

## DISABILITY BENEFIT SPECIALIST PROGRAM

Program Updates – December 2011

### I. SOCIAL SECURITY ADMINISTRATION (SSA)

#### A. Compassionate Allowances List Expanded to Include 13 Neurological and Immune Disorders

Effective December 10, 2011, the Compassionate Allowances list will be expanded to include thirteen conditions involving the immune system and neurological disorders. The Compassionate Allowances initiative identifies claims where the nature of the applicant's disease or condition clearly meets the statutory standard for disability. With the help of information technology, SSA can quickly identify potential Compassionate Allowances and then quickly make decisions. SSA started the Compassionate Allowances program in 2008 with a list of 50 diseases and conditions. The announcement of 13 new conditions will increase the total number of Compassionate Allowances conditions to 113. The conditions include certain cancers, adult brain disorders, a number of rare genetic disorders of children, early-onset Alzheimer's disease, idiopathic pulmonary fibrosis, and other disorders.

The new additions are: Malignant Multiple Sclerosis; Paraneoplastic Pemphigus; Multicentric Castleman Disease; Pulmonary Kaposi Sarcoma; Primary Central Nervous System Lymphoma; Primary Effusion Lymphoma; Angelman Syndrome; Lewy Body Dementia; Lowe Syndrome; Corticobasal Degeneration; Multiple System Atrophy; Progressive Supranuclear Palsy; and the ALS/Parkinsonism Dementia Complex.

The complete list of Compassionate Allowance conditions can be found at:

<http://www.ssa.gov/compassionateallowances/conditions.htm>

The list of pre December 2011 conditions, including links to descriptions and relevant Listings, can be found at:

<https://secure.ssa.gov/apps10/poms.nsf/lnx/0423022080>

#### B. New SSR Released on Documenting and Evaluating Disability in Young Adults

SSA has released SSR (Social Security Ruling) 11-2p which provides guidance on how SSA determines whether a young adult is disabled. A young adult is someone between the ages of 18 to approximately 25 years old.

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SSR 11-2p discusses disability determinations in several situations:

- When a young adult files a claim for SSI or for SSDI on the adult's own record
- When a young adult files a claim for child benefits on a parent's record based on a disability that began before he or she attained age 22
- When a child who is receiving Title XVI childhood disability benefits attains age 18 and must undergo a disability redetermination
- When a young adult receiving disability benefits under Titles II or XVI undergoes a continuing disability review (CDR) to determine whether he or she is still disabled.

Although the SSR is lengthy (17 pages with 56 footnotes!) and doesn't contain new information, it is worth reading for a complete overview on this topic.

SSR 11-2p can be found at:

[http://ssa.gov/OP\\_Home/rulings/di/01/SSR2011-02-di-01.html](http://ssa.gov/OP_Home/rulings/di/01/SSR2011-02-di-01.html)

### **C. SSA Announces New Spanish On-Line Services**

SSA now offers on-line services in Spanish for applications for SSDI, retirement, Medicare and Part D Extra Help, and also for calculating retirement benefits. The new online services are available at [www.segurosocial.gov](http://www.segurosocial.gov). The on-line disability report (i3368) is not yet available in Spanish, however. If the SSDI application is filed in Spanish, applicants are given the choice of completing the i3368 in English or clicking a button that says they do not wish to continue on-line. If they chose the latter option, a message instructs the applicant that an SSA representative will contact them within 10 business days. The applicant may also schedule an appointment for assistance by calling the national 800 number. Applicants who complete the SSDI on-line application in Spanish will receive notices in both English and Spanish.

Benefit Specialists who regularly serve Spanish-speaking applicants may want to contact their local offices for guidance on how to best process these on-line applications.

### **D. SSA to Offer Electronic 827 in Spring 2012**

SSA expects to roll out the "e827" in April, 2012. The e827 is a signature-less "Authorization to Disclose Information to Social Security Administration" form. As you know, all claimants must sign and submit form 827 in order to have their claim for SSI and/or SSDI processed. The electronic form will speed up the application process as the form can be electronically signed and submitted along with the application and disability report on-line, and not have to take the time to travel through the U.S. mail.

