

CHAPTER 49

PUBLIC ASSISTANCE

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Cross-reference: See s. 46.011 for definitions applicable to chs. 46 to 51, 55 and 58.

GENERAL RELIEF

49.001 Public assistance recipients' bill of rights.

The department and all public assistance and relief-granting agencies shall respect rights for recipients of public assistance. The rights shall include all rights guaranteed by the U.S. constitution and the constitution of this state, and in addition shall include:

- (1) The right to be treated with respect by state agents.
- (2) The right to confidentiality of agency records and files on the recipient. Nothing in this subsection shall prohibit the use of such records for auditing or accounting purposes.
- (3) The right to access to agency records and files relating to the recipient, except that the agency may withhold information obtained under a promise of confidentiality.
- (4) The right to a speedy determination of the recipient's status or eligibility for public assistance, to notice of any proposed change in such status or eligibility, and, in the case of assistance granted under s. 49.19, 49.46, 49.468 or 49.47, to a speedy appeals process for resolving contested determinations.

History: 1977 c. 29; 1989 a. 31.

49.002 Legislative declaration. (1) It is declared to be legislative policy that all recipients of general relief shall have maximum exposure to job training and job opportunities through the Wisconsin state employment service as well as other govern-

ment agencies. Applicants and recipients of general relief shall comply with the established work-seeking rules of the general relief agency. Recipients of general relief shall also comply with the established work relief rules of the general relief agency. If a recipient of general relief refuses a bona fide offer of employment or training without good cause, or accepts a bona fide offer and subsequently performs inadequately through wilful neglect, or fails to comply with the work-seeking or work relief rules of the general relief agency, the general relief agency may discontinue general relief payments to the recipient for a period not to exceed 30 days for a first refusal, inadequate performance or failure to comply and for a period not to exceed 60 days for a 2nd or subsequent refusal, inadequate performance or failure to comply. The department shall promulgate rules to establish standards for determinations of benefit discontinuances under this subsection that exceed 30 days. Any Wisconsin taxpayer shall have standing in the circuit court for the purpose of obtaining an injunction to enforce this subsection.

(2) It is the declared legislative policy that general relief is the payer of last resort in all cases, except those cases involving crime victim awards under s. 949.06, where a dispute may arise over payment for costs associated with maintaining the health and welfare of recipients of general relief, including disputes concerning health care costs with private or public payees of health care costs, other governmental welfare programs, rehabilitation programs and programs requiring institutionalization or long-term medical and psychiatric treatment.

History: 1983 a. 27; 1985 a. 29 ss. 931, 3200 (23); 1991 a. 39, 322.

Administrative rule under which applicants for general relief benefits were, in effect, deemed unwilling to work if they had lost 2 jobs without justification within past 12 months created impermissible, irrebuttable presumption that otherwise eligible applicants were presently unwilling to comply with this section. *Garcia v. Silverman*, 393 F Supp 590.

49.01 Definitions. As used in this chapter:

(1) "Accommodated person" means any person in a hospital or in a skilled nursing facility or intermediate care facility, as defined in Title XIX of the social security act, who would have been eligible for benefits under s. 49.177 or 49.19 or federal Title XVI if the person were not in such a hospital or facility, and any person in such an institution who can be found eligible for Title XIX under the social security act.

(2) "Dependent person" or "dependent" means an individual without the presently available money, income, property or credit, or other means by which it can be presently obtained, excluding the exemptions set forth under s. 49.06, sufficient to provide the necessary commodities and services specified in sub. (5m).

(4) "Essential person" means any person defined as an essential person under federal Title XVI.

(5) "Federal Title XVI" means Title XVI of the federal social security act.

(5g) "Foster home" has the meaning given in s. 48.02 (6).

(5m) "General relief" means such services, commodities or money as are reasonable and necessary under the circumstances to provide food, housing, clothing, fuel, light, water, medicine, medical, dental, and surgical treatment (including hospital care), optometrical services, nursing, transportation, and funeral expenses, and include wages for work relief. The food furnished shall be of a kind and quantity sufficient to provide a nourishing diet. The housing provided shall be adequate for health and decency. Where there are children of school age the general relief furnished shall include necessities for which no other provision is made by law. The general relief furnished, whether by money or otherwise, shall be at such times and in such amounts, as will in the discretion of the general relief official or agency meet the needs of the recipient and protect the public.

(5r) "General relief agency" means a county department under s. 46.215, 46.22 or 46.23.

(6) "Municipality" means any town, city or village.

(6m) "Poverty line" means the poverty line as defined and revised annually under 42 USC 9902 (2).

(7) "Public medical institution" has the meaning designated in Title XIX of the federal social security act.

(8g) "Residence" means the voluntary concurrence of physical presence with intent to remain in a place of fixed habitation. Physical presence is prima facie evidence of intent to remain.

(8m) "Treatment foster home" has the meaning given in s. 48.02 (17q).

(8r) "Voluntary" means according to a person's free choice, if competent, or by choice of a guardian if incompetent.

(9) "Work relief" means any moneys paid to dependent persons entitled to general relief who have been required by any general relief agency to work on any work relief project.

(10) "Work relief project" means any undertaking performed in whole or in part by persons receiving work relief.

History: 1973 c. 147, 333; 1979 c. 34; 1981 c. 20; 1983 a. 27; 1983 a. 189 ss. 35 to 37, 329 (19); 1985 a. 29 ss. 932 to 935, 996, 997, 3200 (23); 1985 a. 176; 1989 a. 359; 1991 a. 316; 1993 a. 99 s. 72; 1993 a. 446.

Cross-reference: See s. 46.011 for definitions applicable to chs. 46 to 51, 55 and 58.

A man who quits a job for personal reasons may not be denied welfare if he is otherwise "dependent." Section 49.002 establishes a condition for continued eligibility, not a bar to initial eligibility. *State ex rel. Arteaga v. Silverman*, 56 W (2d) 110, 201 NW (2d) 538.

AFDC recipient may qualify as "dependent." *State ex rel. Tiner v. Milwaukee County*, 81 W (2d) 277, 260 NW (2d) 393.

"Dependent person" defined. *St. Michael Hosp v. County of Milwaukee*, 98 W (2d) 1, 295 NW (2d) 189 (Ct. App. 1980).

Indigent veteran's right to apply for veteran's emergency relief grant did not disqualify veteran as "dependent." *Luther Hospital v. Eau Claire County*, 115 W (2d) 100, 339 NW (2d) 798 (Ct. App. 1983).

"Relief" is not broad enough to include attorneys' fees incurred by eligible dependent person to prosecute or defend divorce action. 61 Atty. Gen. 330.

See note to Art. I, s. 1, citing *Lavine v. Milne*, 424 US 577.

Constitutional law: residency requirements. 53 MLR 439.

49.015 General relief eligibility. (1) (a) In this subsection, "close relative" means the person's parent, grandparent, brother, sister, spouse or child.

(b) No person is eligible for general relief under this chapter unless the person has resided in this state for at least 60 consecutive days before applying for general relief. This requirement does not apply if the person resides in this state and meets any of the following conditions:

1. The person was born in this state.

2. The person has, in the past, resided in this state for at least 365 consecutive days.

3. The person came to this state to join a close relative who has resided in this state for at least 180 days before the arrival of the person.

4. The person came to this state to accept a bona fide offer of employment and the person was eligible to accept the employment.

(2) (a) A person is not eligible for general relief under this chapter for a month in which the person has received aid to families with dependent children under s. 49.19 or supplemental security income under 42 USC 1381 to 1383c or in which aid to families with dependent children or supplemental security income benefits are immediately available to the person.

(b) No person is eligible for general relief under this chapter for a month in which the person is denied, or his or her needs are removed from a grant of, food stamps or aid to families with dependent children under 7 USC 2015 (d) (1), 42 USC 602 (a) (19) (F), 42 USC 607 (b) (2) (C), 42 USC 609 (c) or 42 USC 645 (b) 1 (B) because the person has failed to comply with requirements related to employment or training. A general relief agency may not deny general relief under this subsection to any person other than the person who has failed to comply with those requirements. If the adult caretaker of a child is denied general relief under this subsection and the case involves mismanagement, the general relief agency shall make the general relief payment for the child in the form of a protective payment.

(c) If the person is or was a member of a work-not-welfare group, as defined in s. 49.27 (1) (c), other than a nonlegally responsible relative caretaker of a dependent child, as defined in s. 49.19 (1) (a), or an adult who was a dependent child at the time that he or she was a member of the work-not-welfare group, the person is not eligible for general relief cash benefits under s. 49.032, if the work-not-welfare group received benefits determined under s. 49.27 (4) or (11) (a) to (f) for any of the preceding 36 months.

(3) After December 31, 1986, a general relief agency may waive the requirement under sub. (1) (b) or (2) (a) in a medical emergency or in case of unusual misfortune or hardship. Each waiver shall be reported to the department. The department may deny reimbursement under s. 49.035 for any case in which a waiver is inappropriately granted.

(4) (a) Except as provided in par. (b), no person is eligible for general relief under this chapter for a month in which the person's needs are removed from a grant of aid to families with dependent children under s. 49.123 (2).

(b) A general relief agency may provide general relief under this chapter to a person for a month in which the person's needs are removed from a grant of aid to families with dependent children under s. 49.123 (2) in case of extreme hardship, as determined by the general relief agency.

History: 1985 a. 120; 1987 a. 27, 399; 1991 a. 313; 1993 a. 99.

Sixty day waiting period under (1) (b) does not unconstitutionally penalize an individual's right to travel. *Jones v. Milwaukee County*, 168 W (2d) 892, 485 NW (2d) 21 (1992).

49.02 General relief administration. (1m) Every county shall furnish general relief to all eligible dependent persons within the county and shall establish or designate a general relief agency to administer general relief. The general relief agency shall establish written criteria to be used to determine dependency and shall establish written standards of need to be used to determine the type and amount of general relief to be furnished. The general relief agency shall review the standards of need at least annually. The general relief agency may establish work-seeking rules for general relief applicants and recipients.

(2r) A general relief agency may require the person who is receiving general relief to authorize any program or resource for which he or she is determined to be eligible to reimburse the general relief agency for general relief benefits paid to the person if the program or resource permits retroactive reimbursement for the period that general relief benefits were paid.

(3) (a) A general relief agency may plainly print or stamp on each check issued as a general relief benefit payment words explaining that the check is valid for 60 days beginning on the date of issuance. The general relief agency may cancel any check that is not presented for payment within the 60-day period indicated on the check and, except as provided in par. (b), the person entitled to the check forfeits the right to the benefit payment. Section 49.037 (6) does not apply to the cancellation of a check under this paragraph.

(b) The general relief agency shall issue a new check to the person entitled to the check under par. (a) if the person entitled to the check establishes that the check was not presented for payment because it was lost, stolen or destroyed or because the person was unable to present the check for payment within the 60-day period due to incapacitating injury or illness.

(4) (a) In this subsection, "shelter facility" means a temporary place of lodging for homeless individuals or families.

(b) A general relief agency may establish rules for the conduct of general relief recipients in shelter facilities that are operated by or receive funding from the county furnishing the general relief. The purpose of the rules shall be to ensure the safety and well-being of residents of the shelter facility.

(c) If a general relief recipient fails to comply with rules established under par. (b), the general relief agency may deny the recipient access to the shelter facility for a period not to exceed 30 days for a first failure, and for a period not to exceed 60 days for a 2nd or subsequent failure.

(d) The department shall promulgate rules to establish standards for determinations of denial of access to a shelter facility under par. (c) that exceed 30 days.

(5) (am) Except as otherwise provided in this section, the county under par. (ar) shall be liable for emergency hospitalization and care if a physician hospitalizes on an emergency basis or renders care on that basis to a person who is determined to be an eligible dependent person under this chapter, without previously authorizing the same, when, in the reasonable professional judgment of a physician, emergency medical treatment or hospitalization is necessary because severe physical or psychological damage to the person would result if the treatment or hospitalization was delayed pending the receipt of prior authorization from the general relief agency of the county under par. (ar).

(ar) If an eligible dependent person under this chapter receives emergency medical treatment or hospitalization under par. (am) the county of the person's residence at the time the injury or incident which necessitated emergency medical treatment or hospitalization occurred is liable for the costs of the emergency medical treatment or hospitalization and for all treatment or hospitalization provided under this section as a result of the injury or illness for which the emergency medical treatment was provided. If an eligible dependent person under this chapter has no residence, the county in which the injury or incident which necessitated emergency medical treatment or hospitalization occurred is liable.

(b) A county is not liable for hospitalization or care provided under par. (a) if the hospital provides the care or hospitalization to the person as uncompensated services required under 42 USC 291c.

(c) Except as provided in par. (d), a county is not liable for the costs of treatment or hospitalization provided under par. (am), unless:

1m. Within 3 working days after the patient is initially provided emergency medical treatment or hospitalization by a hospital or other health care provider an agent of the hospital or other health care provider has written notice of the treatment or hospitalization mailed or delivered to the general relief agency of the county which is liable under par. (ar). Each notice provided under this subdivision shall include the patient's name, address and county of residence, if any, and a statement about the nature of the illness or injury and the probable duration of necessary treatment and hospitalization. Each written notice provided under this subdivision shall also include a written statement by the attending physician certifying the need for the emergency medical treatment or hospitalization;

2g. Within 10 days after the patient is initially provided emergency medical treatment or hospitalization by a hospital or other health care provider an agent of the hospital or other health care provider mails or delivers the form required under this subdivision to the general relief agency of the county which is liable under par. (ar).

(ar) The hospital or other health care provider shall provide the information that it has obtained that is requested on a form developed and provided by the department. The hospital or other health care provider shall make reasonable efforts to obtain the information requested on the form either from the patient, if able, or some other person who has knowledge of the facts. The form shall, at a minimum, include the patient's name, address and county of residence, if any, phone number, the name of the patient's closest relative, the name of the patient's employer, information regarding the patient's finances including income, assets, liabilities and insurance coverage and information related to the patient's eligibility for other medical and hospital or other health care provider assistance programs. The form shall also include a sworn statement of facts relating to the patient's residence from the patient, if able, or some other person who has knowledge of the facts. For 20 days after the initial information is provided under this subdivision, the hospital or other health care provider has a continuing obligation to seek and report information relevant to the patient's care and eligibility under this section to the general relief agency of the county which is liable under par. (ar);

2r. Within 10 days after the patient is initially provided emergency medical treatment or hospitalization by a hospital or other health care provider an agent of the hospital or other health care provider mails or delivers to the general relief agency of the county which is liable under par. (ar) a form signed by the patient, if able, that authorizes the general relief agency to verify any information submitted to that agency by the hospital or other health care provider; and

3. If a county elects to require hospitals or other health care providers to obtain authorization as provided in this subdivision, within 72 hours after the patient is initially provided emergency medical treatment or hospitalization by a hospital or other health care provider an agent of the hospital or other health care provider obtains authorization for continued treatment or hospitalization of the patient from the county which is liable under par. (ar). If an agent of the hospital or other health care provider fails to obtain the authorization within the 72-hour period, either because he or she was unable to reach the county or because the county has failed to grant or deny the authorization within the 72-hour period, the hospital or other health care provider may continue to provide the treatment or hospitalization until the authorization is denied if an agent of the hospital or other health care provider makes daily good faith efforts to obtain authorization from the county for continued treatment or hospitalization of the patient.

A county is liable for such continued treatment and hospitalization if all other requirements under this subsection are met.

(cr) Each general relief agency of a county that elects to require hospitals or other health care providers to obtain authorization under par. (c) 3. shall either establish a written procedure using medical criteria for responding to requests for authorization for continued treatment or hospitalization under par. (c) 3., or it shall delegate the authorization responsibility to the requesting hospital, the attending physician or other medical personnel designated by the general relief agency. Each general relief agency shall inform the department as to whether it has developed a procedure for responding to requests or whether it has delegated the responsibility. Each general relief agency that develops a written procedure for responding to requests shall provide a copy to the department.

(cw) 1. A county which receives a notice under par. (c) 2g. shall, within 30 days after receipt of the notice, mail or deliver a written acceptance or denial that it is the county of liability under par. (ar) to the hospital or other health care provider. Except as provided in subd. 3., if the county fails to provide the written response within 30 days, the county is liable under par. (ar).

2. The sworn statement under par. (c) 2g. establishes a person's residency under this section unless the county which receives the sworn statement provides evidence to rebut the facts in the sworn statement.

3. This paragraph does not preclude a county from denying liability for emergency medical treatment or hospitalization provided to a person on the grounds that the person is not eligible for benefits under this section.

(d) Notwithstanding par. (c), if a hospital or other health care provider provides treatment or hospitalization under par. (am) and makes a good faith effort to determine the county which is liable under par. (ar) but an agent of the hospital or other health care provider fails to timely comply with par. (c) 1m., 2g., 2r. or 3. solely as the result of an error in determining the county which is liable under par. (ar), then the county under par. (ar) is liable for the costs of the treatment or hospitalization if an agent of the provider complies with the requirements of par. (c) 1m., 2g. or 2r. and, if the patient is still receiving treatment or hospitalization, the requirements of par. (c) 3. within 10 working days after discovering the error.

(e) A general relief agency may establish written standards to be used to determine what is reasonable care for the purposes of this section.

(g) A general relief agency may preauthorize general relief medical treatment for a period not to exceed 3 months in cases where repeated medical treatment for the same illness is required and general relief eligibility is continuous during the 3-month period.

(6) Officials and agencies administering general relief shall assist eligible dependent persons to regain a condition of self-support through every proper means at their disposal and shall give such service and counsel to those likely to become dependent as may prevent such dependency.

(6c) No individual who receives treatment or hospitalization under sub. (5) may be liable for the costs of the treatment or hospitalization otherwise reimbursable under this section if both of the following conditions exist:

(a) The individual is an eligible dependent person.

(b) The provider of the health care treatment or hospitalization fails to meet the requirements of sub. (5) (c) unless the provider's failure to meet those requirements results from an individual's wilful false representation.

(6g) No individual who receives treatment or hospitalization under sub. (5) may be liable for the difference between the costs of the treatment or hospitalization charged by the health care provider and the amount paid by the general relief agency.

(6r) Except as provided in sub. (5), unless the general relief agency first gives prior authorization for medical treatment or

hospitalization for an eligible dependent person or certifies a health care provider as required under s. 49.035 (6) (am), no county may be liable for medical treatment or hospitalization provided the eligible dependent person.

(7) Whenever the authorities charged with the administration of this section have reason to believe that a person receiving relief is engaging in conduct or behavior prohibited in ch. 944 or ss. 940.225, 948.02, 948.025 or 948.06 to 948.11 they shall promptly notify the law enforcement officials of the county thereof, including facts relating to such person's alleged misconduct or illegal behavior.

(8) Any person found ineligible for medical assistance because of the divestment provisions under s. 49.453 is ineligible for medical care under this section for the same period during which ineligibility exists under s. 49.453.

(9) (a) Any county may limit its liability for medical or dental care furnished as general relief, including emergency care provided under sub. (5), by adopting income and resource limitations which are not more restrictive than those set forth under s. 49.06. This limitation applies only to medical or dental care furnished as general relief on or after the date the county acts to limit its liability.

(b) A general relief agency may provide medical treatment to a person if the person expends his or her income in excess of the general relief eligibility level for his or her family on personal medical care or if the person incurs costs for that medical care in an amount that exceeds the income that is in excess of the general relief eligibility level.

(10) (a) Except as provided under par. (b), a county shall limit its liability for medical or dental care furnished as general relief, including emergency care provided under sub. (5), to the amount payable by medical assistance under ss. 49.43 to 49.47 for care for which a medical assistance rate exists.

(b) 1. Except as provided in subd. 1m, the department shall establish maximum rates for inpatient and outpatient hospital care furnished as general relief, including emergency care provided under sub. (5), equal to the interim rates payable under s. 49.45 (3) (e) in effect on December 31, 1986, adjusted annually to reflect any general inflationary rate increase provided for hospitals under medical assistance.

1m. If 2 or more hospitals merge or a new hospital is created after December 31, 1986, and the department establishes rates for inpatient and outpatient care furnished by the merged or newly created hospital under s. 49.45 (3) (e), then the department shall establish maximum rates for inpatient and outpatient care furnished by the merged or newly created hospital as general relief, including emergency care furnished under sub. (5), equal to the rates established under s. 49.45 (3) (e) following the merger or creation of the new hospital, adjusted annually to reflect any general inflationary rate increases provided for hospitals under medical assistance.

2. A county shall limit its liability for inpatient and outpatient hospital care furnished as general relief to the rates established under subd. 1. or 1m.

(c) No provider of medical or dental care may bill a general relief recipient for the cost of care exceeding the amount paid under this subsection by the county.

(11) A general relief agency may use vehicle registration information from the department of transportation in determining eligibility for general relief.

(12) (a) A law enforcement officer may review information provided under s. 49.53 (4) to determine whether an outstanding warrant has been issued for the arrest of a recipient of general relief.

(b) If a law enforcement officer believes, on reasonable grounds, that an outstanding warrant has been issued for the arrest of a general relief recipient, the law enforcement officer may request that a law enforcement officer be notified when the recipient appears to obtain his or her check.

(c) At the request of a law enforcement officer under par. (b), a county employe who disburses general relief checks may notify a law enforcement officer when the recipient appears to obtain a general relief check.

