know where the father currently resides and does not have contact information for him, the pregnant woman cannot be penalized unless it is proven that the pregnant woman is not cooperating (such as concealing the father’s location).

- The pregnant woman cannot be penalized for not providing absent parent information if she does not know who is the father of the child.

- If there is an abusive relationship that physically or emotionally threatens the pregnant woman applying for Healthy Start or her children, a waiver can be requested so that the contact information for the absent parent does not have to be provided. A form will be sent to the pregnant woman from the child support office in her county. She must complete this form and return it, and a decision will be made as to whether or not the circumstances meet the waiver criteria. Documentation that will be accepted includes: police or hospital records, shelter records, a statement from a physician or nurse, counselor/social worker or member of the clergy, family member or friend, that documents the abusive relationship.

What services are covered?

Healthy Start pays for doctor visits, hospital costs, prescription drugs, delivery costs, medical, dental, vision and counseling services for pregnant women, newborns and children up to age 19. For pregnant women, Healthy Start coverage ends on the last day of the month 60 days after the birth of the baby.

For help with coverage questions, call 1-800-585-4222 statewide / 261-6939 in Madison

ABC for Health provides free health benefits counseling to families anywhere in Wisconsin. Benefits advocates will talk with you about health coverage options.
Who can get coverage?

Presumptive Eligibility provides pregnant women immediate payment for pregnancy-related, ambulatory health care services.

Note: You must be a U.S. citizen to qualify for Presumptive Eligibility.

Are there income limits?

A pregnant woman is eligible for Presumptive Eligibility if her household income is at or below 185% FPL. However, if the pregnant woman is living with someone who is not legally responsible for her, that person’s income does not count (i.e. her boyfriend). There is no asset test for Presumptive Eligibility. Eligibility determinations are based on pregnancy and income only.

For pregnant women, the fetus is counted for the purpose of income eligibility. For example, a pregnant woman with no other children is a family of two and must have an income at or below $1,789 per month (see chart).

Applying for coverage

The pregnant woman must provide written verification of her pregnancy. She needs to have a written statement signed by a medical provider that includes her expected due date and the number of fetuses she is carrying. A temporary Medicaid card will be provided immediately at the Presumptive Eligibility site.

Pregnant women must apply in person at a certified Presumptive Eligibility application site. Application sites may include:

- public health departments;
- medical clinics;
- hospitals; or
- county/tribal human or social service departments.

Call your local human or social service department for information about Presumptive Eligibility certified application sites in your area.
Presumptive Eligibility coverage is valid for 30 days. If the 30 days goes into the next month, coverage is valid until the end of that month. A pregnant woman may re-apply for additional Presumptive Eligibility coverage through the duration of the pregnancy.

What services are covered?
The Presumptive Eligibility Medicaid card will pay for ambulatory, pregnancy-related health care needs which may include medical, pharmacy, counseling and any other health care services that would have a direct affect on the health of the fetus.

Presumptive Eligibility will not cover hospital bills related to the birth of the baby.

Advocacy tip
Presumptive Eligibility can give a pregnant woman immediate coverage, however the woman should apply for Healthy Start while being covered by Presumptive Eligibility for two reasons:

- Healthy Start will cover the hospital bills for the birth of the baby; and
- Newborns born to mothers on Healthy Start or any other Medicaid category are eligible for a 12-month continuous eligibility extension if the mother reports the birth to her economic support worker (see Healthy Start fact sheet for more information).
What are lying-in costs?

Lying-in costs is the term used to describe medical bills incurred by a woman while giving birth to a child at the hospital (these are sometimes called “birthing costs”). Lying-in costs apply only to women whose birthing costs are paid by the Medicaid program. They include room costs, delivery costs, prescription drug costs and charges for food. County child support enforcement officers may get a court-ordered judgment to collect lying-in costs from the fathers of these newborns if the parents are not married at the time of application or delivery.

How are lying-in costs assessed?

The method of determining who will pay lying-in costs and what amount those lying-in costs will be varies from county to county. Federal law restricts recovery of lying-in costs to the amount Medicaid paid for the cost of pregnancy and delivery. The actual amount will depend on several factors:

- if the delivery was uncomplicated, caesarean section or had other complications;
- whether or not the mother was a member of a Medicaid HMO; and
- some counties include charges for infants that require neo-natal care.