### **E. Recovery Period for Overpayments is Extended**

Previously there was a 10 year limit on the recovery of SSI and SSDI overpayments collected by "administrative offsets," that is, by reducing other federal payments, such as tax refunds. The time limit meant that if an overpayment hadn't been paid back within 10 years it could not be

collected from tax refunds. Effective November 21, 2011, the period for recovery is no longer 10 years but is unlimited. In addition, overpayments can now be collected by offsetting state tax refunds.

Before SSA requests the collection of an SSI or SSDI overpayment by the reduction of federal and state tax refunds, SSA will send a written notice of intent. The individual can at least temporarily stop the offset if within 60 days from the date of the notice the individual repays the amount in full, provides evidence that the overpayment is not past due or legally enforceable, or asks for a waiver. If the overpayment is in fact accurate and a waiver is not granted, the offset will occur and the tax refunds will be reduced/eliminated in order to pay the overpayment.

DBSs should pay close attention to any notices brought to them by clients to determine the exact deadline (the time limit appears to run from the date of the notice, not the date of receipt, but the notice will provide more information) and to determine exactly what providing additional evidence involves.

#### **F. Annual SSDI Adjustment for Working Recipients Impacts SSI and MA**

In October of every year, SSA recalculates the SSDI monthly benefit rate being paid in the current year based on wages earned in FICA covered employment by recipients in the previous year. (Obviously, recipients who did not work in the prior year are not subject to this recalculation). The recalculation results in an increase in SSDI benefits for the current year retroactive to January of the current year. The increase for the underpaid benefits is made in December of the current year, and included in the December benefit payment. If the recipient is also getting SSI, the retroactive payment made in December of the current year may make the recipient financially ineligible for SSI for December, or reduce the amount of SSI benefits for December.

If the individual loses their SSI payment entirely for December because of the size of the retroactive payment, they will also lose their Medicaid for December.

The new benefit rate is then established for December of the current year and the next calendar year (until next year's calendar adjustment). If the new SSDI amount is high enough, the recipient may lose their SSI eligibility for the next year entirely. Even if the increased benefit rate due to past wages doesn't kick them off SSI, the COLA increase for 2012 on top of the recalculated amount may. So some individuals may lose their SSI permanently with their last check being for November or December of the current year.

The increase in benefits may cause the individual to lose their Medicaid as well. However, they are eligible to continue receiving Medicaid via "1619(b)" which allows Medicaid recipients to continue to receive Medicaid when their SSI payments are reduced to zero because of work earnings, if their annual earnings do not exceed the "threshold" which in 2011 was \$32,284 (or higher for individuals with high medical expenses).

Individuals who have income above the threshold and thus are not eligible for 1619 (b) Medicaid may be eligible to continue Medicaid coverage via MAPP and HEC.

Eligibility for Medicare is not affected by the benefit recalculation or the COLA increase.

### **G. SSDI Date Last Insured and Blindness**

**Deb Ehr, Iowa County DBS**, recently had a case where a client was found disabled at hearing because of blindness. The client's date last insured was in 2006, but she didn't meet the blindness listing until 2009, so she was found eligible SSI only. However, Deb discovered that the date last insured for SSDI is calculated differently for blind individuals. In fact, under the blindness rules, the client's date last insured is 2025 rather than 2006! So it turns out that the client should have been eligible for SSDI back to the date of the judge's decision in 2009.

### **H. Speed Up Cases by Doing the Adult Function Report Right Away**

**Natalie Wilmot, Sauk County DBS**, recently got a call from a DDB case development worker. The worker said that part of the reason that cases take so long for a decision is because of the time it takes to generate, mail out, and wait for claimants to return the Adult Function Report (these reports are used in most, but not all cases). The worker said that DBS's could speed up the decision process by printing out the 3373 from the SSA website, completing it with the client early on, and sending it in. The Adult Function Report is available here: <http://www.ssa.gov/online/ssa-3373.pdf>

### **I. Extra-Help from Social Security, FPL and Group Size**

**Brenda WelshMcLean, Columbia County DBS**, recently discovered a significant difference between MSP's and Extra Help through Social Security. For MSP's, the maximum group size for determining financial eligibility is two: the applicant + the spouse. But for Extra Help through Social Security, there is no limit to the group size. The group size includes "any relatives who are living with the individual, and who are dependent on the individual or the individual's spouse for at least one-half of their financial support." POMS HI 03020.055. Since FPL depends on the group size, there will be some people who are eligible for Extra Help through Social Security who won't be eligible for SLMB+.