History: 1975 c. 184 s. 13; 1981 c. 20, 317; 1983 a. 27 ss. 1005 to 1011, 2202 (20); 1983 a. 205; 1985 a. 29 ss. 936g to 962m, 3200 (23); 1985 a. 120; 1987 a. 18, 27; 1987 a. 332 s. 64; 1989 a. 31, 36, 359; 1991 a. 39, 322; 1993 a. 227, 437

A county is liable under (5) for emergency services given a person who would be eligible for general relief even though that person refuses to apply therefor. *Mercy Medical Center v. Winnebago County*, 58 W (2d) 260, 206 NW (2d) 198

Prerequisites for municipal liability under (5) discussed. *Clintonville Community Hosp. v. Clintonville*, 87 W (2d) 635, 275 NW (2d) 655 (1979)

Hospital has no duty to undertake credit investigation of apparently dependent patient prior to rendering medical services; county should investigate after receiving notice under (5). *Trinity Memorial Hosp. v. Milwaukee*, 98 W (2d) 220, 295 NW (2d) 814 (Ct. App. 1980)

County's income guidelines under sub. (9) upheld; there is no requirement that the county consider the applicant's level of need. *Hiller v. Adams County*, 166 W (2d) 1038, 480 NW (2d) 563 (Ct. App. 1992)

Counties may not require relief recipient to surrender auto title and plates as condition of receipt of assistance. 61 Atty Gen. 313

Liability for cost of providing medical care to indigent person under arrest discussed. 67 Atty Gen. 245

Section 53.38, 1987 stats., [now 302.38] is exclusively applicable in providing relief from medical and hospital care costs incurred by indigent prisoner while receiving emergency medical treatment in hospital. 69 Atty Gen. 230

Rights and obligations of hospitals, counties and individual patients under Hill-Burton Act discussed. 70 Atty Gen. 24

Welfare applicants are entitled to a statement of reasons and administrative hearing after their application for general welfare relief is denied. *Alexander v. Silverman*, 356 F Supp. 1179

Duty of a private hospital to render emergency treatment. 1974 WLR 279

49.032 General relief benefits. (1) (c) Each general relief agency shall determine need and make a benefit payment at least monthly. Benefit payments for an eligible dependent person without other sources of income or resources, except as provided under s. 49.06 (1), shall be based on the following minimum monthly schedule: [See Figure 49.032 (1) (c) following]

Figure: 49.032 (1) (c)

Case size	Benefit amount
1	\$175
2	298
3	352
4	412
5	474

(d) For each general relief case in par. (c) whose size exceeds 5 persons, the general relief agency shall make an additional monthly payment of \$35 per person in excess of 5 in the case.

(e) Depending on the type and amount of the eligible dependent person's income or resources, if any, or number of days or type of need during a month, the benefit payments under this section may be adjusted by an amount that reflects the eligible dependent person's reduced need.

(f) Notwithstanding par. (c), if a person is eligible for benefits under s. 49.19 and, if the person received benefits under s. 49.19, the person would receive benefits calculated under s. 49.19 (11m) on the basis of the aid to families with dependent children level in the state in which the person most recently resided, the person may not receive general relief payments in an amount that exceeds the amount that he or she would receive under s. 49.19.

(2) If a general relief agency calculates for an eligible dependent person who is in need of general relief a general relief benefit amount for shelter and utility needs separately from a general relief benefit amount for basic maintenance needs, including food and clothing, the general relief benefit amount for basic maintenance needs shall be not less than one-third of the total payment amount required under this section, except that sub. (1) (e) applies.

(4r) If a general relief agency provides a monthly general relief benefit to an eligible dependent person which exceeds the monthly benefit amount required under sub. (1) (c), the department shall reimburse the general relief agency at the rate set forth

under s. 49.035 (1) (d), from the appropriation under s. 20.435 (4) (eb), for the amount paid to the eligible dependent person.

History: 1985 a. 29 ss. 966, 3200 (23); 1985 a. 120; 1987 a. 403 s. 256; 1989 a. 31, 359; 1991 a. 39; 1993 a. 16

49.035 State aid for general relief. (1) As provided in sub. (4e), the department shall reimburse, except for medical costs:

(d) A county for up to 37.5% of the eligible costs paid by the general relief agency for general relief provided under s. 49.02.

(2) As provided in sub. (4e), the department shall reimburse, for general relief medical costs:

(b) A county for:

7. Up to 40% of eligible medical costs incurred by the county on behalf of an individual client that are not more than \$10,000 per claim period.

8. Up to 70% of eligible medical costs incurred by the county on behalf of an individual client that exceed \$10,000 per claim period.

(cm) A county for up to 60% of the eligible medical costs for individual clients who are enrolled in a prepaid health care system with a uniform fee per person, if the following requirements are met:

1. The system is established through a process of competitive bidding that shall be among health care providers that are health maintenance organizations as defined under s. 609.01 (2).

2. The accepted bid or bids must meet acceptable standards, criteria for which shall be developed by the department.

3. The full range of medical or dental care furnished by the general relief agency as general relief, including emergency medical treatment and hospitalization, must be available for general relief clients under a contract between a general relief agency and a health maintenance organization for provision of general relief medical treatment and hospitalization.

(4) Claims for reimbursement under subs. (1) and (2) shall be filed with the department by March 1 of the year immediately following the calendar year in which the costs were incurred.

(4e) (a) If claims for eligible general relief costs at the maximum rates under subs. (1) and (2) do not exceed the total of the funds available under s. 20.435 (4) (eb) and the payments to county hospitals and county mental health complexes under par. (c) for that fiscal year, the department shall determine the amount of a county's reimbursement from the appropriation under s. 20.435 (4) (eb) by applying the maximum rates under subs. (1) and (2) to the county's eligible costs and subtracting the amount paid to county hospitals and county mental health complexes in the county under par. (c).

(b) If claims for eligible general relief costs at the maximum rates under subs. (1) and (2) do exceed the total of the funds available under s. 20.435 (4) (eb) and the payments to county hospitals and county mental health complexes under par. (c) for that fiscal year, the department shall prorate the funds available under s. 20.435 (4) (eb) among the counties. Under this paragraph, the department shall determine the amount of a county's reimbursement from the appropriation under s. 20.435 (4) (eb) by subtracting the amount paid to county hospitals and county mental health complexes in the county under par. (c) from its prorated share of the funds available under s. 20.435 (4) (eb).

(c) The department shall distribute the payments under s. 49.45 (6y) and (6z) to county hospitals and county mental health complexes that qualify for these payments at the time that the county is paid under par. (a) or (b). For the year for which the payment under par. (a) or (b) is made, the county shall treat the payments to county hospitals and county mental health complexes as reimbursement for general relief claims under sub. (4).

(4m) The department shall reimburse the general relief agency for claims submitted under sub. (4) on or before the July 31 immediately following the March 1 filing date or within 30

days after the effective date of the act that provides funding for the general relief appropriation from which general relief claims are paid, whichever is later.

(5m) The department shall establish a uniform reporting system for use by counties to provide the department with case and fiscal information relating to general relief costs.

(6) No county may receive reimbursement for any general relief expenditures unless the county does all of the following:

(am) Requires prior authorization or health care provider certification for a specified period of time by the general relief agency for all nonemergency medical care that is provided.

(b) Develops and files with the department on or before October 1 of each year a medical cost containment plan for the subsequent calendar year. The plan shall include provisions limiting the inappropriate use of emergency room care and controlling payments to providers and may include provisions on supplying case management services. The department shall approve or disapprove the plan within a reasonable period of time after the plan is timely filed.

(c) Provides information to the department relating to general relief costs.

(6m) Notwithstanding sub. (6), the department may deny any general relief reimbursement if the county fails to comply with the general relief requirements of this chapter.

(7) In this section "medical costs" means costs for medicine, medical, chiropractic, surgical, dental, hospital and nursing care and optometrical services.

History: 1983 a. 27, 192; 1985 a. 29 ss. 967 to 974m, 3200 (23); 1985 a. 120; 1987 a. 27; 1989 a. 31, 359; 1991 a. 39, 269; 1993 a. 16.

49.037 Procedural rights. (1) An individual may apply for general relief and shall have the opportunity to do so. A general relief agency shall, in a prominent place in the general relief agency office, post notice of the right of any individual to apply.

(2) A general relief agency shall make available to an applicant for or recipient of general relief the following printed documents:

(a) A description of the general relief program which shall include at least the following information:

1. The kinds and levels of benefits available as general relief.
2. The application process, including time limitations.
3. The appeal rights for applicants and recipients and a description of the appeals process, including any time limitations.

(b) A statement of standards of general relief policies and procedures concerning all of the following:

1. Application for assistance.
2. Eligibility for benefits.
3. Amounts of assistance provided.
4. Actions of a recipient that will cause the termination, suspension or reduction of assistance.

(3) An application shall be in writing. A general relief agency shall make an application form available to an individual upon request. The general relief agency shall notify an applicant in writing of the disposition of the application within 15 working days after receipt of the application.

(4) The general relief agency shall inform each applicant for general relief of other public assistance programs administered by county, state or federal agencies, including temporary and interim assistance, low-income energy assistance authorized under 42 USC 8621 to 8629, aid to families with dependent children, emergency assistance for families with children, medical assistance, food stamps and supplemental security income and shall refer individuals to any local agency administering these programs. Application to or potential eligibility for aid under any of these programs, unemployment compensation or Hill-Burton benefits authorized under 42 USC 291c (e) may not constitute a basis for denial of eligibility for general relief. Any benefits expected by but not immediately available to a general relief applicant from

any of these programs may not be considered presently available money, income, property or credit, or other means by which it can be presently obtained.

(5) Written notice required under sub. (3) to an individual whose application is denied in whole or in part shall contain the following:

(a) Specific reasons for the denial.

(b) A statement of the evidence and policy relied upon in making the denial determination.

(c) A statement of the procedure by which the applicant may petition the general relief agency under sub. (7) for a review of the denial determination.

(6) (a) Except as provided under par. (d), if the general relief agency terminates, suspends or reduces the general relief payment to a recipient in a continuing aid case, the determination to terminate, suspend or reduce is effective 10 working days after mailing or personal delivery of a written notice of the determination to the recipient affected by the action.

(b) Notwithstanding par. (a), if the recipient appeals the determination within 10 working days after the notice in par. (a) is mailed or personally delivered, the general relief agency shall continue the general relief payment to the recipient in the amount paid before the determination of termination, suspension or reduction until a hearing under sub. (7) is held and a decision under sub. (9) is issued.

(c) Written notice under par. (a) to a recipient in a continuing aid case shall contain the following:

1. A statement of the effective date of the determination.
2. Specific reasons for the determination.
3. A statement of the evidence and policy relied upon in making the determination.
4. A statement of the procedure by which the recipient may petition the general relief agency under sub. (7) for a review of the determination.

5. A statement of the recipient's right to continue to receive his or her general relief payment in the amount paid before the determination of termination, suspension or reduction, if the recipient appeals the determination within 10 working days after the general relief agency mailed or personally delivered the notice.

(d) For purposes of this subsection, a reduction of a recipient's general relief payment does not include a reduction made by a general relief agency of the amount of a recipient's general relief payment or voucher based on a reduction in a vendor's actual charge to a recipient.

(7) An individual whose application for general relief is not acted upon within the period required under sub. (3) or who is denied general relief in whole or in part, or whose general relief is terminated, suspended or reduced, may petition in writing, within 30 days after the action, the general relief agency for a review of the action. The general relief agency shall provide a hearing petition form to an individual who requests a review. Upon receipt of the petition, the general relief agency shall hold a hearing at a date and place convenient to the petitioner. Unless the petitioner requests a deferral of the hearing, the general relief agency shall hold the hearing within 10 working days after receipt of the petition.

(8) At a hearing conducted under this section, the general relief agency shall:

(a) Permit the petitioner or his or her representative, at a reasonable time before the date of the hearing and during the hearing, to examine all documents or records to be used at the hearing.

(b) Permit the petitioner to present his or her case personally or with the aid of others, including an attorney.

(c) Permit the petitioner or a representative to subpoena witnesses and, if the petitioner is represented by an attorney, permit the attorney to issue a subpoena to compel the attendance of a witness or the production of evidence. A subpoena issued by an attorney

ney must be in substantially the same form as provided in s. 805.07 (4) and must be served in the manner provided in s. 805.07 (5). The attorney shall, at the time of issuance, send a copy of the subpoena to the decision maker specified in par. (f).

(d) Permit the petitioner or a representative to establish all facts and circumstances pertinent to his or her case.

(e) Permit the petitioner or a representative to question or refute any testimony or evidence, including permission to confront and cross-examine adverse witnesses.

(f) Furnish an impartial decision maker who is familiar with the general relief program and who may not communicate outside a hearing with either party concerning a hearing.

(g) Keep a record of the proceedings and make the record available to the petitioner upon appeal.

(9) The general relief agency shall issue its decision within 5 working days after the hearing under sub. (8). The hearing decision shall:

(a) Be based exclusively on evidence presented at the hearing, except that if an issue of credibility or veracity exists the decision may not be based on mere uncorroborated hearsay.

(b) Be issued and implemented within 5 working days after the date of the hearing.

(c) Inform the petitioner of the evidence and policies relied upon in reaching the decision and of the right to appeal to circuit court, including identification of the proper party to the appeal, the time limits and procedure for the appeal.

(10) Appeal of the decision under sub. (9) is to the circuit court. The review shall be conducted by the court without a jury and shall be confined to the record, except that in case of an alleged irregularity in procedure before the general relief agency, testimony on it may be taken in the court. If leave is granted to take this testimony, depositions and written interrogatories may be taken as set forth in ch. 804 before the date set for hearing if proper cause is shown for doing so.

(11) The provisions of s. 893.80 do not apply to claims arising as a result of a denial, suspension, reduction or termination of general relief.

History: 1983 a 27; 1985 a 29 ss. 975, 3200 (23); 1985 a 120; 1987 a 27, 403; 1989 a 139, 359; 1991 a 322.

49.043 Health insurance for unemployed persons.

Any municipality or county may purchase health or dental insurance for unemployed persons residing in the municipality or county who are not eligible for medical assistance under s. 49.46, 49.468 or 49.47.

History: 1983 a 386; 1989 a 31.

49.046 Relief of needy Indian persons. (1) DEFINITIONS

In this section:

(a) "American Indian" means a person who is recognized by an elected tribal governing body in this state as a member of a federally recognized Wisconsin tribe or band of Indians.

(b) "Tax-free land" means land in this state within the boundaries of a federally recognized reservation or within the bureau of Indian affairs service area for the Winnebago tribe, which is not subject to assessment or levy of a real property tax either as a general tax or as a payment in lieu of taxes.

(2) **ELIGIBILITY.** A person is eligible for aid under this section if all of the following conditions exist:

(a) The person is an American Indian residing on tax-free land or is the spouse or child of such a person residing in the same household.

(b) The person is ineligible to receive the type of aid needed under s. 49.177, 49.19 or 49.46.

(c) The person complies with s. 49.047.

(d) The person meets the financial standard of need as determined under s. 49.19.

(e) The person is not a member of a work-not-welfare group, as defined in s. 49.27 (1) (c), that received benefits determined under s. 49.27 (4) or (11) (a) to (f) during that month.

(f) If the person is or was a member of a work-not-welfare group, as defined in s. 49.27 (1) (c), other than a nonlegally responsible relative caretaker of a dependent child, as defined in s. 49.19 (1) (a), or an adult who was a dependent child at the time that he or she was a member of the work-not-welfare group, the work-not-welfare group has not received benefits determined under s. 49.27 (4) or (11) (a) to (f) for any of the preceding 36 months.

(3) **AID.** (a) 1. From the appropriation under s. 20.435 (4) (e), the department shall pay aid to eligible persons based on family size. The department shall designate 2 areas of the state based on variations in shelter cost. Except as provided under subd. 1m., monthly payments shall be as follows:

a. Family of one, \$216 in area I and \$209 in area II.

b. Family of 2, \$381 in area I and \$369 in area II.

c. Family of 3, \$448 in area I and \$434 in area II.

d. Family of 4, \$535 in area I and \$519 in area II.

e. Family of 5, \$614 in area I and \$597 in area II.

f. Family of 6, \$664 in area I and \$644 in area II.

g. Family of 7, \$719 in area I and \$698 in area II.

h. Family of 8, \$761 in area I and \$741 in area II.

i. Family of 9, \$798 in area I and \$774 in area II.

j. Family of 10, \$817 in area I and \$792 in area II.

k. For each additional member in the family over 10, \$17 shall be added to the amount under subd. 1. j.

1m. The administering agency shall reduce the monthly benefit payment under subd. 1. by the value of other benefits provided to the family by the tribe and pay the amount of that reduction directly to the elected tribal governing body.

2. In determining family size, the administering agency shall include all eligible persons living in the same household. Only one grant per household may be paid.

3. The administering agency may make the monthly payment for a household to one adult beneficiary or it may prorate the payment among all adult beneficiaries who are included in the family size.

(b) 1. Payments for medical care may be made for any benefit authorized under s. 49.46 (2).

2. Payments shall be equal to the rates established under s. 49.45.

3. Recipients of aid for medical care are subject to the copayment provisions established under s. 49.45 (18).

(4) **ADMINISTRATION** (a) The department, after consulting with all elected tribal governing bodies in this state, shall promulgate rules for the uniform administration of aid under this section.

(b) The department shall appoint each elected tribal governing body administering federal assistance on tax-free land to administer this section. If a tribal governing body elects not to administer this section, the department, with the consent of the elected tribal governing body, shall appoint an American Indian organization in the county or municipality, or the county department under s. 46.215 or 46.22, as the administering agency.

(c) If an administering agency fails to administer this section according to the rules promulgated under par. (a), the department shall notify the administering agency of the rules it has violated, give it a reasonable opportunity to correct the violations and assist it in doing so.

(d) If the violations are not corrected, the department shall notify the administering agency of its intent to appoint another administering agency and provide it with an opportunity for a hearing before the secretary. If the administering agency is an American Indian organization, the department shall notify the

elected tribal governing body of its intent to remove the organization as administering agency.

(e) If the administering agency waives a hearing under par (d) or if the secretary determines that another administering agency should be appointed, the department shall, after consulting with the elected tribal governing body, appoint an American Indian organization in the county or municipality as the administering agency, or shall appoint the county department under s. 46.215 or 46.22 as the administering agency.

(f) The department, after consulting with all elected tribal governing bodies in this state, shall promulgate rules establishing the allowable costs of administering this section and shall reimburse each administering agency for its allowable costs from the appropriation under s. 20.435 (4) (de).

(g) The administration of this section by any elected tribal governing body or other American Indian organization does not confer on this state jurisdiction over any American Indian tribe or organization.

(5) FAIR HEARING AND REVIEW. Any person whose application for aid under this section is not acted upon with reasonable promptness, whose application is denied in whole or in part, whose award is modified or canceled or who believes the award to be insufficient may petition the department for a fair hearing and review in the manner provided under s. 49.50 (8). The procedures described in s. 49.50 (8) apply to the fair hearing and review under this subsection, except that the rights and duties of counties and county officers that administer public assistance apply to any elected tribal governing body or American Indian organization, and to the officers of the body or organization, that administers this section. In all proceedings for judicial review arising from the administration of this section, the department is the respondent. If any elected tribal governing body, American Indian organization or officer fails to comply with a departmental decision issued under s. 49.50 (8) (b), the department may execute the order.

History: 1973 c. 147, 330, 333; 1975 c. 41; 1977 c. 29, 418; 1979 c. 32; 1979 c. 34 s. 2102 (20) (a); 1979 c. 221; 1981 c. 20 ss. 809, 2202 (20) (r); 1981 c. 392; 1983 a. 27; 1983 a. 245 s. 15; 1983 a. 404; 1985 a. 176; 1985 a. 332 s. 251 (1); 1987 a. 27; 1989 a. 31; 1991 a. 39; 1993 a. 99.

49.047 Relief of needy Indian persons; work experience program. (1) The purpose of the work experience program is to provide a useful work experience, and when possible, work training opportunities which may lead to gainful employment for the persons receiving relief under s. 49.046. The work experience program may include a grant diversion program under s. 49.048.

(2) In this section, "work experience program" means a program authorized and sponsored by the agency appointed to administer relief under s. 49.046 for eligible recipients of relief under s. 49.046.

(3) (a) The agency administering relief under s. 49.046 shall operate a work experience program. The department may waive this requirement for any agency if it finds that requiring the agency to operate the program is not cost effective due to the low number of participants.

(b) Any county department under s. 46.215 or 46.22 operating a work experience program is liable to persons participating in the program for any worker's compensation benefits recoverable under ch. 102. The agency may contract with any governmental unit for whose benefit a work experience project is primarily designed to assume wholly or to share liability. Any governmental unit benefited by a work experience project may contract to assume this liability. If an elected tribal governing body or an Indian organization is operating the work experience program, liability for worker's compensation benefits attaches only if the elected tribal governing body or Indian organization contracts to assume this liability with the department.

(4) Recipients of relief under s. 49.046 shall participate in a work experience program. Nonparticipation shall be cause for terminating assistance. The department, after consultation with

all elected tribal governing bodies, shall by rule provide exceptions to this policy, but the department may not exempt individuals from participation in the work experience program because of their status as students.

(5) Work experience programs shall not be operated so as to supplant regular employes of the administering entity or other municipal, county or state governmental units.

(6) Section 49.05 does not apply to this section.

(7) An agency administering relief of needy Indian persons under s. 49.046 may use work experience program funds to obtain tools and equipment for use in the program if the agency receives approval from the department.

History: 1977 c. 418; 1981 c. 20; 1983 a. 404; 1985 a. 176; 1987 a. 27.

49.048 Relief of needy Indian persons; grant diversion. (1) In this section:

(a) "Agency" means an agency administering relief of needy Indian persons under s. 49.046 (4).

(b) "Operator" means an agency, if the agency administers a grant diversion program under this section directly, or the person operating a grant diversion program under a contract with an agency.

(2) An agency may administer, directly or by contract, a grant diversion program. Under the program, the agency may use all or part of the grant provided under s. 49.046 to subsidize, for a period not to exceed 6 months, up to 50% of the wages an employer pays a recipient for a job performed by the recipient under a written contract between the operator and the employer.