Local child support agencies can provide more information specific to their agency’s policies regarding collecting lying-in costs. The child support office should also have information about the amount of lying-in costs that will have to be paid. This amount will be based on whether or not the woman had a fee-for-service Medicaid card or if she was in an HMO at the time she gave birth.

For more information contact your local child support agency. A list of local child support agencies is available at http://www.dwd.state.wi.us/bcs/cslist.htm.

Exception to paying lying-in costs

An exception to the requirement that an unmarried father repay lying-in costs is when the couple already has an older child together and the father’s income is taken into consideration when the woman applied for Medicaid. A father does not have to repay lying-in costs while his income is below the income guidelines for Healthy Start. He will have to begin paying these costs if his income goes above the Healthy Start limit.
What effect do lying-in costs have on pregnant women?

Women may be reluctant to apply for Medicaid because of lying-in costs. However, they should be reminded that if they have no insurance, they may be held responsible for the cost of their care when the baby is born. If they have a high-risk pregnancy or complications during delivery, the cost of care for these problems will be much higher than the repayment of lying-in costs by the baby's father. (See Healthy Start Fact Sheet for more information). Federal law forbids the recovery of lying-in costs from the mother.

A pregnant woman cannot be required to cooperate with child support in providing contact information for the father. However, if the mother does not identify the father, once her Healthy Start benefits have ended she will not be eligible for other Medicaid programs. This will not affect continuing or future coverage for her child.

For more info on lying-in costs, call 1-800-585-4222 statewide / 261-6939 in Madison
ABC for Health provides free health benefits counseling to families anywhere in Wisconsin. Benefits advocates will talk with you about health coverage options.
What is the FFU?
An FFU can be calculated when a family is denied Medicaid eligibility because they are over income or if the family group has a large Medicaid deductible. The FFU is an individual eligibility determination. This means that only the income of the individual and those who are legally responsible for that individual are used to determine eligibility for Medicaid coverage. Legal responsibility refers to two specific relationships. Those are the relationship between a natural or adoptive parent and his or her minor children, and the relationship of one spouse to another.

There are specific categories of families that can take advantage of the FFU feature. These are limited to the following five categories:

- A household with a pregnant woman;
- A household with a step-parent;
- A household with a non-marital co-parent (this refers to the situation where a couple who is the natural or adoptive parents of a child live together, but are not married);
- A household that has children with their own income (such as interest income or child support); or
- A household with a non-legally responsible relative caregiver (for example, grandparents caring for a grandchild or an aunt or uncle caring for a niece or nephew).

When using the FFU, the income test is almost always more generous for people applying for Medicaid, especially for pregnant women. The FFU also allows families with higher incomes to become eligible for Medicaid coverage. However, using the FFU is complicated and it is often overlooked for families in the categories listed above, so it is important to request that an FFU calculation be done.

How does the FFU work?
In an FFU calculation being done for children, the parent’s income is divided equally among their natural or adoptive children. Then, based on that child’s countable income, each child is tested individually against the income limit for the specific Medicaid program for which they qualify.

Families who qualify for the Family Fiscal Unit may have an individual Medicaid Deductible calculation done (see Medicaid Deductible fact sheet for more information).

For more info on the FFU, call 1-800-585-4222 statewide / 261-6939 in Madison
ABC for Health provides free health benefits counseling to families anywhere in Wisconsin. Benefits advocates will talk with you about health coverage options.
What is the Medicaid Deductible?

The Medicaid Deductible allows families or individuals at higher income levels to deduct outstanding medical debts, expenses, and health insurance premiums to qualify for Medicaid coverage. The deductible can only be used once an applicant has been denied Medicaid eligibility because their income is too high. Medical bills for anyone in the family count towards meeting the deductible, however only the following people are eligible for the Medicaid Deductible feature:

- children under age 19;
- pregnant women; and
- adults who are blind, disabled, or over age 65.

The Medicaid Deductible allows applicants to deduct the following types of debts and expenses from their income:

- outstanding medical bills regardless of how old;
  
  **Note:** medical bills count only if the family is responsible for payment; bills that will be paid by an insurance company or Medicare cannot be used. Old medical bills count on the first day of the deductible period.

- health insurance premiums; or
- payments for medical services.

The Medicaid Deductible feature cannot be used with BadgerCare.