### **J. SSI Reapplication Within One Year of Prior Favorable SSI Disability Determination – Disability Determination Stands**

If the claimant files a new SSI application within 12 months of the date of the favorable determination and meets all non-medical entitlement factors, they won't need to get a new disability determination. POMS DI 11055.075. For example, Ashley's SSI application is approved, but afterwards the local SSA field office finds out that Ashley had a bank account with \$4,000 in it when she applied—so she was never eligible to get SSI. Under this rule, if within the next 12 months Ashley's bank account dwindles to less than \$2,000 (\$3,000 if married), and she reapplies for SSI, she will automatically win without having to get another disability determination.

## **K. Flat Fee Rental Agreements Can Be Used to Avoid the 1/3 Reduction of SSI for Clients Living in the Household of Another**

When clients are living in the household of another, their SSI amount can be reduced by 1/3 unless they show that they are contributing their 'fair share' to household expenses. The easiest way to show that the client is paying their 'fair share' is to have them sign a flat fee rental agreement equal to 1/3 of the federal SSI amount + \$20 (technically this is known as the 'presumed maximum value' (PMV) of in-kind support and maintenance). The current calculation of 1/3 Federal SSI + \$20 can be found at POMS SI 00835.901 <https://secure.ssa.gov/poms.nsf/lnx/0500835901>

Since the Federal SSI amount is going up to \$698 in 2012, the rental agreement should be made for at least \$252.66 per month [ $1/3 \times \$698 + 20 = 252.66$ ].

Current beneficiaries could sign and date a document that says something like: "I agree to pay Mr./Ms. [Name] \$255 per month to contribute to household expenses, starting on [date]."

For clients that are applying for SSI but not yet receiving it, in order to avoid a reduction, they could sign and date an agreement at the time of application that states something like: "I agree to pay Mr./Ms. [Name] \$255 per month to contribute to household expenses, starting on [date]. I agree to pay back any amounts that accrue while my SSI application is pending out of my anticipated SSI lump sum backpayment."

Needless to say, the client **MUST ACTUALLY** contribute \$255 per month to household expenses once their benefits start to come in.

## **L. Practice Tip**

**Natalie Wilmot, Sauk County DBS**, recently had a heart wrenching case involving a client with T-4 paraplegia, who was working part-time as a Walmart door greeter, with the help of a home care worker and an accessible van. His wages were at times slightly over SGA, so the local office terminated his SSDI and gave him notice of a \$42,000 overpayment. The SSA local office never bothered to investigate whether or not the job was subsidized or whether the client had any IRWE's. The loss of the SSDI check caused the client to lose the ability to pay for his van and his home care worker, so he could no longer work as a part-time greeter, and thus had no income at all. Natalie got proof of the IRWE's, and sent it to Bob Monihan, SSA Work Incentive Coordinator, who immediately reinstated SSDI and waived the overpayment.

## **M. Practice Tip**

**Lauren Furrer, Lafayette County DBS**, recently submitted an On the Record Request (OTR) for a client. The client was over 55, and DDB found a light RFC. The client would have won on the grids, but the examiner thought that the client's past relevant work was light—so they denied her at step 4. In fact, the client's past work was medium—not light. So Lauren wrote an OTR to ODAR explaining DDB's mistake—and the client received a fully favorable decision without a hearing!

## II. MEDICARE

### A. ASL Video for Medicare Recipients Who are Deaf or Hard of Hearing

CMS has released an educational video in American Sign Language (ASL) to provide important information about the Medicare program to people who are Deaf or hard of hearing.

The video consists of an overview of the Medicare program, including what Medicare is, who qualifies, the four parts of Medicare (A, B, C, and D), new preventive services under the Affordable Care Act, and help paying Medicare costs.

The video will be available on Medicare.gov, cms.gov and the CMS YouTube channel.

To access go to <http://www.youtube.com/watch?v=eskZVAg7v0o>.

To download, go to <http://downloads.cms.gov/media/video/ASLOverview.mp4>.

### B. January 1, 2012, Dual Eligibles Receiving Family Care and Other Home and Community Based Waiver Services Will Have \$0 Copays on Med D Drugs

The Affordable Care Act eliminates drug co-pays for dual eligibles (those with Medicare and Medicaid) receiving home and community based waiver services (HCBS) starting January 1, 2012. The intent behind this change is to treat individuals at a nursing home level of care in the same manner as those who are institutionalized. This includes the following HCBS programs in Wisconsin: Family Care; IRIS; All Legacy Waivers (COP, CIP, BIW.); Children's Long Term Support Waiver; and Partnership.