(3) A recipient working in a grant diversion program shall be paid by the hour, using as the hourly rate the higher of the following:

(a) The hourly wage rate paid other entry level employes of the employer who perform the same work.

(b) The federal minimum hourly wage under 29 USC 206 (a) (1).

(4) An employer shall repay the agency the total amount of wage subsidy received for employing a recipient if the employer fails to retain the recipient for 3 months following termination of the wage subsidy, unless cause exists for the employer to dismiss the recipient.

(5) A grant diversion contract between an operator and an employer may not contravene a collective bargaining agreement entered into by the employer.

(6) A grant diversion program may not be operated so as to supplant an unsubsidized employe.

(7) The agency may not find a recipient ineligible for relief of needy Indian persons benefits under s. 49.046 on the basis of income earned in a grant diversion program.

(8) A recipient participating in a grant diversion project shall comply with grant diversion rules promulgated under sub. (9). If the recipient violates grant diversion rules the agency may suspend relief of needy Indian persons benefits to the recipient as follows:

(a) For a first violation, for a period not to exceed 30 days.

(b) For a 2nd or subsequent violation, for a period not to exceed 60 days.

(9) The department shall promulgate rules for the grant diversion program.

History: 1987 a. 27.

49.049 Tribal economic development projects.

(1) Elected governing bodies of American Indian tribes may submit proposals for economic development projects to the department.

(2) The department, after consulting with the department of development, shall establish criteria for evaluating proposals submitted under sub. (1).

(3) The department may provide not more than \$30,600 in each fiscal year for economic development projects that satisfy the criteria established under sub. (2) to tribal governing bodies from funds appropriated under s. 20.435 (4) (de) for the administration of the work experience program under s. 49.047. Funds not provided for economic development projects shall be expended for the work experience program.

History: 1987 a. 27; 1993 a. 16.

49.05 Work relief. (1g) Except as provided under s. 49.055 (2), a general relief agency may require an individual entitled to general relief to labor on any work relief project authorized and sponsored by the general relief agency, at work which the individual is capable of performing. If a work relief project requires the employment of a skilled worker, and the number of workers so skilled listed on the general relief rolls of the general relief agency sponsoring the project is not sufficient to meet the requirements of the project, the general relief agency may hire a skilled worker who is not receiving general relief, and he or she shall be paid at the prevailing wage for such labor in the city, village or town in which the work relief project is located.

(1m) A general relief agency that authorizes, operates or sponsors a work relief project shall establish written work relief rules.

(2) The basis of total payment, including any amount of the payment which constitutes state reimbursement under s. 49.035 (1), of an individual granted work relief shall be per hour of work relief performed by that individual, using as the hourly rate at least the federal minimum hourly wage prescribed by 29 USC 206 (a) (1).

(3) A work relief project may be authorized for the performance of any work not prohibited by law. An individual entitled to work relief may be assigned by a general relief agency to work for a work relief project operated by mutual agreement with the state, with another general relief agency, with a municipality, school district, drainage district, utility district, metropolitan sewerage district or other governmental unit or with a nonprofit corporation, under which agreement the governmental unit or nonprofit corporation to which the individual is lent may provide for full or partial work relief reimbursement to the general relief agency lending the individual.

(4) A county granting work relief shall be directly liable to an individual granted work relief for any benefits legally recoverable under the worker's compensation law of this state, but may contract with another governmental unit, for whose benefit the work relief project is primarily designed, to share the liability or wholly assume it, and that other governmental unit may make a contract sharing or totally assuming liability.

(5) A general relief agency may authorize the sale of a product made on any work relief project to a governmental unit or to a religious, charitable or educational institution.

(6) A general relief agency may operate a work relief project which will serve to rehabilitate a disabled individual so as to enable the individual to qualify for employment in public or private industry.

(7) The amount of payment computed under sub. (2) as applied to the amount of monthly general relief benefits paid to the dependent person under this section correspondingly reduces the amount of labor which may be required of the individual. No dependent person may be liable under s. 49.08 for the value of payment so computed.

(7m) From the appropriation under s. 20.435 (4) (eb), the department shall reimburse the county for the value of work relief payment provided under sub. (2) at the reimbursement levels under s. 49.035, less any reimbursement received by the county under sub. (3), and for the educational payment under sub. (9) at the reimbursement levels under s. 49.035.

(8) Any individual assigned to or working on a work relief project shall comply with appropriate work relief rules established

by the general relief agency. If an individual first fails to comply with appropriate work relief rules the general relief agency may discontinue or deny general relief benefits to the individual for a period not to exceed 30 days. If an individual fails to comply 2 or more times with appropriate work relief rules the general relief agency may discontinue or deny general relief benefits to the individual for a period not to exceed 60 days.

(9) A general relief agency may authorize a recipient of general relief to enroll in and attend any of the educational programs set forth under s. 49.055 (1) or any other program that in the judgment of the general relief agency can assist the recipient in achieving financial independence in lieu of the performance by that recipient of labor under a work relief project under this section. The abatement of the benefit payment of any person granted this authorization shall be per hour of in-class attendance, using the hourly rate set forth under sub. (2).

(10) The department shall promulgate rules to establish standards for determinations of benefit denial or discontinuance which exceed 30 days under sub. (8).

History: 1975 c. 147 s. 54; 1983 a. 27; 1985 a. 29 ss. 977 to 986m, 3200 (23); 1989 a. 31, 359; 1991 a. 39.

49.053 General relief grant diversion. (1) In this section, "employer" means a governmental unit, an individual, a corporation, including a nonprofit corporation, a limited liability company, a partnership or any other association.

(1m) A general relief agency may administer, by contract, a program of general relief grant diversion for general relief recipients. Under a grant diversion program, a general relief agency may use all or a part of the benefit payment provided under s. 49.02 to subsidize an employer at up to 50% of the wages he or she pays the recipient for a job performed by the recipient, for a period not to exceed 6 months, under a written contract between the general relief agency and an employer.

(2) The basis for cash wage payment to a general relief recipient performing work through a general relief grant diversion program shall be per hour of labor performed by the recipient, using as the hourly rate the higher of the following:

(a) The hourly wage rate paid other entry level employees of the employer who perform the same work.

(b) The federal minimum hourly wage prescribed by 29 USC 206 (a) (1).

(3) The amount of benefit payment provided under s. 49.02 for a general relief recipient that is used to subsidize the employer under this section correspondingly reduces the amount of labor which may be required of the individual at the rate which is the ratio between the amount used to subsidize the employer and the total wage paid. No dependent person may be liable under s. 49.08 for the value of payment so provided.

(4) From the appropriation under s. 20.435 (4) (eb), the department shall reimburse the county for the value of wage subsidization provided the employer of an individual under a general relief grant diversion program, at the reimbursement levels under s. 49.035.

(5) The contract under sub. (1) shall specify that the employer shall repay to the general relief agency the total amount of wage subsidization received if the employer fails to retain the general relief recipient in employment for 3 months following termination of wage subsidization, unless cause exists for the employer to dismiss the recipient.

(6) No contract between the general relief agency and an employer under sub. (1) may be in contravention of an applicable existing collective bargaining agreement entered into by the employer.

(7) A grant diversion program may not be operated so as to supplant a regular employe of an employer.

(8) A county operating a general relief grant diversion program shall be directly liable to an individual granted grant diversion for any benefits legally recoverable under the worker's com-

pensation law of this state, unless the employer, by contract under sub. (1), agrees to share or totally assume this liability.

(9) A general relief agency that authorizes, operates or sponsors a grant diversion program shall establish written grant diversion rules.

(10) Any individual assigned to or working on a grant diversion project shall comply with appropriate grant diversion rules established under sub. (9). If an individual fails to comply with appropriate grant diversion rules the general relief agency may discontinue or deny general relief benefits to the individual for a period not to exceed 30 days. If an individual fails to comply 2 or more times with appropriate grant diversion rules the general relief agency may discontinue or deny general relief benefits to the individual for a period not to exceed 60 days.

(11) A general relief agency may not base a denial of eligibility for a general relief recipient on the receipt by that recipient of income earned under this section.

(12) The department shall promulgate rules to establish standards for determinations of benefit denial or discontinuance which exceed 30 days under sub. (10).

History: 1985 a 29 ss 987, 3200 (23); 1989 a 31; 1991 a 39; 1993 a 112

49.055 Approved educational program. (1) Eligibility for general relief under s. 49.02 shall not be affected for any otherwise eligible applicant for or recipient of general relief while the applicant or recipient is enrolled in and in good standing in any of the following:

(a) A public school, as described in s. 115.01 (1).

(b) A course of study meeting the approval of or standards established by the state superintendent of public instruction for a determination of high school graduation equivalency under s. 115.29 (4).

(c) A program established by a district board of vocational, technical and adult education [technical college district board] under ch. 38, which provides instruction in English as a 2nd language or is a basic remedial education or literacy program.

NOTE: The vocational, technical and adult education system was renamed the technical college system by 1993 Wis. Act 399.

(2) Eligibility for general relief under s. 49.05 (1g) and (8) shall not be affected for any otherwise eligible applicant for or recipient of general relief while the applicant or recipient is enrolled in and in good standing in any program under sub. (1) if, solely by reason of the enrollment and good standing, the applicant or recipient is unable to meet requirements of grant diversion or work relief rules established by the general relief agency.

History: 1985 a 29 ss 988, 3200 (23); 1989 a 359.

49.057 Enhanced general relief work program.

(1) A general relief agency may operate an enhanced work program for recipients of general relief. Under an enhanced work program, the general relief agency shall do all of the following:

(a) Assess each participant's employability, considering the participant's prior work experience and need for educational and other services.

(b) Develop an employability plan for each participant that includes an employment goal and identifies the services under sub. (2) that the participant needs to reach the employment goal.

(c) Enter into an agreement with each participant that describes the participant's obligations and includes the general relief agency's commitment to provide the services identified in the employability plan under par. (b).

(2) Under an enhanced work program, the general relief agency may only provide services authorized under s. 49.02 (6), 49.05 or 49.053.

(3) A general relief agency that operates an enhanced work program shall establish written rules for the enhanced work program.

(4) (a) A general relief recipient shall comply with rules established for the enhanced work program by the general relief agency. A participant in the enhanced work program shall comply

with the participant-agency agreement under sub. (1) (c), if the general relief agency provides the services identified in the employability plan under sub. (1) (b).

(b) If a general relief recipient fails to comply as provided in par. (a), the general relief agency may discontinue general relief benefits to the recipient for a period not to exceed 30 days for the first failure and for a period not to exceed 60 days for a 2nd or subsequent failure.

(5) The department shall promulgate rules to establish standards for benefit discontinuances that exceed 30 days under sub. (4).

History: 1991 a 39

49.06 Income and property exemptions; property assignment. (1) The following are not money, income, property or credit, or other means by which it can be presently obtained, for purposes of determining status as an eligible dependent person or the amount of general relief benefit due:

(a) A policy of insurance, the cash or loan value of which is not in excess of \$300.

(b) A vehicle, the equity value of which is \$1,500 or less.

(c) Credit received under subch. VIII of ch. 71.

(d) Low-income energy assistance benefits authorized under 42 USC 8621 to 8629.

(e) Food stamp benefits authorized under 7 USC 2011 to 2029.

(f) Expenses constituting up to 20% of gross earned income or \$100 per month, whichever is lower, reasonably related to the performance of work, except work performed on a work relief project under s. 49.05.

(1m) Notwithstanding sub. (1) (b), if the waiver under s. 49.19 (4) (by) is in effect, vehicles with a total equity value of not more than \$2,500 are not property for purposes of determining status as an eligible dependent person or the amount of general relief benefit due.

(2) (a) No person may be denied general relief because the person possesses equity in the home in which he or she lives.

(c) No applicant for general relief may be required to assign the equity under par. (a) or insurance policy under sub. (1) (a) as a condition for receiving general relief. If a person is not in fact dependent, but by reason of a fallen market or economic or other conditions would be required to suffer a substantial loss if the person converted his or her limited real or personal holdings, the person may assign property to the county in order to become qualified to receive general relief. The county may sell, lease or transfer the property, defend and prosecute all actions concerning it, pay all just claims against it and do all other things necessary for the protection, preservation and management of the property.

(3) A general relief agency may adopt written criteria to deny eligibility for general relief medical benefits to a person who, in contemplation of becoming eligible to receive general relief benefits, disposes of his or her assets for significantly less than full value during the 90 days immediately before the person applies for general relief medical benefits.

History: 1985 a 29, 120; 1987 a 312 s 17; 1989 a 359; 1991 a 322

49.08 Recovery of general relief paid. If any person is the owner of property at the time of receiving general relief under this chapter or as an inmate of any county or municipal institution in which the state is not chargeable with all or a part of the inmate's maintenance or as a tuberculosis patient provided for in ss. 58.06 and 252.07 to 252.10, or at any time thereafter, or if the person becomes self-supporting, the authorities charged with the care of the dependent, or the board in charge of the institution, may sue for the value of the general relief from the person or the person's estate. Except as otherwise provided in this section, the 10-year statute of limitations may be pleaded in defense in an action to recover general relief. Where the general relief recipient is deceased, a claim may be filed against the decedent's estate and the statute of limitations specified in s. 859.02 shall be exclusively applicable. The court may refuse to render judgment or allow the

claim in any case where a parent, spouse, surviving spouse or child is dependent on the property for support. The court in rendering judgment shall take into account the current family budget requirement as fixed by the U.S. department of labor for the community or as fixed by the authorities of the community in charge of public assistance. The records kept by the municipality, county or institution are prima facie evidence of the value of the general relief furnished. This section shall not apply to any person who receives care for pulmonary tuberculosis as provided in s. 252.08 (4).

History: 1975 c. 94; 1975 c. 413 s. 18; 1979 c. 102 s. 237; 1983 a. 27; 1985 a. 29; 1989 a. 96; 1993 a. 27.

Dependent of relief applicant incurs no liability to repay any portion of relief granted under the application. Claims against the recipient's estate are not limited to recovery of relief granted less than 10 years prior to death. In re Estate of Bundy, 81 W (2d) 32, 259 NW (2d) 701

49.083 Recovery of general relief overpayments.

The general relief agency may recover an overpayment of general relief paid to a recipient from the general relief payment currently provided to that recipient. The amount of general relief that may be recovered may not exceed 7% of the general relief payment made to the recipient. The general relief agency shall establish written criteria for the recovery of overpayments of general relief under this section.

History: 1991 a. 322.

49.085 No action against members of the Menominee Indian tribe in certain cases.

No action shall be commenced under s. 46.10 or 49.08 or any other provision of law for the recovery from assets distributed to members of the Menominee Indian tribe and others by the United States pursuant to P.L. 83-399, as amended, for the value of relief or old-age assistance under s. 49.20, 1971 stats., as affected by chapter 90, laws of 1973, and the value of maintenance in state institutions under ch. 46, furnished prior to termination date as defined in s. 70.057 (1), 1967 stats., to any legally enrolled member of the Menominee Indian tribe, his or her dependents, or lawful distributees of such member under section 3, said P.L. 83-399, as amended. For purposes of this section, "legally enrolled members of the Menominee Indian tribe" shall include only those persons whose names appear on "Final Roll-Menominee Indian Tribe of Wisconsin" as proclaimed by the secretary of the interior November 26, 1957, and published at pages 9951 et seq. of the federal register, Thursday, December 12, 1957.

History: 1973 c. 147, 243; 1983 a. 192.

49.12 Penalties; evidence. (1) Any person who, with intent to secure public assistance under this chapter, whether for himself or herself or for some other person, wilfully makes any false representations may, if the value of the assistance so secured does not exceed \$300, be required to forfeit not more than \$1,000; if the value of the assistance exceeds \$300 but does not exceed \$1,000, be fined not more than \$250 or imprisoned for not more than 6 months or both; if the value of the assistance exceeds \$1,000 but does not exceed \$2,500, be fined not more than \$500 or imprisoned for not more than 5 years or both; and if the value of the assistance exceeds \$2,500, be punished as prescribed under s. 943.20 (3) (c).

(2) Any person who wilfully does any act designed to interfere with the proper administration of public assistance shall be fined not less than \$10 nor more than \$100 or be punished by imprisonment for not less than 10 nor more than 60 days. The acceptance of any supplies or articles furnished to any person as general relief in exchange for or in payment for any alcohol beverages shall be deemed to be a violation of this subsection, but violations of this subsection shall not be limited to such acts.

(3) Any dependent person who sells or exchanges supplies or articles furnished the person as assistance or who disposes of such supplies or articles in any other way than as directed, with intent thereby to defraud the county or municipality furnishing the assistance, and any person who purchases any article knowing it

to have been furnished to another person as assistance shall be punished as provided in sub. (2).

(4m) Any person who does all of the following shall be fined not more than \$500 or imprisoned for not more than 30 days or both:

(a) Without legal authority, sends or brings a dependent person to a municipality or advises a dependent person to go to a municipality for the purpose of obtaining general relief under s. 49.02, aid to families with dependent children under s. 49.19, medical assistance under ss. 49.45 to 49.47 or food stamps under 7 USC 2011 to 2029.

(b) Obtains a pecuniary advantage because the person is brought or sent or goes to the municipality.

(5) Any person in charge of public assistance or any of the person's assistants who receives or solicits any commission or derives or seeks to obtain any personal financial gain through any purchase, sale, disbursement or contract for supplies or other property used in the administration of public assistance shall be punished as provided in s. 946.13.

(6) Where a person is originally eligible for assistance and receives any income or assets or both thereafter and fails to notify the officer or agency granting such assistance of the receipt of such assets within 10 days after such receipt and continues to receive aid, such failure to so notify the proper officer or agency of receipt of such assets or income or both shall be considered a fraud and the penalties in sub. (1) shall apply.

(7) Any dependent person who uses money, checks, share drafts, other drafts, vouchers or any other thing of value furnished to the person as general relief for purposes other than as directed by the general relief agency furnishing such general relief shall be punished as provided in sub. (2).

(8) Any person who makes any statement in a written application for aid under this chapter shall be considered to have made an admission as to the existence, correctness or validity of any fact stated, which shall be taken as prima facie evidence against the party making it in any complaint, information or indictment, and in any action or proceeding brought for the enforcement of any provision of this chapter.

(9) If any person obtains for himself or herself, or for any other person or dependents or both, assistance under this chapter on the basis of facts stated to the authorities charged with the responsibility of furnishing assistance and fails to notify said authorities within 10 days of any change in the facts as originally stated and continues to receive assistance based on the originally stated facts such failure to notify shall be considered a fraud and the penalties in sub. (1) shall apply. The negotiation of a check, share draft or other draft received in payment of such assistance by the recipient or the withdrawal of any funds credited to the recipient's account through the use of any other money transfer technique after any change in such facts which would render the person ineligible for such assistance shall be prima facie evidence of fraud in any such case.

(10) Any person who accepts a relief voucher granted as relief and fails to tender the commodities authorized by the relief authorities to the relief recipient but in lieu thereof refunds to the relief recipient cash or substitutes any alcohol beverages or cigarettes not authorized by the relief voucher shall be considered to have committed a fraud and the penalties provided in sub. (1) shall apply to said person.

(11) "Public assistance" as used in this section includes general relief.

History: 1971 c. 182; 1977 c. 303; 1981 c. 20; 1981 c. 79 s. 17; 1981 c. 390 s. 252; 1983 a. 368; 1985 a. 29 ss. 1002 to 1004, 3200 (23); 1987 a. 27, 403; 1991 a. 39, 316, 322.

Sub. (9) is not unconstitutionally vague. *Weber v. State*, 59 W (2d) 371, 208 NW (2d) 396.

A welfare fraud involving a sum between \$100 and \$500 constitutes a felony, because it authorizes imprisonment in such event for not more than one year and the section was amended after enactment of the new criminal code. *Zastrow v. State*, 62 W (2d) 381, 215 NW (2d) 426.

Welfare fraud under (9) is a continuing offense. *John v. State*, 96 W (2d) 183, 291 NW (2d) 502 (1980).

Insurance payment compensating for loss of personal and household property, which are exempt assets under AFDC regulations, is not exempt asset and must be reported under (6). *State v. Salzer*, 133 W (2d) 54, 393 NW (2d) 121 (Ct. App. 1986).

Welfare fraud is chargeable as continuing offense. *State v. Schumacher*, 144 W (2d) 388, 424 NW (2d) 672 (1988).

Sub (6) requires recipients to report all assets or income, regardless of whether they were illegally obtained. *State v. Baeza*, 156 W (2d) 651, 457 NW (2d) 522 (Ct. App. 1990).

49.123 Loss of eligibility or participation. (1) A court may declare as ineligible for aid under s. 49.046 or general relief under this chapter any person who, with intent to secure that aid or general relief, whether for himself or herself or for some other person, is found under s. 49.12 (1) to have wilfully made any false representation concerning that aid or general relief as follows:

(a) If the value of the aid under s. 49.046 or general relief so secured exceeds \$100 but does not exceed \$500, the period of ineligibility is one month.

(b) If the value of the aid under s. 49.046 or general relief so secured exceeds \$500 but does not exceed \$2,500, the period of ineligibility is one month for each amount equaling \$500 by which the value of the aid or general relief so secured exceeds \$500.

(2) If a court finds or it is determined after an administrative hearing that meets the requirements in regulations of the federal department of health and human services under 42 USC 616 (b) that an individual who is a member of a family applying for or receiving aid under s. 49.19, for the purpose of establishing or maintaining eligibility for aid under s. 49.19 or of increasing the amount of aid received under s. 49.19, intentionally made a false or misleading statement, intentionally misrepresented or withheld facts or committed an act intended to mislead or to misrepresent or withhold facts, the department shall consider the income and assets of the person but shall remove the needs of the person in determining the amount of any payment made to the person's family under s. 49.19 as follows:

(a) Upon the first occurrence, for 6 months.