How does the deductible work?

When using the Medicaid Deductible feature, eligibility will be calculated for a period of six months. The deductible amount is the sum of each month’s excess income (the income amount over the Medicaid eligibility limit) for the six-month deductible period. An applicant can either pay the deductible or verify that their outstanding medical debt is equal to or greater than the deductible amount. For example, if a pregnant woman is over the income requirements for Healthy Start by $100, her deductible amount for the six-month period is $600. She needs to either pay that amount to access Healthy Start or bring in medical bills that show she has a $600 outstanding medical debt.

A medical bill can only be used once to meet the Medicaid Deductible. Even though each dollar of a bill can be used only once to reach a deductible, applicants can use a large bill to secure eligibility for several
consecutive six-month deductible periods. For example, if the deductible amount is $500 and the applicant has $1,000 in medical debt, this outstanding debt will cover two six-month deductible periods.

There is no limit on how many times someone can apply for a Medicaid Deductible.

Other important things about the Medicaid Deductible

- If a family doesn’t have enough medical expenses to meet their deductible until late in the deductible period, they can start a new six-month deductible period by asking for a new application. Eligibility can be secured on the day the family’s medical bills equal the deductible amount.
- Since income eligibility standards are different for children of different ages, a family may have different deductible amounts if they have more than one child.
- Income rules for pregnant women make it especially easy for them to become eligible for Medicaid using the deductible.
- Bills that have been paid with a credit card or bank loan can no longer be counted.
Who can get coverage?

Medicaid for Emergency Services provides payment of health care costs for an eligible non-citizen who has experienced a medical emergency. Medicaid may cover emergency medical care for the following:

- children under age 19
- pregnant women
- a disabled adult
- a parent of a child under age 19

An emergency means a medical condition, including labor and delivery, which shows acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in one or more of the following:

- serious jeopardy to the patient’s health;
- serious impairment to bodily functions; or
- serious dysfunction of a bodily organ or part.

Transplant-related services are not covered for non-citizens.

Are there income limits?

Noncitizens applying for Medicaid for Emergency Services must meet all other eligibility requirements for Medicaid (for example, a child under age six or a pregnant woman must meet the eligibility requirements for Healthy Start). However, if the applicant only meets the eligibility requirements for BadgerCare and does not qualify for any other Medicaid program, the applicant is not eligible for Medicaid for Emergency Services.

Eligibility is determined on an individual basis for the person who experienced the medical emergency or for the pregnant woman.

If a person is ineligible for Medicaid for Emergency Services for no other reason than because they are over income, the individual may be able to use the Medicaid Deductible feature to bring their income below the income limits they must meet to become eligible for coverage (see the Medicaid Deductible fact sheet).

Medicaid for Emergency Services coverage can be backdated up to three months preceding the month of application. Therefore, an applicant must sign and date an application as soon as possible to preserve the maximum backdating period possible.
Applying for coverage

- Undocumented individuals need only to provide their birth date to apply.
- Individuals who are legally in the United States must provide a photocopy of their Alien Registration card when they apply.

Applying for or getting Medicaid will not affect a person’s application to become a citizen of the United States.

Steps for applying

1. Complete the Family Medicaid/BadgerCare Application.
2. Mail, fax or deliver the application (applications can be taken over the phone, but the date of eligibility will be determined based on when the signed application is received at the county human or social service department, not the date of the phone request).
3. An individual or family can also apply in person at their county/tribal human or social service department, W-2 agency or Medicaid outstation site. Contact your local human or social service department for details.

What to do once accepted

Once an individual receives Medicaid coverage for Emergency Services, the individual must contact the hospital, clinic or doctor where they received care to give the provider the Medicaid ID number from the Positive Notice. A provider must have this ID number to bill the Medicaid program and get the outstanding bill paid.

What services are covered?

Medicaid will pay the health care cost from the time of the first treatment for the emergency until the condition is no longer an emergency. For pregnant women, Medicaid for Emergency Services will pay for the cost of the delivery. Medicaid for Emergency Services recipients do not receive a Forward card because coverage ends at the same time the emergency ends.

For help with coverage questions, call 1-800-585-4222 statewide / 261-6939 in Madison

ABC for Health provides free health benefits counseling to families anywhere in Wisconsin. Benefits advocates will talk with you about health coverage options.