For more information, please review the attached memo, which was prepared by **Eva Shiffrin** of **DRW** and previously sent to you in October.

### **III. MEDICAID & BADGERCARE PLUS/CORE/BASIC**

#### **A. SSA COLA Increase and Its Effect on Medicaid Eligibility**

The Cost of Living Adjustment (COLA) for 2012 is **3.6%** for SSDI and SSI programs. The federal COLA increase will result in changes in the EBD Medicaid income limits, allowances and deductions. The changes associated with these adjustments will be included in a future MEH release.

The 2012 Federal Poverty Levels have not yet been set, which means that COLA increases for Medicare Saving Program (QMB, SLMB and SLMB+) and MAPP participants should be disregarded until the new FPL figures are programmed into CARES. If you have clients who are terminated for being over the income limits in January, be sure to check with ES that the COLAs were disregarded. Ops-Memo 11-65

#### **B. IM Agency Must Redetermine MA Eligibility for Youths Exiting Foster Care**

Youths receiving Foster Care as of their 18<sup>th</sup> birthday may continue to receive BadgerCare Plus (Also known as Foster Care MA) until the end of their 21<sup>st</sup> birthday month. IM agencies must now redetermine MA eligibility for youths losing Foster Care MA *before* the Foster Care MA is terminated. IM agencies must develop procedures with the local Child Welfare agency to identify youths in Foster Care who are losing coverage. The only exception to this requirement is when a youth dies or leaves Wisconsin.

New rules require that Foster Care MA eligibility will be extended until a redetermination of MA is completed by IM. If IM does not have sufficient eligibility information from the youth or their family, the agency must request the needed information. If the youth or their family does not comply with an information request within 30 days, MA can be terminated with adverse action notice. See: BC+ Manual 11.1 Out of Home Care

#### **C. BadgerCare Plus Core Applications/Renewals Now Accepted In-Person**

As BadgerCare Plus Core cases transition from the ESC in Madison to local IM agency consortia, Core renewals/verifications can now be completed in-person with a local IM worker; as well as by telephone or online via the ACCESS website. Those submitting new applications for Core may also do so in-person. There are currently 115,600 applicants on the Core waitlist and enrollment is frozen.

#### **D. Medicaid / Badgercare Plus Changes**

On November 10, 2011, the Legislature's Joint Finance Committee approved DHS's proposal to reduce Medicaid funding. However, many of the changes are prohibited by the Maintenance of Effort provisions of the Patient Assistance and Affordable Care Act (health care reform law passed by Congress in March 2010). Therefore, DHS has asked the Federal government to allow these changes to go into effect by waiving the requirements of Patient Assistance and Affordable

Care Act. If the Federal Government does not grant Wisconsin's Medicaid Waiver by December 31, 2011, then Wisconsin plans to terminate all parents and childless adults on BadgercarePlus or Badgercare Core above 133% of the Federal Poverty Level on July 1, 2012.

Here are some of the proposed changes in the Medicaid Waiver request:

1. Persons above 150% of FPL may have premiums up to 5% of their household incomes.
2. Young Adult Eligibility Restrictions - Anyone between 19 and 26 who is eligible to obtain health insurance through his or her parent's health insurance plan would be ineligible for BadgercarePlus.
3. Parents who have income over 100% of FPL and children whose household income above 133% FPL would be ineligible for BadgercarePlus if they have access to employer group health insurance with premiums less than 9.5% of the family income.
4. Express enrollment for pregnant women and BadgercarePlus kids would be eliminated.

The Legislative Fiscal Bureau estimated that over 64,000 people, including over 29,000 children, will lose their BadgercarePlus if these changes are implemented.

In addition, DHS has also proposed to shift all Badgercare Recipients with household incomes between 100% and 200% of the Federal Poverty Level into the Badgercare Plus Alternative Benchmark Plan. Currently, only those above 200% of FPL are enrolled into the Benchmark Plan. The Alternative Benchmark Plan has additional copays and coverage limitations that the Standard plan does not. This shift does not require a Medicaid Waiver from the Maintenance of Effort requirements under PPACA.