(b) Upon the 2nd occurrence, for one year.

(c) Upon the 3rd occurrence, permanently.

History: 1985 a 29; 1991 a 313; 1993 a 16.

49.124 Food stamp employment and training program. The department shall administer an employment and training program for recipients of food stamp benefits under 7 USC 2011 to 2029.

History: 1987 a 27.

49.125 Recovery of food stamps. (1) The department, or a county or elected governing body of a federally recognized American Indian tribe or band acting on behalf of the department, may recover overpayments that arise from an overissuance of food coupons under the food stamp program administered under s. 46.215 (1) (k) or 46.22 (1) (b) 5. Recovery shall be made in accordance with 7 USC 2022.

(2) A county or governing body of a federally recognized American Indian tribe may retain a portion of the amount of an overpayment the state is authorized to retain under 7 USC 2025 which is recovered under sub. (1) due to the efforts of an employee or officer of the county or tribe. The department shall promulgate a rule establishing the portion of the amount of the overpayment that the county or governing body may retain. This subsection does not apply to recovery of an overpayment that was made as a result of state, county or tribal governing body error.

History: 1985 a 29, 176; 1987 a 27; 1991 a 269.

49.127 Food stamp offenses. (1) In this section:

(a) "Eligible person" means a member of a household certified as eligible for the food stamp program or a person authorized to represent a certified household under 7 USC 2020 (e) (7).

(b) "Food" means items which may be purchased using food coupons under 7 USC 2012 (g) and 2016 (b).

(c) "Food stamp program" means the federal food stamp program under 7 USC 2011 to 2029.

(d) "Supplier" means a retail grocery store or other person authorized by the federal department of agriculture to accept food coupons in exchange for food under the food stamp program.

(e) "Unauthorized person" means a person who is not one of the following:

1. An employe or officer of the federal government, the state, a county or a federally recognized American Indian tribe acting in the course of official duties in connection with the food stamp program.

2. A person acting in the course of duties under a contract with the federal government, the state, a county or a federally recognized American Indian tribe in connection with the food stamp program.

3. An eligible person.

4. A supplier.

5. A person authorized to redeem food coupons under 7 USC 2019.

(2) No person may misstate or conceal facts in a food stamp program application or report of income, assets or household circumstances with intent to secure or continue to receive food stamp program benefits.

(2m) No person may knowingly fail to report changes in income, assets or other facts as required under 7 USC 2015 (c) (1) or regulations issued under that provision.

(3) No person may knowingly issue food coupons to a person who is not an eligible person or knowingly issue food coupons to an eligible person in excess of the amount for which the person's household is eligible.

(4) No eligible person may knowingly transfer food coupons except to purchase food from a supplier or knowingly obtain or use food coupons for which the person's household is not eligible.

(5) No supplier may knowingly obtain food coupons except as payment for food or knowingly obtain food coupons from a person who is not an eligible person.

(6) No unauthorized person may knowingly obtain, possess, transfer or use food coupons.

(7) No person may knowingly alter food coupons.

(8) (a) For a first offense under this section:

1. If the value of the food coupons does not exceed \$100, a person who violates this section may be fined not more than \$1,000 or imprisoned not more than one year in the county jail or both.

2. If the value of the food coupons exceeds \$100, a person who violates this section may be fined not more than \$10,000 or imprisoned not more than 5 years or both.

(b) For a 2nd or subsequent offense under this section:

1. If the value of the food coupons does not exceed \$100, a person who violates this section may be fined not more than \$1,000 or imprisoned not more than one year in the county jail or both.

2. If the value of the food coupons exceeds \$100, a person who violates this section may be fined not more than \$10,000 or imprisoned not more than 5 years or both.

(d) In addition to the penalties applicable under par. (a) or (b), the court may suspend a person who violates this section from participation in the food stamp program up to 18 months. The person may apply to the county department under s. 46.215, 46.22 or 46.23 or the federally recognized American Indian tribal governing body or, if the person is a supplier, to the federal department of agriculture for reinstatement following the period of suspension.

History: 1987 a 27, 399.

49.13 Verification of public assistance applications.

(1) Any person who applies for any public assistance shall execute the application or self-declaration in the presence of the wel-

fare worker or other person processing the application. This subsection does not apply to any superintendent of a mental health institute, director of a center for the developmentally disabled, superintendent of a state treatment facility or superintendent of a state correctional facility who applies for public assistance on behalf of a patient.

(2) At the time of application, the agency administering the public assistance program shall apply to the department for a certified copy of a birth certificate for the applicant if the applicant is required to provide a birth certificate or social security number as part of the application and for any person in the applicant's household who is required to provide a birth certificate or social security number. The department shall provide without charge any copy for which application is made under this subsection.

(3) Notwithstanding subs. (1) and (2), personal identification documentation requirements may be waived for 10 days for an applicant for general relief, if all of the following occur:

(a) An authorized staff member of a shelter facility for homeless individuals and families or of an agency that provides or purchases that shelter prepares a sworn statement personally assuring the identity of the applicant.

(b) The applicant agrees to cooperate with the general relief agency by providing information necessary to obtain proper identification.

(4) Notwithstanding sub. (2), the general relief agency receiving an application under sub. (3) shall pay on behalf of any applicant under sub. (3) fees required for the applicant to obtain proper identification.

(5) A person applying for aid to families with dependent children under s. 49.19, medical assistance under ss. 49.45 to 49.47 or food stamp program benefits under 7 USC 2011 to 2029 shall, as a condition of eligibility, provide a declaration and other verification of citizenship or satisfactory immigration status as required in 42 USC 1320b-7(d).

History: 1971 c. 334; 1979 c. 221; 1985 a. 29 ss. 1005m, 3200 (23); 1985 a. 315; 1989 a. 31

49.133 Periodic records matches. (1) The department shall conduct a program to periodically verify the eligibility of recipients of aid to families with dependent children under s. 49.19 through a check of school enrollment records of local school boards as provided in s. 118.125 (2) (i).

(2) The department shall conduct a program to periodically match records of recipients of medical assistance under s. 49.46, 49.468 or 49.47, aid to families with dependent children under s. 49.19 and the food stamp program under 7 USC 2011 to 2029 with the records of recipients under those programs in other states. If an agreement with the other states can be obtained, matches with records of states contiguous to this state shall be conducted at least annually.

(3) The department shall conduct a program to periodically match the address records of recipients of medical assistance under s. 49.46, 49.468 or 49.47, aid to families with dependent children under s. 49.19 and the food stamp program under 7 USC 2011 to 2029 to verify residency and to identify recipients receiving duplicate or fraudulent payments.

(5) The department, with assistance from the department of corrections, shall conduct a program to periodically match the records of persons confined in state correctional facilities with the records of recipients of medical assistance under s. 49.46, 49.468 or 49.47, aid to families with dependent children under s. 49.19 and the food stamp program under 7 USC 2011 to 2029 to identify recipients who may be ineligible for benefits.

History: 1987 a. 27; 1989 a. 31.

49.14 County home; establishment. (1) Each county may establish a county home for the relief and support of dependent persons pursuant to s. 46.17.

(2) In all counties whose population is less than 250,000 such county home shall be governed pursuant to ss. 46.18, 46.19 and 46.20.

(3) No county in which a county home is established shall contract to conduct the same or to support and maintain the inmates thereof; and all agreements in violation of this subsection are void.

(4) The trustees or any person employed by the county board pursuant to subs. (1) and (2), may administer oaths concerning any matter submitted to the trustees or person employed by the county board, in connection with their functions.

(5) The uniform accounting system established by s. 50.03 (10) shall be used by each county home and shall be subject to the conditions enumerated therein.

History: 1971 c. 125; 1975 c. 413 s. 18; 1977 c. 26 s. 75; 1991 a. 316.

County didn't violate (3) by terminating county home operations, conveying home's assets and leasing physical plant to private operator. Local Union 2490 v. Waukesha County, 143 W (2d) 438, 422 NW (2d) 117 (Ct. App. 1988).

49.15 County home; commitments; admissions.

(1) Any person upon his or her application to the board of trustees may be admitted to the county home upon such terms as may be prescribed by the board. If the person or his or her relatives are unable to pay for his or her care and maintenance the person may be admitted as a charge of the county of his or her residence.

(2) The actual cost for care and maintenance rendered a general relief recipient who has residence in another county shall be a proper general relief charge and a liability against the county of residence.

(3) The county board of any county may by resolution provide that the county shall bear the expense of maintaining all dependent persons committed or admitted to the county home, and may repeal any resolution adopted under this subsection.

History: 1977 c. 428; 1985 a. 29

49.16 County hospital; establishment. (1) Each county may establish a county hospital for the treatment of dependent persons, under s. 46.17, and other persons authorized under s. 46.21 (4m).

(2) In counties with a population of 500,000 or more, an institution established under sub. (1) shall be governed under s. 46.21 or 59.07 (153), but in all other counties it shall be governed under ss. 46.18, 46.19 and 46.20.

(3) The uniform accounting system established by s. 50.03 (10) shall be used by each county hospital and shall be subject to the conditions enumerated therein.

History: 1971 c. 125; 1975 c. 413 s. 18; 1977 c. 26 s. 75; 1985 a. 176; 1993 a. 186

49.17 County hospitals; admissions. (1) Any person upon application to the board of trustees may be admitted to the county hospital upon such terms as may be prescribed by the board. If the person or his or her relatives are unable to pay for his or her care and maintenance the person may be admitted as a charge of the county of his or her residence.

(2) The actual cost for hospitalization and treatment rendered a general relief recipient who has residence in another county shall be a proper general relief charge and a liability against the county of residence.

(3) The county board of any county may by resolution provide that the county shall bear the expense of maintaining all dependent persons admitted to the county hospital, and may repeal any resolution adopted under this subsection.

History: 1985 a. 29

49.171 County infirmaries; establishment. (1) Each county, or any 2 or more counties jointly, may establish, pursuant to s. 46.17 or 46.20 a county infirmary for the treatment, care and maintenance of the aged infirm.

(2) In counties with a population of 500,000 or more, such institution shall be governed pursuant to s. 46.21, but in all other

counties it shall be governed pursuant to ss. 46.18, 46.19 and 46.20.

(3) As used in ss. 49.171 to 49.173:

(a) An aged infirm person is a person over the age of 65 years so incapacitated mentally by the degenerative processes of old age, or so incapacitated physically, as to require continuing infirm care.

(b) A county infirmary is a county institution created pursuant to sub. (1) or (2) under the general supervision and inspection of the department pursuant to ss. 46.16 and 46.17 as to adequacy of equipment and staff to treat, care for and maintain the physical and mental needs of aged infirm persons.

(4) The uniform accounting system established by s. 50.03 (10) shall be used by each county infirmary and shall be subject to the conditions enumerated therein.

History: 1971 c. 125; 1975 c. 413 s. 18; 1977 c. 26 s. 75.

49.172 County infirmaries, admissions; standards.

(1) The following standards shall apply to admissions to a county infirmary:

(a) The primary standard shall be need of infirm care, rather than ability to pay for care, and no person shall be excluded from an infirmary solely because of ability or inability to pay for care.

(b) The person admitted must be an aged infirm individual, and it must be reasonably apparent that unless admitted the person will be without adequate care.

(cm) Except as provided in par. (d), any person who meets the standards for admission is eligible for admission.

(d) An applicant who has removed residence to Wisconsin from a state which requires that one who has removed residence from Wisconsin to that state reside in the latter more than one year before being eligible for a similar type of care shall be required to reside in this state for a like period before becoming eligible for admission.

(2) The board of trustees of a county infirmary (subject to regulations approved by the county board) shall establish rules and regulations governing the admission and discharge of voluntary patients.

(3) If it appears to the satisfaction of the circuit court for the county in which an infirmary is located, upon petition for commitment, that a person meets the standards under sub. (1), it may, after affording the person an opportunity to be heard in person or by someone on his or her behalf, commit the person to a county infirmary. The power to commit includes persons who entered an infirmary voluntarily. The court may also, on petition and after a hearing, order the discharge of any patient, upon a showing that the patient is no longer in need of infirm care, or that the patient can be adequately cared for elsewhere.

(4) The board of trustees on receipt of an application for voluntary admission, or the circuit court on the filing of a petition for commitment, shall appoint a person licensed to practice medicine and surgery in this state to examine personally the applicant or the subject of the petition and to advise the board or court whether such person meets the standard prescribed by sub. (1) (a).

(5) The department shall prescribe and prepare the forms to be used for the voluntary admission or commitment of patients.

(6) The circuit court in the case of a commitment, and the board of trustees in the case of a voluntary admission, shall pass on the economic status of the patient at the time of commitment or admission, and in all cases in which the patient has residence in another county shall notify the county of residence of the fact of such commitment or admission.

History: 1977 c. 449 ss. 130, 497; 1985 a. 29; 1989 a. 359.

49.173 County infirmaries; cost of treatment, care and maintenance of patients. (1) In the first instance the county or counties operating an infirmary shall defray the actual per capita cost of treatment, care and maintenance. To the extent that a patient is a public charge, such county or counties shall be

reimbursed for such expenditures, as determined from annual infirmary reports filed with the department under s. 46.18 (8), (9) and (10), by the county of residence.

(2) To the extent that a patient is not a public charge, such cost shall be charged and paid in advance for each calendar month, and payment may be enforced by the board of trustees.

(4) The records and accounts of each county infirmary may be audited by the department. In addition to other findings, such audits shall ascertain compliance with the mandatory uniform cost record-keeping system requirements of s. 46.18 (8), (9) and (10), and verify the actual per person cost of maintenance, care and treatment of patients.

History: 1971 c. 108 ss. 5, 6; 1971 c. 125 s. 523; 1985 a. 29.

49.174 Fees and expenses of proceedings. The fees of examining physicians, witnesses and guardians ad litem and other expenses of proceedings under ss. 49.171 to 49.173 shall be governed by s. 51.20 (18).

History: 1975 c. 430 s. 80; 1977 c. 428 s. 115.

49.175 Residential care institution; establishment.

(1) Any county or combination of counties may establish and staff a county residential care institution for the reception and care of dependent persons which shall be governed by the county board. The institution shall be licensed under s. 50.03 by the department before receiving or caring for any dependent person.

(2) Residential care institutions may be established and staffed by private vendors for the reception and care of dependent persons. The institution shall be licensed under s. 50.03 by the department before receiving or caring for any dependent persons.

(3) Any county operated or private residential care facility not certifiable as a Title XIX facility shall be licensed and governed under s. 50.03 by the department before receiving or caring for any dependent persons.

(4) The cost of care of such patients shall be determined by multiplying the per day patient rate for such facility as determined by applying the formula under s. 49.45 (6m) (ag), except that interest on capital expenditures which are reimbursable under s. 51.91 shall be excluded, times the number of days of care of such patients in the time period being considered. Any amounts received by the facility from the patient or resident shall be deducted from the costs determined under this subsection. This section shall not be construed to require that as a condition of reimbursement any facility must meet any skilled or intermediate care standards established by the department.

(6) The care, services and supplies provided under this section shall be a liability against the patient's county of residence.

History: 1971 c. 216; 1973 c. 90, 333; 1975 c. 413 s. 18; 1975 c. 430 s. 80; 1977 c. 418 s. 929 (55); 1985 a. 29; 1987 a. 27.

49.177 State supplemental payments. (1) DEFINITION In this section "secretary" means the secretary of the U.S. department of health and human services or the secretary of any other federal agency subsequently charged with the administration of federal Title XVI.

(2) ELIGIBILITY (a) The following persons who meet the resource limitations and the nonfinancial eligibility requirements of the federal supplemental security income program under 42 USC 1381 to 1383d are entitled to receive supplemental payments under this section:

1. Any needy person or couple residing in this state who, as of December 31, 1973, was receiving benefits under s. 49.18, 1971 stats., s. 49.20, 1971 stats., or s. 49.61, 1971 stats., as affected by chapter 90, laws of 1973.

2. Any needy person or couple residing in this state and receiving benefits under federal Title XVI.

3. Any needy person or couple residing in this state whose income, after deducting income excludable under federal Title XVI, is less than the combined benefit level available under federal Title XVI and this section.

4. Any essential person.

(b) The department may submit a proposal to change the amount of supplemental payments under this section to the secretary of administration. If the secretary of administration approves the proposal, he or she shall submit it to the joint committee on finance for approval, modification or disapproval. Joint committee on finance approval of a change in the amount of supplemental payments will be considered to be given, if within 14 calendar days after the secretary of administration files a proposal with the joint committee on finance, the committee has not scheduled a public hearing or executive session to review the proposal. Payment changes approved by the joint committee on finance are subject to the approval of the governor. Following action by the joint committee on finance, the governor shall have 10 days, not including Sundays, to communicate approval or disapproval in writing. If no action is taken by the governor within that time, the decision of the joint committee on finance shall take effect. The procedures under s. 13.10 do not apply to this paragraph.

(3) MINIMUM SUPPLEMENTAL PAYMENT IN CERTAIN CASES. The total monthly benefits received under this section and federal Title XVI by a person or couple described in sub. (2) (a) 1. shall not be less than the total state cash assistance payment amount plus gross earned and unearned income, received by such person or couple for December of 1973.

(3g) FEDERAL PAYMENTS If federal supplemental security income payments increase, the department may, with approval as provided under sub. (2) (b), reduce payments under this section by all or part of the amount of the increase, subject to 42 USC 1382g.

(3s) INCREASED SUPPLEMENTAL PAYMENT IN CERTAIN CASES (a) The department shall authorize the payment of an increased state supplement to a person receiving payments under this section who resides in a residential setting if the person needs at least 40 hours per month of supportive home care, daily living skills training or community support services.

(b) 1. If a person receiving payments under this section is a minor child residing with a parent, only services needed when the parent is away from the residence for purposes of employment count toward the 40-hour requirement in par. (a).

2. If a person receiving payments under this section resides with a spouse, only services needed either because the spouse is away from the residence for purposes of employment or because the spouse is physically or mentally unable to provide the care count toward the 40-hour requirement in par. (a).

(c) The department shall establish a uniform assessment process for determining eligibility under this subsection.

(d) The amount payable under this subsection equals the amount of the state supplement under sub. (2) (a) paid to persons living in nonmedical group homes.

(4) OPTIONAL FEDERAL ADMINISTRATION. (a) The department may enter into an agreement with the secretary under which the secretary will provide supplemental payments to all eligible persons on behalf of the state or any of its subdivisions. Under the agreement the department shall pay to the secretary an amount specified in accordance with agreed procedures. The department may make advance payments to the secretary if the agreement so provides.

(b) The department may enter into an agreement with the secretary under which the secretary may determine eligibility for medical assistance in the case of aged, blind or disabled individuals under the state plan approved under Title XIX of the social security act.

(c) Agreements made under this subsection or modifications to such agreements require prior approval or amendment by the joint committee on finance. Prior approval will be deemed to be given if within 21 calendar days following the department filing a proposed modification with the joint committee on finance, the committee has not scheduled a public hearing or executive session to review the proposed modification. Agreements or modifications to such agreements approved by the joint committee on finance shall be subject to the approval of the governor. Following

action by the joint committee on finance, the governor shall have 10 days, not including Sundays, to communicate approval or disapproval in writing. If no action is taken by the governor within that time, the decision of the joint committee on finance shall take effect. The procedures under s. 13.10 do not apply to this paragraph.

History: 1973 c. 90, 147; 1975 c. 39, 199, 224; 1977 c. 29; 1979 c. 34; 1981 c. 20; 1981 c. 314 s. 144; 1983 a. 27; 1985 a. 29, 120, 176; 1987 a. 27; 1987 a. 403 s. 256; 1989 a. 31, 56; 1993 a. 16.

49.178 Institutions subject to chapter 150. Any institution created under the authority of s. 49.14, 49.16, 49.171 or 49.175 is subject to ch. 150.

History: 1977 c. 29.

AID TO DEPENDENT CHILDREN

49.19 Aid to families with dependent children. (1) (a) In this section, "dependent child" means a child under the age of 18 or, if the child is a full-time student at a secondary school or its vocational or technical equivalent and is reasonably expected to complete the program before reaching 19, is under the age of 19, who:

1. Has been deprived of parental support or care by reason of the death, continued absence from the home other than absence occasioned solely by reason of the performance of active duty in the uniformed services of the United States, unemployment or incapacity of a parent; and

2. a. Is living with a parent; a blood relative, including those of half-blood, and including first cousins, nephews or nieces and persons of preceding generations as denoted by prefixes of grand, great or great-great; a stepfather, stepmother, stepbrother or step-sister; a person who legally adopts the child or is the adoptive parent of the child's parent, a natural or legally adopted child of such person or a relative of an adoptive parent; or a spouse of any person named in this subparagraph even if the marriage is terminated by death or divorce; and is living in a residence maintained by one or more of these relatives as the child's or their own home, or living in a residence maintained by one or more of these relatives as the child's or their own home because the parents of the child have been found unfit to have care and custody of the child; or

b. Is living in a foster home or treatment foster home licensed under s. 48.62 if a license is required under that section, in a foster home or treatment foster home located within the boundaries of a federally recognized American Indian reservation in this state and licensed by the tribal governing body of the reservation, in a group home licensed under s. 48.625 or in a child-caring institution licensed under s. 48.60, and has been placed in the foster home, treatment foster home, group home or institution by a county department under s. 46.215, 46.22 or 46.23, by the department or by a federally recognized American Indian tribal governing body in this state under an agreement with a county department.

(b) Any individual may apply for aid to families with dependent children and shall have opportunity to do so. Application for aid shall be made on forms prescribed by the department. Any person having knowledge that any child is dependent upon the public for proper support or that the interest of the public requires that such child be granted aid may bring the facts to the notice of an agency administering such aid in the county in which the child resides.

(c) 1. "Aid to families with dependent children" means money payments with respect to, or vendor payments as prescribed by the department, or medical care in behalf of or any type of remedial care recognized under subs. (1) to (10) or s. 49.46 or necessary burial expenses as defined in sub. (5) in behalf of a dependent child or dependent children.

2. "Aid to families with dependent children" also includes such aid to meet the needs of the relative with whom any dependent child is living and the spouse of the relative if:

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a. The spouse is living with the relative, the relative is the child's parent and the child is a dependent child by reason of the physical or mental incapacity of a parent; or

b. The spouse is a convicted offender permitted to live at home but precluded from earning a wage because the spouse is required by a court imposed sentence to perform unpaid public work or unpaid community service.

3. "Aid to families with dependent children" also includes payments made to another individual not a relative enumerated under par. (a), pursuant to federal regulations, if:

a. The individual has been appointed by a court of competent jurisdiction as a legal representative of the dependent child; or

b. The individual who may be a caseworker has been designated by the county department under s. 46.215 or 46.22 to receive payment of the aid or cash payments to recipients who are engaged in an approved work relief or training project.

(d) The rate of payment for skilled nursing care provided under this section shall be determined by the county under guidelines established by the department pursuant to s. 49.45 (6m). Payment for limited care shall not exceed 90% of the applicable Title XIX skilled care rate. Payment for personal care shall not exceed 80% of the applicable Title XIX skilled care rate.

(e) In this section, "strike" has the meaning provided in 29 USC 142 (2).

(2) (a) A home visit may be made at the option of the county to investigate the circumstances of the child before granting aid. The department may, however, require a county to make a home visit for this purpose if the department finds that a need exists. A report upon a home visit shall be made in writing and become a part of the record in the case. Every applicant shall be promptly notified in writing of the disposition of his or her application. Aid shall be furnished with reasonable promptness to any eligible individual.

(am) A county department under s. 46.215, 46.22 or 46.23 may not accept a rent receipt to verify the residence of an applicant for or recipient of aid under this section unless the receipt shows the name, address and home and business telephone numbers of the landlord or the landlord's designee.

(b) Recipients of aid under this section shall, as a condition for continued receipt of the aid, provide accurate monthly reports of any circumstances which may affect their eligibility or the amount of assistance. The department shall promulgate rules selecting categories of recipients who may report less frequently in order to reduce administrative expense and shall specify monthly dates by which reports shall be submitted.

(c) An alien shall provide the department with reports the department requires to determine eligibility and the amount of aid, including reports about the alien's sponsor.

(d) Eligibility for aid to families with dependent children for any month shall be based on estimated income, resources, family size and other similar relevant circumstances during that month. The amount of aid for any month shall be based on income and other relevant circumstances in the first or, at the option of the department, the 2nd month preceding such a month, except that the amount of aid in the first month or, at the option of the department, the first and 2nd months of a period of consecutive months for which aid is payable is based on estimated income and other relevant circumstances in such first month or first and 2nd months. The department may promulgate rules establishing payment and reporting months as needed to administer this paragraph.

(p) Any person who has conveyed, transferred or disposed of any asset that would be included in determining the value of assets under sub. (4) (bm) within 2 years prior to the date of making application, or of redetermination of eligibility, for benefits under this section at less than fair market value shall, unless shown to the contrary, be presumed to have made the transfer, conveyance or disposition in contemplation of receiving benefits under this section and shall be ineligible to receive the benefits thereafter until the uncompensated value of the asset is expended by or on behalf

of the person for his or her maintenance needs, including needs for medical care. The department shall promulgate rules for the administration of this paragraph. This paragraph shall apply to the extent permitted under federal law.

(3) (a) After the investigation and report and a finding of eligibility, aid as defined in sub. (1) shall be granted by the county department under s. 46.215 or 46.22 as the best interest of the child requires. No such aid shall be furnished any person for any period during which that person is receiving supplemental security income or for any month if, on the last day of the month, that person is participating in a strike or to any person who fails to apply for or provide such social security account numbers as required by federal law.

(b) If the county department under s. 46.215 or 46.22 finds a person eligible for aid under this section, that county department shall, on a form to be prescribed by the department, direct the payment of such aid by order upon the state treasurer. Payment of aid shall be made monthly, based on a calendar month or fiscal month as defined by the department; except that the director of the county department may, in his or her discretion for the purpose of protecting the public, direct that the monthly allowance be paid in accordance with sub. (5) (c).

(4) The aid shall be granted only upon the following conditions:

(a) There must be a dependent child who is living with the person charged with its care and custody and dependent upon the public for proper support. Aid may also be granted for minors other than those specified, but not for a dependent child 18 years of age or older who is living in a home or institution specified under sub. (1) (a) 2. b.

(b) The person applying for aid has allowed the county department under s. 46.215 or 46.22 15 to 30 days to process his or her application and, if not already a resident of the county, has notified the county department under s. 46.215 or 46.22 of his or her intent to establish residence in the county. The effective date of eligibility for aid to eligible individuals is the date the applicant submits a signed and completed application to the county department under s. 46.215 or 46.22, or the first date on which the applicant meets all of the eligibility criteria, whichever is later.

(bm) The person applying for aid shall document, to the department's satisfaction, actual income as claimed in the application, and shall reveal all assets. Except as specified in par. (br), aid is available only if the combined equity value of assets does not exceed \$1,000. One automobile with an equity value not exceeding \$1,500, one home, as specified in par. (e), and, for each person, one burial plot and one burial agreement under s. 445.125 (1) (b) and (c) with a value of not more than \$1,500 may not be included when determining the combined equity value of assets. Any amount received under section 32 of the internal revenue code, as defined in s. 71.01 (6), and any payment made by an employer under section 3507 of the internal revenue code, as defined in s. 71.01 (6), may not be included in determining the combined equity value of assets in the month of receipt and the following month.

(br) Aid may be paid for up to 9 months to an otherwise eligible owner of real property other than that specified under par. (bm) and that real property may be excluded as an asset for up to 9 months if all of the following conditions are met:

1. The owner enters into a signed, written agreement with the county department under s. 46.215 or 46.22 that he or she shall make a good faith effort to sell the real property and repay the amount of aid granted during the asset exclusion period up to the amount of net proceeds of the sale of the real property.

2. The net proceeds of the sale of the real property plus the combined equity value of all other countable assets exceed \$1,000 on the date of the agreement made under subd. 1.

(bu) 1. The department shall request a waiver from the secretary of the federal department of health and human services to allow a recipient of aid under this section to accumulate funds in

an education and employability account, as described in subd. 2., the first \$10,000 in which is not considered against the amount of assets that a recipient is allowed to own under par. (bm). If the waiver is granted, the department shall promulgate rules to implement the waiver and shall implement the waiver beginning no sooner than January 1, 1995. Subdivision 2. does not apply unless the waiver is in effect.

2. The department may authorize a person to establish an education and employability account at a financial institution, as defined in s. 705.01 (3), after the person is determined to be eligible for aid under this section. The first \$10,000 in the account is not considered against the asset limit if the person provides to the county department under s. 46.215, 46.22 or 46.23, at the time of establishing the account and at other times required by the department, a signed statement identifying the financial institution, the account number of the account and the amount in the account. Interest earned on the account and retained in the account is not considered income under this section. Money withdrawn from the education and employability account will be considered income in the month that it is withdrawn unless it is used for one of the following purposes:

- a. The recipient's own education or training or the education or training of his or her child.
- b. Improving the employability of a member of the family.
- d. Not more than \$200 every 12 months for emergency needs, as determined by the county department under s. 46.215, 46.22 or 46.23.

(by) No later than September 1, 1992, the department shall request a waiver from the secretary of the federal department of health and human services under which the equity value of automobiles with a total equity value of not more than \$2,500 would not be included when determining the combined equity value of assets under par. (bm). If the waiver is granted, the equity value of automobiles with a total equity value of not more than \$2,500 shall not be included when determining the combined equity value of assets under par. (bm), rather than one automobile with an equity value not exceeding \$1,500.

(c) The person having the care and custody of the dependent child must be fit and proper to have the child. Aid shall not be denied by the county department under s. 46.215 or 46.22 on the grounds that a person is not fit and proper to have the care and custody of the child until the county department obtains a finding substantiating that fact from a court assigned to exercise jurisdiction under ch. 48 or other court of competent jurisdiction; but in appropriate cases it is the responsibility of the county department to petition under ch. 48 or refer the case to a proper child protection agency.

(d) Aid may be granted to the mother or stepmother of a dependent child if she is without a husband or if she:

- 1. Is the wife of a husband who is incapacitated for gainful work by mental or physical disability; or
- 2. Is the wife of a husband who is incarcerated or who is a convicted offender permitted to live at home but precluded from earning a wage because the husband is required by a court imposed sentence to perform unpaid public work or unpaid community service; or
- 3. Is the wife of a husband who has been committed to the department pursuant to ch. 975, irrespective of the probable period of such commitment; or
- 4. Is the wife of a husband who has continuously abandoned or failed to support her, if proceedings have been commenced against the husband under ch. 769; or
- 5. Has been divorced and is without a husband or legally separated from her husband and is unable through use of the provisions of law to compel her former husband to adequately support the child for whom aid is sought; or
- 6. Has commenced an action for divorce or legal separation and obtained a temporary order for support under s. 767.23 which

order is either insufficient to adequately meet the needs of the child or cannot be enforced through the provisions of law; or

7. Has obtained an order under s. 767.08 from the court to compel support, which order is either insufficient to adequately meet the needs of the child or cannot be enforced through the provisions of law; or

8. Is incapacitated and the county department under s. 46.215 or 46.22 believes she is the proper payee.

(dm) Aid may be paid to parents of a dependent child if the parents are unable to supply the needs of the child because of the unemployment of the parent, in a home in which both parents live, who earned the most income during the 24-month period immediately preceding the month for which aid is granted and who meets the federal requirements as to past employment and current unemployment. The department shall count up to 4 calendar quarters of full-time attendance at an elementary school, a secondary school, or a vocational or technical training course that satisfies the requirements under 42 USC 607 (d) (1) (B) toward the federal requirement as to past employment. Aid to dependent children of unemployed parents may be granted only if federal aid for this purpose is available to the state. No aid may be granted if the unemployed parent:

4. Qualifies for unemployment compensation but refuses to apply for or accept unemployment compensation; or

5. Fails to meet any applicable federal or state work, work registration or training requirement. The department shall promulgate rules listing the applicable requirements under this subdivision.

(e) The ownership of a home and the lands used or operated in connection therewith or, in lieu thereof, a house trailer, if such home or house trailer is used as the person's abode, by a person having the care and custody of any dependent child shall not prevent the granting of aid if the cost of maintenance of said home or house trailer does not exceed the rental which the family would be obliged to pay for living quarters.

(es) In determining eligibility for aid to families with dependent children, all earned and unearned income of the applicant shall be considered, except any amount received under section 32 of the internal revenue code, as defined in s. 71.01 (6), and any payment made by an employer under section 3507 of the internal revenue code, as defined in s. 71.01 (6), and aid received under this section. Eligibility does not exist if the total income considered exceeds 185% of the standard of need or if the total income considered after disregards are applied exceeds the standard of need.

(et) In determining eligibility for aid, the income of a dependent child's stepparent who lives in the same home as the child shall be considered as required under 42 USC 602(a) (31).

(ez) If an alien applies for aid, the income and resources of any person or public or private agency which executed an affidavit of support for the alien are deemed unearned income and resources of the alien for a 3-year period after the alien enters the United States, unless the department determines that the public or private agency no longer exists or has become unable to meet the alien's needs. The income and resources of the spouse of the executor, if the executor is an individual, are also deemed unearned income and resources of the alien for a 3-year period after the alien enters the United States, if the spouse is living with the executor. The department may, by rule, specify the method of computing income and resources under this paragraph and may reduce the level of income and resources that are deemed unearned income and resources of the alien, to the extent required by P.L. 97-35, section 2320 (b). This paragraph does not apply if the alien is a dependent child and if the executor or the executor's spouse is the parent of the alien.

(f) Whenever better provisions, public or private, can be made for the care of such dependent child, aid under this section shall cease. Prompt notice shall be given to the appropriate law

enforcement officials of the county of the furnishing of aid under this section in respect of a child who has been deserted or abandoned by a parent.

(g) 1. If the pregnancy is medically verified, a pregnant woman receiving aid under this section who notifies the county department under s. 46.215 or 46.22 before the 7th month of pregnancy begins shall receive a monthly payment determined under sub. (11) (a) 4. from the first day of the month in which the 7th month of pregnancy begins, in addition to the payment determined according to family size under sub. (11) (a). If the recipient provides notification after the 7th month of pregnancy begins, the woman shall receive the additional monthly payment determined under sub. (11) (a) 4. beginning with the first day of the month following notification.

2. Aid to a pregnant woman who is otherwise eligible but has no children is available from the first day of the month in which the 7th month of pregnancy begins or the date the woman submits a signed and completed application for aid to the county department under s. 46.215 or 46.22, whichever is later, if the pregnancy is medically verified. The pregnant woman has a family size of one for grant determination purposes under sub. (11) (a) and is additionally eligible for a monthly payment determined under sub. (11) (a) 4.

3. Eligibility for the additional monthly payment under this paragraph continues through the month of the child's birth.

(h) 1. a. As a condition of eligibility for assistance under this section, the person charged with the care and custody of the dependent child or children shall fully cooperate in efforts directed at establishing the paternity of a nonmarital child and obtaining support payments or any other payments or property to which that person and the dependent child or children may have rights. Such cooperation shall be in accordance with federal law, rules and regulations applicable to paternity establishment and collection of support payments.

b. Except as provided under sub. (5) (a) 1m., when any person applies for or receives aid under this section, any right of the parent or any dependent child to support or maintenance from any other person, including any right to unpaid amounts accrued at the time of application and any right to amounts accruing during the time aid is paid under this section, is assigned to the state. If a minor who is a beneficiary of aid under this section is also the beneficiary of support under a judgment or order that includes support for one or more children not receiving aid under this section, any support payment made under the judgment or order is assigned to the state in the amount that is the proportionate share of the minor receiving aid under this section, except as otherwise ordered by the court on the motion of a party.

c. Notice of the requirements of this subdivision shall be provided applicants for aid under this section at the time of application.

2. If the person charged with the care and custody of the dependent child or children does not comply with the requirements of subd. 1. a., that person shall be ineligible for assistance under this section. In such instances, aid payments made on behalf of the dependent child or children shall be made in the form of protective payments. If the county department under s. 46.215 or 46.22 has been unsuccessful in finding a person other than the person charged with the care of the dependent child to receive the protective payment on behalf of the child, after performance of a reasonable effort to do so, the county department may make the payment on behalf of the child to the person charged with the care of the dependent child.

(k) The total income of the AFDC group, including any non-recurring lump sum payment of earned or unearned income and any other income not disregarded, may not exceed the applicable standard of need under sub. (11). If the total income exceeds the standard of need, all members of the AFDC group remain ineligi-

ble for the number of months that equals the total income divided by the standard of need.

(4e) (a) Except as provided in par. (b), if a person applying for aid is under 18 years of age, has never married and is pregnant or has a dependent child in his or her care, the person is not eligible for aid unless he or she lives in a place maintained by his or her parent, legal guardian or other adult relative as the parent's, guardian's or other adult relative's own home or lives in a foster home, treatment foster home, maternity home or other supportive living arrangement supervised by an adult.

(b) Paragraph (a) does not apply in any of the following situations:

1. The person applying for aid has no parent or legal guardian whose whereabouts are known.

2. No parent or legal guardian of the person applying for aid allows the person to live in the home of that parent or legal guardian.

3. The department determines that the physical or emotional health or safety of the person applying for aid or the dependent child would be jeopardized if the person and the dependent child lived with the person's parent or guardian.

4. The person applying for aid lived apart from his or her parent or legal guardian for at least one year before the birth of any dependent child or before the person applied for aid.

5. The county department under s. 46.215, 46.22 or 46.23 otherwise determines that there is good cause not to apply par. (a).

(4h) Student loans and grants, including work study funds, are not considered income in determining eligibility for aid under this section or the amount of monthly payments under this section.

(4m) Aid under this section is unavailable to a family for any month in which the caretaker relative of the dependent child is participating in a strike on the last day of the month. Aid under this section is unavailable to any person for a month in which the person is participating in a strike on the last day of the month.

(5) (a) The aid shall be sufficient to enable the person having the care and custody of dependent children to care properly for them. The amount granted shall be determined by a budget for the family in which all income shall be considered, except:

1. All earned income of each dependent child included in the grant who is: a) a full-time student or b) a part-time student who is not a full-time employee. For purposes of this subdivision a student is an individual attending a school, college, university or a course of vocational or technical training designed to fit him or her for gainful employment.

1e. Any amount received under section 32 of the internal revenue code, as defined in s. 71.01 (6), and any payment made by an employer under section 3507 of the internal revenue code, as defined in s. 71.01 (6), to a family receiving aid.

1m. The first \$50 of any money received by the department in a month under an assignment to the state under sub. (4) (h) for a person applying for or receiving aid to families with dependent children that shall be paid to the family applying for or receiving aid.

2. The first \$90 shall be disregarded from the earned income of:

a. Any dependent child or relative applying for or receiving aid.

b. Any other person living in the same home as the dependent child whose needs are considered in determining the budget.

4. Except as provided under par. (am), after disregarding the amounts specified under subd. 2., \$30 of earned income and an amount equal to one-third of the remaining earned income not disregarded, from the earned income of any person specified in subd. 2. These disregards do not apply to:

a. The earned income of a person who has received the disregards for 4 consecutive months, until the person ceases to receive aid for 12 consecutive months.

b. Earned income derived from a training or retraining project.

c. The earned income of a person whose income exceeds the person's need, unless the person has received aid under this section in any of the 4 months preceding the month in which the income exceeds the need.

4m. Except as provided under par. (am), after the person has received the benefit of the disregards under subd. 4. for 4 consecutive months, a disregard of \$30 of earned income shall be available for 8 additional consecutive months. This disregard does not apply to:

a. Earned income derived from a training or retraining project.

b. The earned income of a person whose income exceeds the person's need, unless the person has received aid under this section in any of the 4 months preceding the month in which the income exceeds the need.

4s. After disregarding the amounts under subd. 2. and either subd. 4. or par. (am), an amount equal to expenditures and not to exceed \$175 per month for each dependent child or incapacitated person, or \$200 per month for each child under the age of 2, shall be disregarded from the earned income of any person listed in subd. 2. if:

a. The amount is used to provide care for a dependent child or for an incapacitated person who is living in the same home as the dependent child;

b. The person receiving care is also receiving aid under this section; and

c. The person requires care during the month that aid is received.

5. The disregards specified in subds. 2. to 4s. and par. (am) do not apply to the earned income of any person who violates 45 CFR 233.20 (a) (11) (iii).

(am) 1. Except as provided under subd. 1m, instead of the disregards under par. (a) 4. and 4m., after disregarding the amounts specified under par. (a) 2., \$30 of earned income and an amount equal to one-sixth of the remaining earned income not disregarded shall be disregarded from the earned income of a person specified in par. (a) 2. These disregards do not apply to:

a. The earned income of a person who has received the disregards for 12 consecutive months, until the person ceases to receive aid for 12 consecutive months.

b. Earned income derived from a training or retraining project.

c. The earned income of a person whose income exceeds the person's need, unless the person has received aid under this section in any of the 4 months preceding the month in which the income exceeds the need.

1m. If a waiver under subd. 2. is granted, the department may select individuals to whom the disregards under par. (a) 4. and 4m. apply, rather than the disregard under subd. 1., as a control group for all or part of the period during which the waiver is in effect.

2. The department shall request a waiver from the secretary of the federal department of health and human services to permit the application of the earned income disregards in subd. 1. Subdivision 1. does not apply unless a federal waiver is in effect. If a waiver is received, the department shall implement subd. 1. no later than the first day of the 6th month beginning after the waiver is approved.

(as) The department shall request, but may not implement, a waiver from the secretary of the federal department of health and human services to establish an earned income disregard that is equal to the first \$200 of earned income plus 50% of the remaining earned income, instead of the amount under par. (a) or (am), and

that is not reduced after a specified period. The department shall request the waiver no later than September 1, 1992.

(b) Such family budget shall be based on a standard budget, including the parents or other person who may be found eligible to receive aid under this section.

(c) The aid allowed under this subsection may be given in the form of supplies or commodities or vouchers for the same, in lieu of money, as a type of remedial care authorized under sub. (1) (c), whenever the giving of aid in such form is deemed advisable by the director of the county department under s. 46.215, 46.22 or 46.23 dispensing such aid as a means either of attempting to rehabilitate a particular person having the care and custody of any such children or of preventing the misuse or mismanagement by such person of aid in the form of money payments.

(ce) At the request of a recipient of aid under this section, the department shall provide the portion of the grant equal to the amount of the recipient's rent to the recipient's landlord in the form of a rent voucher or by an alternative payment method.

(cm) 1. In this paragraph, "2-party payment" means a check which is drawn in favor of a recipient of aid under this section and the recipient's landlord, jointly.

2. A 2-party payment shall be made whenever a recipient of aid under this section has failed to pay rent to the landlord for 2 months or more, unless the failure to pay rent is authorized by law.

3. If a landlord reports to a county department under s. 46.215, 46.22 or 46.23 that a recipient has failed to pay rent for 2 or more months, the county department shall do all of the following:

a. Inform the recipient of the report.

b. Investigate the report.

c. If it determines that the conditions for issuing a 2-party payment under subd. 2. are met, inform the recipient of the right to a fair hearing on the issue of whether 2-party payment of rent should be made and inform the department of health and social services of its determination.

d. If it determines that 2-party payments should not be made, inform the recipient and the landlord of that determination.