We will inform you if the changes become final and when they will take effect.

#### **IV. HEALTH CARE - GENERAL**

##### **A. Health Care Reform**

In November 2011, the United States Supreme Court agreed to decide whether the health care reform law passed in 2010 is constitutional. The Supreme Court will hear oral arguments on the case in March 2012 and most likely decide the case before July 2012.

## V. FOODSHARE

### A. New FoodShare Income Reporting Requirements

FoodShare households must report and verify all earned and unearned income on a Six Month Review Form (SMRF) even if there has been no change in their employment or unearned income since the last application or renewal. Effective January 1, 2012, only the following changes in income must be reported on the SMRF for FS members:

1. A change of \$50 or more in unearned income based on the most recently verified amount.
2. Changes in earned income (from the most recently verified information) that must be reported includes:
  - rate of pay,
  - number of hours worked,
  - loss of job,
  - change from full to part-time, or
  - new employment.

Income verification at SMRF is only required for employment that meets the criteria listed above. Child Care households must continue to report and verify all income on the SMRF.

#### *Changes to the Other Income Section (Section 5) of the SMRF:*

Beginning with the December SMRF, the paper form and the online form on ACCESS RMB will have the most recently verified unearned income source and amount pre-populated on the form. FS households only have to re-verify this income if the amount has changed by more than \$50. CC household must continue to verify all reported income.

#### *Changes to the Employment Income Section (Section 4) of the SMRF:*

Beginning with the December SMRF, the paper form and the online form available to the member on ACCESS Renew My Benefits page will have the employment fields pre-populated to reflect the most recently verified information in CWW. This is the income that is being used in the current FS benefit calculation. If the income is entered as 'zero' on the Earned or Unearned income pages using the override field, that employment information will not display on the SMRF. The household will be instructed to report changes in employer, rate or type of pay and hours worked. If there are no changes in those items, no further verification is required for FS. CC households must verify all income.

**Note:** Due to space issues, the paper form will display a maximum of five jobs. If the household has more than five jobs, the additional jobs will be listed in Section B: Report Income.

Ops-Memo 11-64

## VI. LONG TERM CARE

### A. Policy for Assigning County of Residency and County of Responsibility Clarified

DHS published an Operations Memo on December 1, 2011, that clarifies how a long term care participant's county of residence and county of responsibility are determined. Specific procedures are spelled out in three attachments to the memo. To summarize, an individual's county of residence is defined by the state as a "voluntary concurrence of physical presence with intent to remain in a place of fixed habitation." The County of Responsibility is defined as "the county responsible for the provision of services under Chapter 56, 48, 51, 54, or 55 to an individual."

When a person enrolled in long term care services leaves his or her county of residence to receive services in another county, the individual will retain his or her residency in his or her home county as long as the services being received in a different county are part of the individual's approved long term care plan. The county of responsibility will retain its responsibility even though the individual is no longer living in his or her county of residence. If an individual voluntarily moves to a different county for a reason other than treatment or services that are part of the long term care plan, the individual's county of residence will change. The individual will be considered a resident in the new county and the county of responsibility will shift.

To read the Ops Memo or reference the attached procedures, follow this link:  
[http://www.dhs.wisconsin.gov/dsl\\_info/shared/cy2011/nmemo201109.pdf](http://www.dhs.wisconsin.gov/dsl_info/shared/cy2011/nmemo201109.pdf)

## VII. W-2

### A. Face-to-Face Meeting Requirement Loosened for W-2 Employability Plan

Recent changes to W-2 rules required face-to-face Employability Plan (EP) appointments except when there are extreme circumstances that prevent a participant from coming to the agency such as when a participant is hospitalized or homebound due to illness.

After hearing concerns from a number of agencies about the difficulties they experience with attempting to bring employed individuals into the agency for a face-to-face appointment, the Department of Children and Families has decided to add an exception to the EP policy for certain W-2 recipients. The following changes to the W-2 Manual reflect the new policy:

#### **New Section 6.2.1:**

If an individual who is transitioning from a paid placement to a case management follow-up (CMF) placement has a work schedule that makes it difficult to come into the office for a face-to-face EP appointment, the agency may conduct the EP appointment by phone.