4. When it has been determined that a 2-party payment of rent should be made, the department of health and social services shall issue the recipient's monthly grant in 2 checks, a 2-party payment for the amount of the rent and a check drawn in favor of the recipient for the balance of the grant amount.

5. The county department shall review each case in which a 2-party payment is being made at least once every 12 months and whenever a recipient reports that a condition under subd. 6. for the cessation of 2-party payments exists.

6. The county department shall inform the department of health and social services, and the department of health and social services shall cease making a 2-party payment, when the county department determines that any of the following conditions exists:

a. A 2-party payment has been made for 24 consecutive months.

b. The recipient has reimbursed the landlord for all back rent owed.

c. The recipient has moved and has a different landlord.

7. The department shall promulgate rules for the administration of this paragraph.

(d) The department shall reimburse the county for the funeral, burial and actual cemetery expenses of a dependent child or the child's parents as provided in s. 49.30.

(e) No aid may continue longer than 6 months without reinvestigation, except that the department may provide that in certain cases or groups of cases aid may continue up to 12 months without reinvestigation. The county department under s. 46.215, 46.22 or 46.23 may conduct a reinvestigation of a case whenever there is reason to believe circumstances have changed. The county department shall submit information concerning reinvestigations, at such times and in such form as the department requires.

(f) This subsection does not prohibit such public assistance as may legitimately accrue directly to persons other than the beneficiaries of this section who may reside in the same household.

(6) The county department under s. 46.215, 46.22 or 46.23 may require the child's parent to do such remunerative work as in its judgment can be done without detriment to the parent's health or the neglect of the children or the home; and may prescribe the hours during which the parent may be required to work outside of the home.

(7) The county board shall annually appropriate a sum of money sufficient to carry out the provisions of this section. The county treasurer shall pay out the amounts ordered paid under this section.

(9) If the head of a family is a veteran, as defined in s. 45.37 (1a), and is hospitalized or institutionalized because of disabilities in a county other than that of his or her residence or settlement at time of admission, aid shall be granted to the dependent children of the veteran by the county wherein the head of the family had his or her residence or settlement at the time of admission so long as he or she remains hospitalized or institutionalized.

(10) (a) Aid under this section may also be granted to a non-relative who cares for a child dependent upon the public for proper support in a foster home or treatment foster home having a license under s. 48.62, in a foster home or treatment foster home located within the boundaries of a federally recognized American Indian reservation in this state and licensed by the tribal governing body of the reservation or in a group home licensed under s. 48.625, regardless of the cause or prospective period of dependency. The state shall reimburse counties pursuant to the procedure and the percentage rate of participation set forth in s. 49.52 for aid granted under this subsection except that if the child does not have legal settlement in the granting county, state reimbursement shall be at 100%. The county department under s. 46.215 or 46.22 shall determine the legal settlement of the child. A child under one year of age shall be eligible for aid under this subsection irrespective of any other residence requirement for eligibility within this section.

(b) Aid under this section may also be granted on behalf of a child in the legal custody of a county department under s. 46.215, 46.22 or 46.23 or on behalf of a child who was removed from the home of a relative specified in sub. (1) (a) as a result of a judicial determination that continuance in the home of a relative would be contrary to the child's welfare for any reason when such child is placed in a licensed child-caring institution by the county department. Reimbursement shall be made by the state pursuant to par. (a).

(c) Reimbursement under par. (a) may also be paid to the county when the child is placed in a licensed foster home, treatment foster home, group home or child-caring institution by a licensed child welfare agency or by a federally recognized American Indian tribal governing body in this state or by its designee, if the child is in the legal custody of the county department under s. 46.215, 46.22 or 46.23 or if the child was removed from the home of a relative specified in sub. (1) (a) as a result of a judicial determination that continuance in the home of the relative would be contrary to the child's welfare for any reason and the placement is made pursuant to an agreement with the county department.

(d) Aid may also be paid under this section to a foster home or treatment foster home, to a group home licensed under s. 48.625 or to a child-caring institution by the state when the child is in the custody or guardianship of the state, when the child is a ward of an American Indian tribal court in this state and the placement is made under an agreement between the department and the tribal governing body or when the child was part of the state's direct service case load and was removed from the home of a relative specified in sub. (1) (a) as a result of a judicial determination that continuance in the home of a relative would be contrary to the child's welfare for any reason and the child is placed by the department.

(e) Notwithstanding pars. (a), (c) and (d), aid under this section may not be granted for placement of a child in a foster home or treatment foster home licensed by a federally recognized American Indian tribal governing body, for placement of a child in a foster home, treatment foster home or child-caring institution by a tribal governing body or its designee, for the placement of a child who is a ward of a tribal court if the tribal governing body is receiving or is eligible to receive funds from the federal government for that type of placement or for placement of a child in a group home licensed under s. 48.625.

(11) (a) 1. a. Except as provided in sub. (11m), monthly payments made under s. 20.435 (4) (d) and (p) to persons or to families with dependent children shall be based on family size and shall be at 80% of the total of the allowances under subs. 2. and 4. plus the following standards of assistance beginning on September 1, 1987:

Figure 49.19 (11) (a) 1. a.:

FAMILY SIZE	AREA I	AREA II
1	\$ 311	\$ 301
2	550	533
3	647	626
4	772	749
5	886	861
6	958	929
7	1,037	1,007
8	1,099	1,068
9	1,151	1,117
10	1,179	1,143

c. Grants shall vary in 2 areas which shall be groups of counties designated by the department based on variation in shelter cost.

2. A monthly allowance of \$25 per person for each additional member in the family above 10 shall be added to the standard of assistance specified under subd. 1. a.

3. In determining family size only those who are eligible for assistance shall be included.

4. In accordance with s. 49.19 (4) (g), a monthly allowance of \$71 for each person in the family who qualifies for a payment under s. 49.19 (4) (g) shall be added to the standard of assistance specified under subd. 1. a.

6. All payments that are not whole dollar amounts shall be rounded down to the nearest whole dollar.

7. The department may not make a payment for a month if the amount of the payment would be less than \$10.

(b) The department shall implement a program of emergency assistance to needy persons in cases of fire, flood, natural disaster, homelessness or energy crisis. Eligibility shall not exceed the limitations for federal participation defined by federal regulations, including 45 CFR 233.120. The aid granted, except for cases of energy crisis, shall not exceed \$150 per family member. Emergency assistance provided to needy persons under this paragraph in cases of homelessness may be used only to obtain a permanent living accommodation. For the purposes of this paragraph, a family is considered to be homeless if any of the following applies:

1. The family must leave its current housing because it is uninhabitable as determined by a local building inspector, a local health department or another appropriate local authority.

2. The family has a current residence that is a shelter designed for temporary accommodation such as a motel, hotel, shelter facility or transitional shelter facility.

3. A member of the family was a victim of domestic abuse, as defined in s. 968.075 (1) (a).

4. The family is without a fixed, regular and adequate night-time residence.

5. The family is living in a place that is not designed for, or ordinarily used as, a regular sleeping accommodation.

(11g) When the department submits a copy of the reevaluation of the need standard and payment standard under sub. (11) (a), as required by 42 USC 602 (h), the department shall submit a copy of that reevaluation to the chief clerk of each house of the legislature for distribution to the legislature in the manner provided under s. 13.172 (3).

(11m) (a) The department shall apply to the secretary of the federal department of health and human services for approval of a demonstration project under which the department provides a person eligible for aid under this section who is described in par. (am) with monthly payments, for the first 6 months that he or she lives in this state, calculated on the basis of the aid to families with dependent children benefit level in the state in which the family most recently resided. The department shall promulgate a rule, which it shall update annually, establishing the aid to families with dependent children benefit that will be paid under the demonstration project according to family size and state of former residence. The department shall base the benefit for a family on the aid to families with dependent children benefit available to a typical family of the same size in the other state, taking into account all factors that may affect the amount of the benefit. The rule shall specify the factors that the department uses to establish the benefit for participants in the demonstration project. If a family moves from a state that allows a family to keep a different amount of income without reducing benefits than a family would be allowed to keep in this state, the department shall allow the family to keep a similar amount of income without reducing benefits.

(am) Under the demonstration project, a person is subject to receiving the payments under par. (a) if he or she has not previously resided in this state for at least 6 months and either:

1. Applies for benefits more than 90 days but fewer than 180 days after moving to this state and is unable to demonstrate to the satisfaction of the county department of social services or human services that he or she was employed for at least 13 weeks after moving to this state; or

2. Applies for benefits within 90 days after moving to this state.

(b) If approval under par. (a) is granted and if the supreme court determines, within 9 months after the department notifies the attorney general that the approval has been granted, that the demonstration project does not violate either the state constitution or the U.S. constitution or the supreme court does not make a decision on the constitutionality of the demonstration project within that time, the department shall implement the demonstration project. The department may conduct the demonstration project for a period not to exceed 36 months. The department may not start the demonstration project before a computerized system for determining the amount of benefits payable to recipients under the demonstration project is complete.

(c) Subject to pars. (b) and (d), the department shall conduct the demonstration project in Kenosha county, Milwaukee county, Racine county and up to 3 other counties. If the department does not initially select Rock county as one of the other counties and if one of the counties specified in this paragraph or initially selected by the department enacts an ordinance or adopts a resolution under par. (d), the department shall give Rock county priority for consideration as a replacement county.

(d) The department may not conduct the demonstration project in a county if the county enacts an ordinance or adopts a resolution objecting to participating in the demonstration project.

(e) If the department conducts the demonstration project, the department shall enter into a contract with the legislative audit bureau under which the legislative audit bureau will contract with a private or public agency for the performance of an evaluation of the demonstration project, including whether the demonstration

project deters persons from moving to this state, and will submit the evaluation of the demonstration project to the governor and to the chief clerk of each house of the legislature for distribution to the legislature under s. 13.172 (2).

(13) When a county department under s. 46.215, 46.22 or 46.23 proposes to terminate, discontinue, suspend or reduce assistance to a recipient under this section such county department shall provide at least the minimum notice required under 42 USC 601 to 613.

(14) (a) If any check or draft drawn and issued for payment of aid under this section is lost, stolen or destroyed, the department shall request a replacement as provided under s. 20.912 (5).

(b) If the state treasurer is unable to issue a replacement check or draft requested under par. (a) because the original has been paid, the department shall promptly authorize the issuance of a replacement check or draft. If the state treasurer recovers the amount of the original check or draft that amount shall be returned to the department. If the state treasurer is unable to obtain recovery, the department may pursue recovery.

(15) By January 1, 1990, the department shall apply for approval of a demonstration project under 42 USC 1315 (d) (1) (A) which would test and evaluate the elimination, on a statewide basis, of the limit on the number of hours a parent may work and still be considered unemployed for purposes of eligibility for aid under this section. If the application is approved, the department shall inform the joint committee on finance. The department may implement the demonstration project only if the joint committee on finance approves the demonstration project.

(16) The department shall provide written notice of the penalties under s. 49.123 (2) to each applicant for aid under this section at the time of application and to each person who receives aid under this section on June 18, 1992, at the time of the next redetermination of the person's eligibility.

(17) The department may recover an overpayment of aid under this section from an overpaid family who continues to receive aid by reducing the amount of the family's monthly aid payment by no more than 10% of the maximum monthly payment allowance under sub. (11) for a family of that size, in the case of overpayments of aid resulting from an intentional violation of ss. 49.19 to 49.41 or the rules promulgated under those sections by a member of the family receiving the overpayment, and by no more than 7% of the maximum monthly payment allowance under sub. (11) for a family of that size, in all other cases.

(19) The department shall request a waiver from the secretary of the federal department of health and human services to allow the department to determine eligibility and payment amounts under this section for a woman entrepreneur who receives a start-up or capital expansion loan through the revolving loan program operated by the women's business initiative corporation without consideration of that loan or of any business income during the start-up period of the woman's business. If the waiver is approved, the department shall implement the waiver.

(20) After December 31, 1998, no person is eligible to receive benefits under this section and no aid may be granted under this section. No additional notice, other than the enactment of this subsection, is required to be given under sub. (13) to recipients of aid under this section to terminate their benefits under this subsection.

History: 1971 c. 125, 215, 217; 1973 c. 90, 147, 186, 328, 333; 1975 c. 39, 82, 94, 224, 307, 422; 1977 c. 29, 203, 271, 418, 449; 1979 c. 32 s. 92 (4); 1979 c. 34, 206, 221, 352; 1981 c. 1, 20, 93, 314, 317, 391; 1983 a. 27, 161, 192, 245, 310, 430, 447; 1985 a. 29, 120, 176, 281, 332; 1987 a. 27, 307, 399; 1989 a. 31, 107, 122, 359; 1991 a. 39, 178, 269, 313, 315, 316, 322; 1993 a. 16, 99, 326, 395, 437, 446, 481.

A mother receiving aid to dependent children is herself receiving aid so as to support a prosecution under 49.12 for failing to report a change in circumstances within 7 days. *Weber v. State*, 59 W (2d) 371, 208 NW (2d) 396.

AFDC recipient whose need is both temporary and extraordinary may be entitled to general relief. See note to 49.01, citing *State ex rel. Tiner v. Milwaukee County*, 81 W (2d) 277, 260 NW (2d) 393.

State may not deny aid to person eligible under federal standards unless Congress has clearly indicated that supplementary state restrictions are permissive. *Woodman v. HSS Dept.* 101 W (2d) 315, 304 NW (2d) 723 (1981).

The assignment to the state of child support by AFDC recipients under s. 49.19 (5) does not prevent a trial court acting under s. 767.51 (5) from giving the father credit

for amounts actually contributed for support prior to the entry of an order even though the credit results in there being no payments owing from the father from which AFDC payments made during the same period can be recovered. *Paternity of Cheyenne D L 181 W (2d) 868, 112 NW (2d) 522 (Ct App 1994).*

An AFDC budget must be computed on the basis of actual income. 60 Atty. Gen 431.

Sub (6) has not been affected by amendments to the work incentive program, nor does it violate equal protection provisions of the Fourteenth Amendment. 62 Atty. Gen 120.

"Dependent child" under AFDC does not include unborn children. *Burns v. Alcalá, 420 US 575*

See note to Art I, sec. 1, citing *Alvarado v. Schmidt, 317 F Supp 1027*.

Various provisions of sub. (4) (d) are invalid as inconsistent with the Social Security Act. *Doe v. Schmidt, 330 F Supp 159*

Unconstitutional conditions on welfare eligibility. *Redlich, 1970 WLR 450*

Procedural due process and the welfare recipient: A statistical study of AFDC fair hearings in Wisconsin. *Hammer and Hartley, 1978 WLR 145*

49.193 Job opportunities and basic skills program.

(1) PLAN; ADMINISTRATION. (a) The department shall submit a plan that meets the requirements under 42 USC 682 (a) to the federal secretary of health and human services. If the plan is approved, the department shall administer a job opportunities and basic skills program under 42 USC 682 (a) to provide employment and training and educational and supportive services to assist recipients of aid under s. 49.19 in obtaining gainful employment.

(b) 1. The department shall administer the program under this section directly or through a contract with an agency in each county or in groups of counties or through contracts with federally recognized American Indian tribes or bands. If upon reviewing the performance of an agency administering the program the department determines that the agency is not complying with the terms of the contract or if an agency wishes to terminate its responsibility to administer the program, the department shall terminate the contract and contract with another agency.

2. Notwithstanding s. 16.75 (1) and (2m), the department may contract with a public or private agency selected by the department without competitive bidding or competitive sealed proposals, to administer the program under this section in a county with a population of 500,000 or more.

(c) The department shall coordinate the program under this section with the programs of the department of administration, the department of industry, labor and human relations, the department of development, the department of public instruction and the vocational, technical and adult education [technical college system] board and with programs operated under the job training partnership act, 29 USC 1501 to 1791j.

NOTE: The vocational, technical and adult education system was renamed the technical college system by 1993 Wis. Act 399.

(d) The department shall ensure that records of the number of participants in the program under this section and of the number of job placements made are kept according to gender and according to whether or not the participant is eligible under s. 49.19 (4) (dm).

(e) The department shall pay the portion of the costs of the services provided under this section that is not paid by the federal government. The department shall, to the extent possible, use available in-kind services to provide that nonfederal share of the costs of this program.

(2) PARTICIPATION. (a) The department shall ensure that all persons required under 42 USC 602 (a) (19) and 42 USC 681 to 687 to participate in a job opportunities and basic skills training program participate in the program under this section.

(b) The department shall give priority for receipt of services under this section to a person who is any of the following:

1. A recipient of aid under s. 49.19 who has received aid for any 36 of the preceding 60 months.

2. A custodial parent under the age of 24 who has not graduated from a public or private high school or obtained a declaration of equivalency of high school graduation under s. 115.29 (4) and who, at the time of application for aid under s. 49.19, is not enrolled in school, as defined in s. 49.50 (7) (a).

3. A custodial parent under the age of 24 who had little or no work experience in the year before applying for aid under s. 49.19.

4. A member of a family in which the youngest child is within 2 years of being ineligible for aid under s. 49.19 because of age.

5. Another long-term or potentially long-term recipient of aid under s. 49.19, as determined by the department.

(d) Following the development of an employability plan under sub. (4) (c) for a participant, the agency administering the program under this section shall assign the participant to one or more activities that are appropriate for the person in accordance with 42 USC 684 (a). The agency shall ensure that a participant receives appropriate supportive services.

(e) The department shall request a waiver from the secretary of the federal department of health and human services to allow the department to require full-time participation in the program under this section by a recipient of aid under s. 49.19 who is a parent or other caretaker of a child who is at least 2 years of age. If the waiver is in effect, the department may require full-time program participation by the parent or other caretaker of a child who is at least 2 years of age as provided in the waiver.

(3) INFORMATION. The department shall, directly or by contract, do all of the following:

(a) Notify applicants for and recipients of aid under s. 49.19 of the availability of employment and training activities and supportive services.

(b) Inform recipients of aid under s. 49.19 of the opportunity to indicate a desire to participate in the program under this section.

(c) Inform persons required to participate in the program under this section of the sanctions for failing, without good cause, to participate in the program, for failing, without good cause, to accept employment and for terminating employment or reducing earnings without good cause.

(d) Provide information concerning the program under this section to a person who does not speak English in a language that the person understands.

(4) COMPONENTS. The department shall ensure that the program under this section includes all of the following:

(a) Enrollment and orientation.

(b) Assessment of each participant's employability based on skills, work experience, needs for educational and supportive services and a review of the family circumstances.

(c) Development of an employability plan for each participant.

(d) Case management.

(e) Job search activities.

(f) On-the-job training.

(g) Work supplementation, as described in 45 CFR 250.62, in which participation is voluntary.

(h) Community work experience, as described in 45 CFR 250.63.

(i) Other work experience activities.

(j) Educational activities which may include payment for or referral to any of the following:

1. High school or equivalent education.

2. Basic and remedial education.

3. Education for individuals with limited English proficiency.

4. Postsecondary education and vocational skills training.

5. Job skills training.

6. Parenting skills training for parents under the age of 20.

(k) Supportive services which may include any of the following:

1. Counseling.

2. Child care.

3. Transportation.

4. Payment for other work-related expenses.

(L) Grievance and conciliation procedures.

(m) Evaluation of the employment status of participants at 2 intervals following the start of employment, the first no sooner than 30 days and the 2nd no sooner than 6 months and no later than one year following the start of employment.

(5) WORK SUPPLEMENTATION (a) The department shall establish a work supplementation component in an area in which a development zone is designated under subch. VI of ch. 560, upon the request of the local governing body, as defined in s. 560.70(4), of the area.

(b) Upon notification from the department of development under s. 560.75(11) that a development zone has been designated, the department shall do all of the following:

1. Provide the department of development with information about whether a work supplementation component is established in the area where the development zone is located.

2. If a work supplementation component has been established in an area where the development zone is located, provide information about how the work supplementation component is administered.

3. With the department of development and the local governing body administering the development zone, help employers in the development zone to participate in the work supplementation component.

(6) COMMUNITY WORK EXPERIENCE (a) A participant in a community work experience component operated by an agency administering the program under this section is considered an employe of that agency for purposes of worker's compensation benefits, except to the extent that the person for whom the participant is performing work agrees to provide worker's compensation coverage or the administrative agency delegates, by contract, the responsibility to provide that coverage to the person administering the community work experience component.

(b) A community work experience component may not be operated so as to fill an established vacant position or supplant a regular employe of any governmental unit.

(c) No person may be required to work more than 32 hours per week in a community work experience component. No person may be required to work more than 16 weeks in a component under this subsection during a 12-month period, except that a person who is eligible for aid under s. 49.19(4)(dm) may be required to work for more than 16 weeks in a component under this subsection in order to comply with 45 CFR 250.33.

(d) The department shall ensure that a person's participation in a community work experience component is reassessed as required in 42 USC 682(f)(2) and that job search and other activities related to employment under the program under this section receive priority over participation in a community work experience component.

(7) POSTSECONDARY EDUCATION The department shall, by rule, define allowable or satisfactory participation in post-secondary education and vocational skills training activities.

(8) CHILD CARE (a) The department shall pay child care costs of persons with approved employability plans who are participating in the program under this section. Payment or reimbursement shall be in an amount based on need, with the maximum amount per child equal to the lesser of the actual cost of care or the rate established under s. 46.98(4)(d), or, if a higher rate is established under s. 46.98(4)(e) and if the child care meets the quality standards established under s. 46.98(4)(e), payment or reimbursement for child care that meets those standards shall be in an amount based on need, with the maximum amount per child equal to the lesser of the actual cost of the care or the rate established under s. 46.98(4)(e).

(b) The department shall establish procedures to ensure that an agency administering the program under this section reimburses the child care costs of a participant in the program under this section within 4 weeks after the participant submits a claim form.

(bm) Beginning on January 1, 1994, a county department under s. 46.215, 46.22 or 46.23 that receives funds to pay or reim-

burse child care costs under this subsection or under s. 49.50(6e)(a) may, with the approval of the department, use those funds to pay or reimburse child care costs under s. 49.50(6e)(b), (6g) or (7)(e). The department shall approve or disapprove of this use of funds under criteria established to maximize state and federal funding available for child care.

(c) The department may only pay child care costs under this subsection if the child care is provided by a child care provider, as defined in s. 49.50(1).

(9) NOTICE CONCERNING SANCTIONS Following conciliation and before imposing a sanction on a person receiving aid under s. 49.19 who fails without good cause to participate in the program under this section or to accept employment or who terminates employment or reduces earnings without good cause, the county department under s. 46.215, 46.22 or 46.23 shall notify the person in writing of the reason for the proposed sanction. The notice shall inform the person of the right to appeal under s. 49.50(8).

(10) EMPLOYMENT AND TRAINING COUNCIL Each agency that administers the program under this section shall appoint an employment and training council to advise the agency concerning employment and training activities. The agency administering the program in a county or group of counties shall consult with the county board of the county or the county boards of the group of counties in making the appointments to the council. The council shall include the following members:

(a) An elected county official.

(b) A representative of the county department under s. 46.215, 46.22 or 46.23.

(c) A representative of a local school district.

(d) A representative of organized labor.

(e) A recipient of aid to families with dependent children or a representative of a recipient advocacy group.

(f) A representative of private business nominated by the area private industry council under the job training partnership act, 29 USC 1501 to 1781.

(g) A representative of the office which administers the program under this section in the county.

(10m) WORK-FIRST PROGRAM The department shall select Kenosha county and additional counties in which to pilot the work-first program under this subsection. The work-first program shall be conducted as part of the job opportunities and basic skills program under this section and shall be funded from s. 20.435(4)(df). The work-first program shall seek to increase the amount of job opportunities and basic skills program services provided to recipients of aid to families with dependent children and to minimize the time between the date on which a person in a pilot county first applies for aid to families with dependent children under s. 49.19 and the date on which the person begins to participate in the job opportunities and basic skills program under this section.

(11) RULES The department shall promulgate rules for the administration of the program under this section.

History: 1993 a 16, 99, 491

49.195 Recovery of aid to families with dependent children. (1) If any parent at the time of receiving aid under s. 49.19 or at any time thereafter acquires property by gift, inheritance, sale of assets, court judgment or settlement of any damage claim, or by winning a lottery or prize, the county granting such aid may sue the parent on behalf of the department to recover the value of that portion of the aid which does not exceed the amount of the property so acquired. The value of aid liable for recovery under this section may not include the value of work performed by a member of the family in a community work experience program under s. 46.215(1)(o), 1991 stats.; s. 46.22(1)(b)11, 1991 stats., or s. 49.50(7j)(d), 1991 stats., or in a community work experience component under s. 49.193(6). During the life of the parent, the 10-year statute of limitations may be pleaded in defense against any suit for recovery under this section; and if

such property is his or her homestead it shall be exempt from execution on the judgment of recovery until his or her death or sale of the property, whichever occurs first. Notwithstanding the foregoing restrictions and limitations, where the aid recipient is deceased a claim may be filed against any property in his or her estate and the statute of limitations specified in s. 859.02 shall be exclusively applicable. The court may refuse to render judgment or allow the claim in any case where a parent, spouse or child is dependent on the property for support, and the court in rendering judgment shall take into account the current family budget requirement as fixed by the U.S. department of labor for the community or as fixed by the authorities of the community in charge of public assistance. The records of aid paid kept by the county or by the department are prima facie evidence of the value of the aid furnished. Liability under this section shall extend to any parent or stepparent whose family receives aid under s. 49.19 during the period he or she is a member of the same household, but his or her liability is limited to such period. This section does not apply to medical and health assistance payments for which recovery is prohibited or restricted by federal law or regulation.

(2) Amounts may be recovered pursuant to this section for aid granted both prior to and after August 31, 1969; and any amounts so recovered shall be paid to the United States, this state and its political subdivisions in the proportion in which they contributed to the payment of the aid granted, in the same manner as amounts recovered for old-age assistance are paid.

(3) Notwithstanding s. 49.41, the department shall promptly recover all overpayments made under s. 49.19 and shall promulgate rules establishing policies and procedures to administer this subsection.

(4) Any county or governing body of a federally recognized American Indian tribe may retain 15% of benefits distributed under s. 49.19 that are recovered due to the efforts of an employee or officer of the county or tribe. This subsection does not apply to recovery of benefits that were provided as a result of state, county or tribal governing body error.

History: 1977 c. 29; 1981 c. 93, 317; 1983 a. 27; 1985 a. 29; 1985 a. 332 s. 251 (1); 1987 a. 27, 307; 1989 a. 31, 96, 173; 1993 a. 16.

The words "both prior to and" as contained in (2) constitute an unconstitutional enactment and are therefore stricken from the statute. Estate of Peterson, 66 W (2d) 535, 225 NW (2d) 644.

Recovery may be had only from parent who immediately received aid. Richland County Dept. of Soc. Serv. v. McHone, 95 W (2d) 108, 288 NW (2d) 879 (Ct. App. 1980).

This section does not authorize recovery against child with guardianship account, where child never applied for, directly received or made representations to obtain aid. There may be common-law authority for claim against guardianship estate. In Matter of Guardianship of Kordecki, 95 W (2d) 275, 290 NW (2d) 693 (1980).

49.197 Fraud investigation and reduction and error reduction. (1m) FRAUD INVESTIGATION From the appropriations under s. 20.435 (4) (de), (L), (n) and (nL), the department shall establish a program to investigate suspected fraudulent activity on the part of recipients of medical assistance under ss. 49.46 to 49.47, aid to families with dependent children under s. 49.19 and the food stamp program under 7 USC 2011 to 2029. The department's activities under this subsection may include, but are not limited to, comparisons of information provided to the department by an applicant and information provided by the applicant to other federal, state and local agencies, development of an advisory welfare investigation prosecution standard and provision of funds to county departments under s. 46.215, 46.22 and 46.23 to encourage activities to detect fraud. The department shall cooperate with district attorneys regarding fraud prosecutions.

(3) STATE ERROR REDUCTION ACTIVITIES. The department shall conduct activities to reduce payment errors in medical assistance under ss. 49.43 to 49.47, aid to families with dependent children under s. 49.19 and the food stamp program under 7 USC 2011 to 2029. The department shall fund the activities under this section from the appropriation under s. 20.435 (4) (L).

(4) COUNTY AND TRIBAL ERROR REDUCTION. The department shall provide funds from the appropriations under s. 20.435 (4)

(de), (L) and (Lm) and federal matching funds from the appropriations under s. 20.435 (4) (n) and (nL) to counties and governing bodies of federally recognized American Indian tribes administering medical assistance under ss. 49.43 to 49.47, aid to families with dependent children under s. 49.19 or the food stamp program under 7 USC 2011 to 2029 to offset administrative costs of reducing payment errors in those programs.

History: 1985 a. 29, 176; 1987 a. 27, 413; 1989 a. 31; 1991 a. 39.

49.20 Aid to 18-year-old students. (1) PURPOSE. The purpose of this section is to provide state aid for the maintenance of 18-year-old high school students who are ineligible for assistance under s. 49.19 solely because of their age, except for those students who were eligible at age 17 under s. 49.19 (10) (a).

(2) ELIGIBILITY. A person is eligible for aid under this section if he or she:

- (a) Is 18 years of age;
- (b) Is enrolled in and regularly attending a secondary education classroom program leading to a high school diploma;
- (c) Received aid under s. 49.19, but not under s. 49.19 (10) (a), immediately prior to his or her 18th birthday; and
- (d) Is living in a home situation specified in s. 49.19 (1) (a), but not including a foster home or treatment foster home.

(3) PAYMENT. Aid under this section shall be paid from the appropriation under s. 20.435 (4) (d) and shall be in an amount equal to that to which the person would be entitled under s. 49.19 if he or she were 17 years of age, except that if the person's family became ineligible for aid under s. 49.19 on the person's 18th birthday, the amount paid shall equal the amount of aid granted to a single person under s. 49.19.

(4) RULES. The department shall promulgate rules for the administration of this program, including rules which provide for the monitoring of classroom attendance of persons receiving aid under this section.

History: 1977 c. 418; 1989 a. 31; 1991 a. 39; 1993 a. 446.

49.25 Parental responsibility pilot program.

(1) WAIVER; APPLICABILITY. The department shall request a waiver from the secretary of the federal department of health and human services to allow the department to conduct a parental responsibility pilot program as part of the program under s. 49.19. If the department receives the federal waiver and if sufficient funds are available, the department may conduct the program in a county with a population of 500,000 or more and up to 3 other counties. The county department under s. 46.215, 46.22 or 46.23 in each pilot county shall administer the program under a contract with the department. Subsections (3) to (8) apply only while the waiver is in effect and the department is conducting the program.

(3) PARTICIPATION. (a) Except as provided in par. (c), a person who lives in a pilot county is subject to the program under this section beginning when the person both receives aid under s. 49.19 and is one of the following:

1. A woman who is under the age of 20, has no children of her own and has entered the 3rd trimester of pregnancy, if that 3rd trimester began after June 30, 1994.
2. A woman who is under the age of 20, is not pregnant and is the mother of only one child, if that child was born after June 30, 1994.
3. A woman who is under the age of 20, is not pregnant and is the mother of more than one child, if the children were all born as a result of one pregnancy and were born after June 30, 1994.
4. A man who is under the age of 20 and is the father of only one child living, if that child was born after June 30, 1994, and, if the man is married and living with his spouse, whose spouse is not pregnant.
5. A man who is under the age of 20 and is the father of more than one child, if the children were all born as a result of one pregnancy and were born after June 30, 1994, and, if the man is married and living with his spouse, whose spouse is not pregnant.

6. Subject to par. (am), the spouse of a woman subject to the program under this section under subd. 1., 2. or 3. if the spouse is living with the woman.

7. Subject to par. (am), the spouse of a man subject to the program under this section under subd. 4. or 5. if the spouse is living with the man.

8. A man who has been adjudicated to be the father of a child of a woman subject to the program under this section under subd. 1., 2. or 3., if the man is living with the woman.

(am) If the spouse of a person subject to the program under this section under par. (a) 1., 2., 3., 4. or 5. is the stepparent of the person's child or children and is living with the person, the couple may decide whether to have the needs of the stepparent taken into consideration for the purposes of determining the amount of aid under s. 49.19. If the couple chooses to have the stepparent's needs taken into consideration, the stepparent is subject to the program under this section.

(b) A person who, under par. (a), becomes subject to the program under this section remains subject to the program under this section as long as he or she lives in a pilot county and the program is in effect unless the person has not received aid under s. 49.19 for at least 36 consecutive months.

(c) A person described in par. (a) is not subject to the program under this section if he or she is assigned to a control group by the department.

(4) LIMITED PAYMENT AMOUNT. Notwithstanding s. 49.19 (11) (a) 1. and 2., the department shall make a monthly payment under s. 49.19 to a family of \$38 for a single child, or \$38 for one of the children and a full payment for the other children who are all born as a result of one pregnancy, if the child or children's parent is a member of the family and is subject to the program under this section and if the child is or children are born or adopted after the family includes either one child of that parent or more than one child who were all born as a result of one pregnancy. Notwithstanding s. 49.19 (11) (a) 1. and 2., the department may not make any monthly payment under s. 49.19 to a family for any later born or adopted child of that parent. This subsection does not affect the payment of the allowance under s. 49.19 (11) (a) 4.

(5) EARNED INCOME DISREGARD. (a) Instead of the earned income disregards in s. 49.19 (5) (a) 2., 4. and 4m. and (am), the department shall apply the earned income disregard in par. (b) in determining the benefit amount of a person subject to the program under this section and in determining eligibility under s. 49.19 of a person subject to the program under this section if the person received benefits under s. 49.19 in one of the 4 months before he or she applies for benefits.

(b) For a person described in par. (a), the department shall disregard \$200 of earned income plus an amount equal to 50% of the person's remaining income not disregarded.

(6) EMPLOYMENT REQUIREMENTS. Notwithstanding s. 49.19 (4) (dm), the department may not apply the federal aid to families with dependent children program requirements as to past employment and past and current unemployment to a married couple subject to the program under this section if the married couple live together.

(7) TRAINING AND PARENTAL EDUCATION. (a) The department shall contract with the county department under s. 46.215, 46.22 or 46.23 to provide education on parenting, human growth and development, family planning and independent living skills and employment-related training to persons subject to the program under this section and to persons subject to orders under s. 767.078 (1) (d). The county department may contract with other agencies for the provision of these services.

(b) The agency providing services under par. (a) shall develop a plan for the provision of the services under par. (a) to a person who is subject to the program under this section or to an order under s. 767.078 (1) (d). If a person who is subject to the program under this section fails to cooperate with his or her services plan,

the person may be sanctioned, as provided by the department by rule.

(8) PILOT COUNTY CHILD SUPPORT ASSISTANCE. (a) From the appropriation under s. 20.435 (4) (ci), the department shall provide funds to pilot counties for assistance in establishing paternity and obtaining child support.

(b) From the appropriation under s. 20.435 (4) (ci), the department shall provide funds to Milwaukee county to fund an additional family court commissioner.

(9) EVALUATION. The department shall evaluate the program under this section or shall contract with a public or private agency for an evaluation of the program under this section.

History: 1991 a. 39; 1993 a. 16.

49.27 Work-not-welfare pilot program. (1) DEFINITIONS. In this section:

(a) "Benefit period" means, with respect to a work-not-welfare group, a period commencing on the work-not-welfare group's enrollment date and ending 48 months later, except as the benefit period may be extended under sub. (4) (g).

(b) "Enrollment date" means the first day of the first month for which a work-not-welfare group receives a benefit payment determined under sub. (4), unless the work-not-welfare group has not received a benefit payment determined under sub. (4) within the previous 36 months, in which case the enrollment date means the first day of the first month, after that 36-month period, for which the work-not-welfare group receives a benefit payment determined under sub. (4).

(c) "Work-not-welfare group" means all persons in an aid to families with dependent children case, if the head of household of the case is subject, under sub. (3), to the work-not-welfare pilot program under this section. "Work-not-welfare group" includes a caretaker of dependent children, regardless of whether the needs of the caretaker are not considered in determining the amount of the benefit determined under sub. (4) or (11) (a) to (f).

(2) WAIVER; APPLICABILITY. The department shall request a waiver from the secretaries of the federal department of health and human services and the federal department of agriculture to conduct a work-not-welfare pilot program as part of the aid to families with dependent children program under s. 49.19, the food stamp program under 7 USC 2011 to 2029 and the medical assistance program under ss. 49.45 to 49.47. If the department receives the federal waivers and if sufficient funds are available, the department shall pilot the program, beginning on January 1, 1995, in one or more pilot counties selected by the department. If a pilot county is a county in which a demonstration project under s. 49.19 (11m) is being conducted or a county selected for participation in the parental responsibility pilot program under s. 49.25, the department shall promulgate rules regarding the relationship between the work-not-welfare pilot program and the other demonstration or pilot programs operating in the pilot counties. These rules shall provide that a person may not be required to participate in more than one of these demonstration or pilot programs at a time. Subsections (3) to (11) apply only while the waiver is in effect and the department is conducting the program.

(3) PARTICIPATION. A person is subject to the work-not-welfare pilot program under this section if at least one of the following conditions is met:

(a) The person resides in a pilot county; is receiving, or is the caretaker of a child who is receiving, aid to families with dependent children benefits, other than benefits under s. 49.19 (10) or (11) (b), on January 1, 1995; and has had a regularly scheduled reinvestigation under s. 49.19 (5) (e) after January 1, 1995.

(b) The person resides in a pilot county and applies for aid to families with dependent children benefits, other than benefits under s. 49.19 (10) or (11) (b), for himself or herself or for a dependent child, on or after January 1, 1995.

(c) The person moves to a pilot county on or after January 1, 1995, and, at the time of the move, the person is receiving, or is

the caretaker of a child who is receiving, aid to families with dependent children benefits, other than benefits under s. 49.19 (10) or (11) (b).

(d) The person resides in this state in a county other than a pilot county and, within the preceding 36 months, the person had resided in a pilot county, was subject to the work-not-welfare program under par. (a), (b) or (c) and received benefits determined under sub. (4).

(4) CASH BENEFITS. (a) *Relation with other public assistance benefits.* Except as determined under this subsection or sub. (7) or (11) (a) to (f), a member of a work-not-welfare group may not receive an aid to families with dependent children benefit, other than aid to families with dependent children benefits under s. 49.19 (10) or (11) (b). Except as determined under this subsection or sub. (11) (a) to (f), a member of a work-not-welfare group may not receive food stamp benefits under 7 USC 2011 to 2029 for a month unless one of the following conditions is met:

1. The work-not-welfare group has received the maximum number of benefit payments permitted under pars. (e) and (g).

2. The portion of the benefit amount calculated under par. (c) 1. for the work-not-welfare group equals \$0, for a reason other than a sanction under sub. (5) (f), and the work-not-welfare group elects to apply for food coupons under 42 USC 2011 to 2029 in lieu of a cash benefit determined under this subsection.

(b) *Eligibility requirements.* A county department under s. 46.215, 46.22 or 46.23 in a pilot county shall determine the eligibility of a work-not-welfare group for benefits determined under this subsection in the same manner as it determines eligibility for aid to families with dependent children benefits under s. 49.19, except as follows:

1. Once eligibility for a work-not-welfare group is established, the work-not-welfare group does not lose continued eligibility solely because one or more wage earners in the work-not-welfare group work more than 100 hours in a month.

2. Once eligibility for a work-not-welfare group is established, the work-not-welfare group remains eligible until the next eligibility review, unless the benefit determined under this subsection could be adjusted under par. (d) prior to the next regularly scheduled reinvestigation under s. 49.19 (5) (e).

3. Instead of the child support disregard under s. 49.19 (5) (a) 1m, the department shall disregard \$50 of the unearned income received under par. (h) by a work-not-welfare group in a month.

(c) *Calculation of benefit amount.* Notwithstanding s. 49.19, subject to the limitations in pars. (d) to (g) and except as provided in subs. (5) (f) and (9), a county department under s. 46.215, 46.22 or 46.23 in a pilot county shall pay to a work-not-welfare group that is eligible under par. (b) a combined monthly aid to families with dependent children benefit under s. 49.19 and monthly food stamp benefit under 7 USC 2011 to 2029. The combined monthly benefit amount is equal to the sum of the following:

1. An amount equal to the aid to families with dependent children benefit that would be payable under s. 49.19 if the waiver under sub. (2) were not in effect, except as follows:

a. Child support payments shall be treated as provided in par. (h).

b. The amount of the portion of the benefit amount determined under this subdivision is not increased to reflect the birth of a child into the work-not-welfare group, if the birth occurs more than 10 months after the work-not-welfare group's enrollment date, unless the work-not-welfare group did not receive benefits determined under this paragraph for a period of at least 6 months, for a reason other than a sanction under sub. (5) (f), and the child is born into the work-not-welfare group no more than 10 months after the date on which the work-not-welfare group began receiving benefits determined under this paragraph after that period or unless the child was conceived as a result of incest in violation of s. 944.06 or 948.06 or a sexual assault in violation of s. 940.225 (1), (2) or (3) in which the mother did not indicate

a freely given agreement to have sexual intercourse and that incest or sexual assault has been reported to law enforcement authorities.

c. The amount of child support to be disregarded in determining the portion of the benefit amount determined under this subdivision is determined by applying par. (b) 3 instead of s. 49.19 (5) (a) 1m.

d. Instead of the earned income disregards under s. 49.19 (5) (a) 2, 4 and 4m. and (am), \$120 and an amount equal to one-sixth of the remaining monthly income earned from the unsubsidized employment of a person who is a member of a work-not-welfare group is disregarded from the monthly earned income of that person. Notwithstanding s. 49.19 (5) (a) 4. or 4m. or (am), the disregard in this subd. 1. d. shall apply to a person as long as the person is a member of a work-not-welfare group.

e. The portion of the benefit amount calculated under this subdivision is based on the average income of the work-not-welfare group, estimated prospectively for a 6-month period, except that for the first 2 months for which benefits calculated under this paragraph are paid the portion of the benefit amount calculated under this subdivision is based on the estimated average income for those first 2 months.

f. The income received as a result of the application of subd. 2. is not considered income in determining the portion of the benefit amount calculated under this subdivision.

2. An amount equal to the cash value of the food coupons that the work-not-welfare group would receive under 7 USC 2011 to 2029 if the waiver under sub. (2) were not in effect, except as follows:

a. Child support payments shall be treated as provided in par. (h).

b. The portion of the benefit amount calculated under this subdivision is based on the average income of the work-not-welfare group, estimated prospectively for a 6-month period, except that for the first 2 months for which benefits calculated under this paragraph are paid the portion of the benefit amount calculated under this subdivision is based on the estimated average income for those first 2 months.

(d) *Partial freezing of benefits.* 1. Notwithstanding s. 49.19 (2) (a), (4) (es) and (k) and (11), the benefit amount calculated under par. (c) may be adjusted, after the first 2 months for which benefits calculated under par. (c) are paid, only at a regularly scheduled reinvestigation under s. 49.19 (5) (e), except as follows:

a. The benefit amount calculated under par. (c) may be adjusted to reflect a significant change in circumstances under subd. 2.

b. The benefit amount calculated under par. (c) may be adjusted to reflect a decrease in earned income if there is good cause, as defined by the department by rule, for the decrease.

c. The benefit amount calculated under par. (c) may be adjusted to reflect an increase in earned income if the head of household of the work-not-welfare group requests a reduction in the benefit amount determined under this subsection.