#### **Updated Section 6.2.2:**

When a CMF, case management for underemployed (CMU) or Trial Job participant has a work schedule that makes it difficult to come into the office for a face-to-face EP appointment, the worker must either conduct a home visit or communicate with the participant by phone to ensure that the participant has the opportunity to provide input into the development of the EP and understands what is expected of him/her.

Division of Family and Economic Security Ops-Memo 11-59

### B. W-2 Case Management Services Available for “Job Ready” Individuals

The 2011-2013 Biennial Budget allows for individuals to receive case management services in lieu of placement in a W-2 paid employment position effective January 1, 2012. The case management placement for job ready individuals is for unemployed individuals able to find and keep full-time employment who otherwise meets W-2 financial and nonfinancial eligibility criteria. The goal of the case management is to rapidly connect the individual to sustainable employment. Case management is only available to W-2 applicants, and, in limited situations, to case management follow-up (CMF), case management for underemployed (CMU) participants, and Caretaker of an Infant (CMC) participants.

Individuals seeking case management must have sufficient skills and work history to obtain employment quickly, but need support and assistance from the W-2 agency to find and keep a job. Examples of support and assistance the W-2 agency may provide include: help creating and implementing a strategy to obtain employment; assistance with child care costs through Wisconsin Shares; and assistance to pay for work-related expenses, transportation or car repairs through either a Job Access Loan or supportive services funding from the W-2 agency. Instead of placing these individuals in a paid W-2 employment position that will count toward their time limits, the FEP may place them in a case management placement.

Division of Family and Economic Security Ops-Memo 11-60

## VIII. VETERANS

### A. New Employment Initiatives for Veterans

On November 11, 2011 the Obama administration announced three new initiatives for veterans seeking employment. These initiatives include skill evaluation, job counseling, job search resources, and case management services.

The first tool is a program known as the Gold Card. Veterans can enroll in this program online. The Gold Card provides access to six months of intensive follow up services to post 9/11 era veterans that have not found employment upon their return to civilian life. This tool allows veterans to access job readiness assessments, including testing. There are also Individual Development Plans, career guidance through group or individual counseling, referrals to employers and apprenticeship sponsors, and information about occupational and skill transferability. There is also monthly follow-up with an assigned case manager. Veterans can contact the nearest One Stop Career Center to enroll in the program. Contact information is available through this link: <http://www.dol.gov/vets/goldcard/revisedgoldcard5.pdf>.

The second tool is a search engine named My Next Move for Veterans. This search engine allows veterans to enter information about their prior military experience and the search engine returns links to related civilian training and employment opportunities. Access the website through this link: <http://www.mynextmove.org/vets/>

The third tool is the Veterans Job Bank. This database contains over 500,000 job opportunities with employers that are interested in hiring veterans. The job bank is located at this web address: <https://www.nationalresourcedirectory.gov/jobSearch/index>

## **IX. OTHER**

### **A. Elimination of HEC Specialist Positions**

There are currently approximately 100 people statewide who are receiving MAPP benefits through the Health and Employment Counseling (HEC) Program. HEC makes it possible to meet the MAPP work requirement for a nine-month period while planning for future employment. Beginning January 1, 2012, there will no longer be HEC Specialists throughout the state to directly assist individuals with developing HEC plans.

The MAPP/HEC Program will continue to be available to individuals. Next year, the HEC Program will become “self-directed.” Individuals will receive the application from the County Economic Support (ES) office where they will receive assistance with completing HEC plans. The State HEC Manager, Amy Thomson of DHS, will also be available by phone to answer questions and assist individuals. There will be an Operations Memo coming out soon that will provide more information regarding the role of ES in the HEC application process.

At this point, it is unclear what the impact of the loss of HEC Specialists will have on the DBS Program. We will share any information we receive as it becomes available. Amy Thompson will be available at either the January or February DBS webcast to provide more information about HEC.

### **B. ESC Caseload to be Transitioned to IM Consortium of Residence**

As previously reported, beginning January 1, 2012 all Income Maintenance (IM) cases will be managed by one of 11 regionally based IM Consortia, with the exception of Menominee and Milwaukee Counties, which will operate independently. This transition includes all open cases that are currently managed by the Enrollment Services Center (ESC).

#### Key Points on Transition Process:

- When clients complete applications, renewals, report changes, etc. on ACCESS the item will be routed to the agency/worker managing their case.
- ESC cases will be transferred automatically to their county of residence.
- At the point of transfer all members will receive a written case transfer notice, requiring no action on their part.
- The agency contact information indicated within their notice(s) will reflect the agency that is currently managing their case.

The transition of FoodShare-only cases to local agencies began on November 1, 2011. January 1, 2012, the consortia will begin processing all applications with a file date of 1/1/12 or later. By March 31, 2011, all open ESC cases will be transitioned from ESC to local consortia. For a more detailed timeline of the transition, see See: Ops-Memo 11-56 <http://www.dhs.wisconsin.gov/em/ops-memos/2011/pdf/11-56.pdf>

Additional information and a map of the consortia areas will be provided during the December 7, 2011 DBS webcast.

### **C. Centralized Document Processing Unit to Facilitate E-Case File Processing**

As part of the transition from the ESC to the local agency consortia, DHS will implement centralized processing for the Electronic Case File (ECF) used in Income Maintenance cases. This process allows agencies to scan a document without first giving it to a worker to process. The worker can view the digital document within the CARES Document Viewer, manipulate and validate the document as necessary, and mark it as processed.

Another option for scanning documents is called Process First. Using Process First, paper documents first go to the assigned worker who reviews, processes, and then sends the document to be scanned.

Effective January 1, 2012, DHS will administer a Centralized Document Processing Unit (CDPU) to scan and validate documents belonging to the ten statewide consortia. The purpose of the CDPU is to perform many of the tasks that local agency staff currently performs. This includes receiving, routing, scanning, manipulating and validating documents for Income Maintenance cases. The CDPU staff will initially be located in Madison and will be comprised of scanning and document validation staff using multiple scanners. The CDPU is required by state law to be moved out of Dane County prior to July 1, 2012. The final location is yet to be determined.

#### Key points on submission of documents:

- Documents received at a local agency must be scanned there.
- All paper IM documents received by the CDPU will be scanned and validated by the CDPU.
- The CDPU will scan and log all six month review forms (SMRFs) that come into the CDPU as received in Cares Worker Web (CWW).
- Documents that are scanned or uploaded via ACCESS by applicants/members will continue to go directly to CWW and ECF.
- Documents that are faxed by customers to the new CDPU fax number will automatically go to the CDPU and be validated there.

#### Contact information for CDPU:

Non-urgent: [VEDSCDPU@wisconsin.gov](mailto:VEDSCDPU@wisconsin.gov)

Urgent: (608) 264-0202

Fax: 1-855-293-1822

Mailing Address: CDPU, PO Box 7190, Madison, WI 53707.

For more information contact your local IM Consortia or see [Ops-Memo 11-55](#).

#### **D. Request for Assistance Telephonic Signature Policy and Process**

Beginning in January 2012, the IM programs will be administered by individual tribal agencies, Miles and 10 consortia made up of groups of local county agencies. Each consortium will have a Call/Change Center that will be responsible for updating cases for all agencies within the consortium. To support the Consortia Call/Change Centers, CWW has been enhanced to allow collection of a telephonic signature during the Client Registration process for Income Maintenance Requests for Assistance (RFA).

The customer must agree to provide his/her signature over the telephone. If the customer agrees; the worker must provide a written summary of the application information that was provided during the RFA creation process. After collecting the telephonic signature, the worker must print the PDF RFA and the RFA cover letter. The RFA cover letter will be saved to CARES notice history.

**Note:** Caretaker Supplement (CTS) is excluded from the telephonic signature process. Child care may be requested in person at the local county office, by telephone, or through ACCESS; however, CC does not accept a telephonic signature, a written signature is required to establish the RFA filing date. W-2 must be requested in person.

#### **E. 2012 Eligibility Checksheet**

Attached is a 2012 Eligibility Checksheet. **NOTE:** The 2012 Federal Poverty Levels (FPLs) have not yet been published. FPLs typically come out after the first of the year. For programs that utilize FPLs, such as MAPP and the Medicare Savings Programs, the SSA cost of living adjustments to SSDI payments should be disregarded until the 2012 FPLs are incorporated into CARES. If you have clients who have been notified that they are losing eligibility for these programs in January 2012, be sure to contact Economic Support to determine whether or not the COLA disregards were applied. **NOTE:** Categorical eligibility for FoodShare will continue to be based on 2011 FPLs until the new FoodShare allotment number are published, which typically occurs in October.