2. A work-not-welfare group experiences a significant change in circumstances, for purposes of subd. 1. a., in any month in which at least one of the following occurs:

a. The number of persons in the work-not-welfare group changes.

b. A person in the work-not-welfare group is sanctioned under sub. (5) (f) or s. 49.12, 49.123 (2), 49.127, 49.19 (4) (h) 2. or 49.49.

c. A person in the work-not-welfare group obtains a new source of unsubsidized employment.

d. A person in the work-not-welfare group receives a new source of unearned income in an amount greater than was estimated and that source of unearned income is expected to continue until the next regularly scheduled reinvestigation under s. 49.19 (5) (e).

e. The work-not-welfare group experiences an increase or decrease in the amount of unearned income in a month that differs from the estimated amount of monthly unearned income by more than \$50.

f. The combined equity value of all of a work-not-welfare group's assets exceeds the limitation in s. 49.19 (4) (bm).

g. A person in the work-not-welfare group enters the 7th month of pregnancy.

h. A person in the work-not-welfare group experiences a life-threatening emergency, as defined by the department by rule.

(e) *Maximum number of benefit payments.* Except as provided in par. (g), a work-not-welfare group may not receive more than 24 monthly benefit payments determined under this subsection during the work-not-welfare group's benefit period. The benefit payments need not be for consecutive months.

(f) *Period of ineligibility.* A work-not-welfare group may not receive a benefit payment determined under this subsection after the work-not-welfare group's benefit period has elapsed unless it has been at least 36 months since the work-not-welfare group received a benefit payment determined under this subsection.

(g) *Additional monthly payments; extension of benefit period.*

1. A work-not-welfare group shall receive one monthly benefit payment in addition to the 24 monthly benefit payments permitted under par. (e) and a one-month extension to the work-not-welfare group's benefit period for each month after the work-not-welfare group's enrollment date in which each person in the work-not-welfare group meets at least one of the following conditions:

a. The person receives a supplemental security income payment under 42 USC 1381 to 1383c or a supplemental payment under s. 49.177 for the month.

b. The person is the head of household of the work-not-welfare group, is a nonlegally responsible relative of a dependent child in the work-not-welfare group and is not included in determining the payment under this subsection.

c. The person is required to attend school as part of the learnfare program under s. 49.50 (7).

d. The person is under 18 years of age.

e. The person is incapacitated or is needed in the home to care for a member of the work-not-welfare group who is incapacitated.

f. The person is needed in the home to care for a child who is under one year of age and who was born not more than 10 months after the work-not-welfare group's enrollment date.

g. The person requires child care services in order to participate in the employment and training program under sub. (5), is subject to the employment and training requirements under sub. (5) (b) and child care services are not available to the person under sub. (10) (d) 3. for at least the number of hours specified as part of the person's assignment under sub. (10) (d) 3.

2. A work-not-welfare group may receive monthly benefit payments in addition to the 24 monthly benefit payments permitted under par. (e) and extensions to the group's benefit period if a county department under s. 46.215, 46.22 or 46.23 determines, in accordance with rules promulgated by the department, that unusual circumstances exist that warrant an additional benefit payment and an extension of the benefit period.

(h) *Child support payments.* Notwithstanding s. 49.19 (4) (h) 1. b., the rights of work-not-welfare group members to support or maintenance from other persons, including rights to unpaid amounts accrued on the work-not-welfare group's enrollment date and rights to unpaid amounts accruing during the time that the work-not-welfare group member is subject to the work-not-welfare pilot program under sub. (3), are not assigned to the state. Work-not-welfare group members shall comply with s. 49.19 (4) (h) 1. a. and are subject to sanction under s. 49.19 (4) (h) 2. Child support payments shall be treated as unearned income in determining eligibility for benefits and in determining the amount of a

monthly benefit determined under this subsection. If child support payments are being received by the work-not-welfare group regularly, such payments shall be budgeted prospectively in determining the amount of any benefit determined under this subsection. If child support payments are not being received regularly, the payments may not be budgeted prospectively in determining the amount of any benefit determined under this subsection.

(5) **EMPLOYMENT AND TRAINING REQUIREMENTS.** (a) *Relation with other public assistance employment and training requirements.* The department shall conduct the employment and training program described in this subsection as part of the job opportunities and basic skills program under s. 49.193. Compliance with the employment and training program described in this subsection by a person in a work-not-welfare group satisfies the employment and training requirements of the job opportunities and basic skills program under s. 49.193 and the food stamps workfare program under 7 CFR 273.22.

(b) *Persons subject to employment and training requirements.* Notwithstanding s. 49.193 (2) and except as provided in par. (c), every person in a work-not-welfare group who is over 16 years of age shall comply with the requirements of the employment and training program described in this subsection, as a condition to receiving a benefit determined under sub. (4).

(c) *Exemptions.* A person is not subject to the requirements of the employment and training program described in this subsection in any month in which at least one of the following conditions is met:

1. The person is ill, incapacitated or of an advanced age within the meaning of 7 USC 602 (a) (19) (C) (i).

2. The person is needed in the home because of the illness or incapacity of another member of the work-not-welfare group.

3. The person receives a supplemental security income payment under 42 USC 1381 to 1383c or a supplemental payment under s. 49.177 for that month.

4. The person is a nonlegally responsible relative of a dependent child in the work-not-welfare group and the person's needs are not considered in calculating the amount of the benefit determined under sub. (4).

5. The person is required to attend school as part of the learnfare program under s. 49.50 (7).

6. The person is the head of household of the work-not-welfare group and is under 18 years of age.

7. The person is the caretaker of a child who is under 6 months of age.

8. The person is the caretaker of a child who is under one year of age and who was born no more than 10 months after the work-not-welfare group's enrollment date.

9. The person is pregnant and a physician has indicated that the person is unable to work.

10. The county department under s. 46.215, 46.22 or 46.23 determines, in accordance with rules promulgated by the department, that the person has good cause for not complying with the employment and training requirements of this subsection.

(d) *Participation requirements.* Within a 2-month period beginning on the work-not-welfare group's enrollment date, each member of the work-not-welfare group who is subject to the employment and training program described in this subsection shall participate in orientation activities under sub. (10) (d) 2. Beginning on the first day of the month following the completion of the orientation activities under sub. (10) (d) 2., each member of the work-not-welfare group who is subject to the employment and training program described in this subsection is required to participate in the employment and training program for a specified number of hours each month. The number of hours of participation required shall be based on the amount of the monthly benefit determined under sub. (4) that is paid to the work-not-welfare group and on the number of persons in the work-not-welfare group who are subject to the the employment and training pro-

gram described in this subsection. The department shall promulgate a rule specifying the manner in which the number of required hours is to be calculated. No person may be required to spend more than 40 hours per week participating in the employment and training program described under this subsection. The number of hours of participation required under this paragraph may not exceed the number of hours that a person is assigned under sub. (10) (d) 3. If the person needs child care services, the number of hours of participation required under this paragraph also may not exceed the number of hours for which child care is made available under sub. (10) (d) 3.

(e) *Program components and requirements.* A county department under s. 46.215, 46.22 or 46.23 shall operate the employment and training program described in this subsection in a manner designed to provide members of a work-not-welfare group who are over age 16 with the means to achieve long-term independence from public assistance, including, where appropriate, education. The employment and training program described in this subsection shall include all of the same program components and requirements as in s. 49.193, except that:

1. The services priorities in s. 49.193 (2) (b) do not apply to persons who are subject to the employment and training program described in this subsection, all of whom shall receive equal priority.

2. A county department under s. 46.215, 46.22 or 46.23 may not give a person subject to the employment and training program described in this subsection an education or training assignment, if the education or training is not likely to be completed within a 24-month period. A person who is subject to the employment and training program described in this subsection may not fulfill the hours of participation requirement under par. (d), in whole or in part, through participation in a self-initiated education or training program, if the program is not likely to be completed within a 24-month period.

3. Notwithstanding s. 49.193 (6) (c), a person who is subject to the employment and training program described in this subsection may be required to work more than 32 hours per week and more than 16 weeks in a 12-month period in a community work experience program.

4. Notwithstanding s. 49.193 (4) (g), a county department under s. 46.215, 46.22 or 46.23 may require participation in a work supplementation program.

5. A person in need of a high school diploma shall be assigned to a course of study meeting the standards established by the state superintendent of public instruction for the granting of a declaration of equivalency of high school graduation unless the person demonstrates a basic literacy level or the employability plan for the individual identifies a long-term employment goal that does not require a high school diploma or a declaration of equivalency.

6. In addition to the employment and training activities under s. 49.193 (4) to (7), the employment and training program described in this subsection shall include an independence jobs program, providing for subsidized employment in the public sector.

7. Participation in alcohol and other drug abuse prevention and treatment programs may be required to fulfill employment and training requirements described in this subsection.

8. The employment and training requirements described in this subsection may be satisfied through working the number of hours required under par. (d) in unsubsidized employment or in a combination of unsubsidized employment and employment and training activities.

9. The subsidized employment components of the employment and training program described in this subsection may not be operated so as to do any of the following:

a. Displace any regular employe or reduce the wages, employment benefits or hours of work of any regular employe.

b. Impair an existing contract for services or collective bargaining agreement.

c. Fill a position when any other person is on layoff from the same or a substantially equivalent job within the same organizational unit.

d. Have the effect of filling a vacancy created by an employer terminating a regular employe or otherwise reducing its work force for the purpose of hiring an individual under this subsection.

e. Infringe in the promotional opportunities of a regular employe.

10. The department shall establish a grievance procedure for resolving complaints by regular employes or their representatives that the subsidized employment components of the employment and training program under this subsection violate subd. 9.

(f) *Sanctions.* If, after the first month for which a work-not-welfare group receives cash benefits determined under sub. (4), a person in the work-not-welfare group fails to meet the employment and training requirements under this subsection in a month, the work-not-welfare group may be sanctioned by reducing, or by not paying, the benefit amount determined under sub. (4) for that month. For purposes of the maximum number of monthly benefit payments permitted under sub. (4) (e), a work-not-welfare group shall be considered to have received a monthly benefit in a month in which, as a result of sanctions under this paragraph, a reduced monthly benefit or no monthly benefit is paid. The notice requirement under s. 49.193 (9) and the fair hearing and review provisions under s. 49.50 (8) apply to a sanction imposed under this paragraph.

(g) *Voluntary participation.* To the extent that funding permits, persons who are exempt under par. (c) may participate in the employment and training program under this subsection and, to the extent that funding permits, persons may participate in the employment and training program described in this subsection for more hours than are required under par. (d).

(6) **TRANSITIONAL CHILD CARE.** (a) *Eligibility.* Except as provided in par. (b), a work-not-welfare group is eligible for transitional child care services under par. (c) in any month in which all of the following conditions are met:

1. The work-not-welfare group has received at least one monthly cash benefit determined under sub. (4).

2. The work-not-welfare group will not receive benefits determined under sub. (4) or (11) (a) to (f) for the month.

3. The work-not-welfare group's benefit period has not yet expired.

4. At least one person in the work-not-welfare group is employed in unsubsidized employment.

(b) *Time limitations on transitional child care benefits.* A work-not-welfare group that is eligible for transitional child care under par. (a) may receive transitional child care benefits under par. (c) for a maximum of 12 months during a benefit period. These months need not be consecutive. A work-not-welfare group may not receive transitional child care benefits under this subsection after the work-not-welfare group's benefit period has elapsed unless it has been at least 36 months since the work-not-welfare group received benefits determined under sub. (4) or (11) (a) to (f).

(c) *Benefits.* A county department under s. 46.215, 46.22 or 46.23 shall provide assistance in paying the child care costs of a work-not-welfare group that is eligible to receive benefits under this paragraph if the child care is provided by a child care provider, as defined in s. 46.98 (1) (am). The formula for determining the amount of assistance shall be the same as the formula established by the department under s. 49.50 (6g). The rates for child care services under this paragraph shall be determined under s. 46.98 (4) (d), or, if a higher rate is established under s. 46.98 (4) (e) and if the child care services meet the quality standards established under s. 46.98 (4) (e), the rates for child care services under this paragraph that meet those standards shall be determined under s. 46.98 (4) (e). The department shall promulgate rules for the disbursement of funds under this paragraph.

(7) SHELTER PAYMENTS. (a) *Eligibility.* A work-not-welfare group is eligible for shelter payment benefits under this subsection if all of the following conditions are met:

1. The work-not-welfare group has received the maximum number of benefit payments determined under sub. (4) or (11) (a) to (f), as provided in sub. (4) (e) and (g).
2. The period of ineligibility under sub. (4) (f) and (g) for the work-not-welfare group has not yet expired.
3. The work-not-welfare group is in danger of becoming homeless, as defined by the department by rule.

(b) *Benefits.* For a work-not-welfare group that is eligible for benefits under this subsection, the department shall pay a shelter benefit equal to the lesser of the work-not-welfare group's shelter expenses or the benefit amount that the work-not-welfare group would have received under s. 49.19 if a waiver under sub. (2) were not in effect, based only on the number of children in the work-not-welfare group. The shelter benefit under this subsection shall be paid directly to the provider of the shelter or in the form of a voucher that may be used only for shelter expenses.

(8) TRANSITIONAL MEDICAL BENEFITS. (a) *Eligibility.* Except as provided in par. (b), all members of a work-not-welfare group are eligible for transitional medical benefits under par. (c) for any month in which all of the following conditions are met:

1. The work-not-welfare group has received at least one monthly cash benefit determined under sub. (4).
2. The work-not-welfare group will not receive benefits determined under sub. (4) or (11) (a) to (f) for the month.
3. The work-not-welfare group's benefit period has not yet expired.
4. At least one member of the work-not-welfare group is employed in unsubsidized employment.

5. The income of the work-not-welfare group is not greater than 185% of the poverty line for a family the size of the work-not-welfare group.

6. If the income of the work-not-welfare group is greater than 100% of the poverty line for a family the size of the work-not-welfare group, the work-not-welfare group pays, notwithstanding ss. 49.45 (18) and 49.47 (8), a health care services premium to the department.

(b) *Time limitation on benefits.* The work-not-welfare group is eligible for transitional medical benefits under par. (c) for a maximum of 12 months during a benefit period. The months need not be consecutive. A work-not-welfare group may not receive transitional medical benefits under this subsection after the work-not-welfare group's benefit period has elapsed unless it has been at least 36 months since the work-not-welfare group received benefits determined under sub. (4) or (11) (a) to (f).

(c) *Benefits.* Each person in a work-not-welfare group that is eligible for benefits under this paragraph in a month shall receive medical assistance coverage under s. 49.46 (1) (cs) or, if a person could be covered by an insurance plan offered by the employer of one of the members in the work-not-welfare group and if the department determines that it would be cost-effective to do so, a payment equal to the amount of the premium that is required to be paid by the employee member of the work-not-welfare group, if any.

(9) COOPERATION REQUIREMENT. As a condition for continued benefits under this section, a person who is subject to the work-not-welfare pilot program under this section shall comply with reasonable requests for cooperation by work-not-welfare case management workers in applying for programs or resources that these workers believe may be available to the person.

(10) ADMINISTRATION IN PILOT COUNTIES. (a) *Contracts.* The department shall enter into a contract with the county department under s. 46.215, 46.22 or 46.23 in each pilot county. The contract shall specify the obligations of the county department in administering the work-not-welfare pilot program in that county and shall require at least the following:

1. The establishment of a community steering committee under par. (b).
2. The establishment of a children's services network under par. (c).

3. The provision of case management services under par. (d).

(b) *Community steering committee.* 1. Each county department under s. 46.215, 46.22 or 46.23 entering into a contract with the department under par. (a) shall establish a community steering committee instead of an employment and training council under s. 49.193 (10). The chairperson and the other members of the community steering committee shall be appointed by the county executive or county administrator in the pilot county or, if the pilot county has no county executive or county administrator, by the chairperson of the county board of supervisors. The appointments shall be made in consultation with the department. The community steering committee shall have at least 12 members but not more than 15 members. The chairperson of the community steering committee shall be a person who represents business interests.

2. The community steering committee shall do all of the following:

a. Perform the functions of an employment and training council under s. 49.193 (10).

b. Identify and encourage employers to provide permanent jobs for persons who are subject to the employment and training program described in sub. (5).

c. Create and encourage others to create subsidized jobs for persons who are subject to the employment and training program described in sub. (5).

d. Create and encourage others to create on-the-job training sites for persons who are subject to the employment and training program described in sub. (5).

e. Foster and guide the entrepreneurial efforts of persons who are subject to the employment and training program described in sub. (5).

f. Provide mentors, both from its membership and from recruitment of members of the community, to provide job-related guidance, including assistance in resolving job-related issues and the provision of job leads or references, to persons who are subject to the requirements of the employment and training program described in sub. (5).

(c) *Children's services network.* Each county department under s. 46.215, 46.22 or 46.23 entering into a contract with the department under par. (a) shall establish a children's services network. The children's services network shall provide information about community resources available to the children in a work-not-welfare group during the work-not-welfare group's benefit period and the work-not-welfare group's period of ineligibility under sub. (4) (f), including charitable food and clothing centers; the state supplemental food program for women, infants and children under s. 253.06; and child care programs under s. 46.98.

(d) *Case management services.* 1. The county department under s. 46.215, 46.22 or 46.23 administering a work-not-welfare pilot program under this section shall assign each work-not-welfare group to a case management team. The case management team shall be composed of case managers representing the income maintenance, job opportunities and basic skills, child care and child support components of the work-not-welfare pilot program under this section.

2. During the month beginning with the work-not-welfare group's enrollment date, the county department under s. 46.215, 46.22 or 46.23 shall provide work-not-welfare group members with orientation services. The services shall include provision of oral and written explanations of the limitations on the benefits described under this section and of the participation requirements for the employment and training program described in sub. (5). As a condition of receiving benefits under this section, adult work-not-welfare group members may be required to sign a statement, which may be referred to as an "Independence Pact", indicating that they received a copy of the written explanation of bene-

fits and understand the employment and training requirements and the time-limited benefits of the work-not-welfare pilot program under this section. The orientation services shall also include the provision of a benefit account book, in which the case management team will indicate the remaining number of months of eligibility for cash and transitional benefits under this section.

3. To the extent that assignments are available, the case management team shall assign to persons who are subject to the employment and training requirements described in sub. (5) an employment or training assignment that enables the person to fulfill the participation requirements described in sub. (5) (d). To the extent that funding for child care is available, the case management team shall also assist persons who are subject to the employment and training program described in sub. (5) in obtaining child care services.

(e) *Child support assistance.* From the appropriation under s. 20.435 (4) (ci), the department may provide funds to pilot counties for assistance in establishing paternity and obtaining child support.

(11) ADMINISTRATION IN NONPILOT COUNTIES A county department under s. 46.215, 46.22 or 46.23 in a nonpilot county may not pay aid to families with dependent children benefits under s. 49.19 to any person in a work-not-welfare group, except as provided in this subsection. With respect to persons in a work-not-welfare group residing in a nonpilot county, the county department in the nonpilot county shall do all of the following:

(a) Determine the eligibility of a work-not-welfare group member for aid to families with dependent children under s. 49.19 without regard to sub. (4) (b).

(b) Determine the amount of aid to families with dependent children under s. 49.19 without regard to sub. (4) (c).

(c) Issue food coupons in administering the food stamp program under s. 46.215 (1) (k) or 46.22 (1) (b) 5. without regard to sub. (4) (c) 2.

(d) Adjust aid to families with dependent children and food stamp benefits without regard to sub. (4) (d).

(e) Apply the limitations contained in sub. (4) (e) to (g) to aid to families with dependent children payments under s. 49.19.

(f) Treat child support payments as provided in s. 49.19 without regard to sub. (4) (h).

(g) Administer the job opportunities and basic skills program under s. 49.193 and the food stamp employment and training program under s. 49.124 without regard to any of the provisions in sub. (5), including the hours-of-participation requirement under sub. (5) (d) and the sanctions provisions under sub. (5) (f).

(h) Give priority for receipt of services under s. 49.193 (2) (b).

(i) Provide transitional child care services under sub. (6), shelter payments under sub. (7) and transitional medical assistance coverage under sub. (8).

(12) EVALUATION If the work-not-welfare program under this section is conducted, the department shall enter into a contract with a public or private agency for the preparation of evaluations of the work-not-welfare program under this section. These evaluations shall include an implementation evaluation, an outcome evaluation and an impact evaluation.

History: 1993 a 99, 437, 491.

49.30 Funeral expenses. (1) If any recipient of benefits under s. 49.046, 49.177 or 49.46, or under 42 USC 1381 to 1385 in effect on May 8, 1980, dies and the estate of the deceased recipient is insufficient to pay the funeral, burial and actual cemetery expenses of the deceased recipient, the county or applicable tribal governing body or organization responsible for burial of the recipient shall pay, to the person designated by the county department under s. 46.215, 46.22 or 46.23 or applicable tribal governing body or organization responsible for the burial of the recipient, the following:

(a) The full amount of actual cemetery expenses.

(b) Except as provided under sub. (2), the lesser of \$650 in state fiscal year 1989-90 and \$1,000 in each state fiscal year thereafter or the funeral and burial expenses not paid by the estate of the deceased and other persons.

(2) The state shall reimburse a county or applicable tribal governing body or organization for any amount paid under sub. (1) (a). The state shall reimburse a county or applicable tribal governing body or organization for the amount paid under sub. (1) (b) if the total amount of actual expenses paid for a deceased recipient under sub. (1) (b) does not exceed the amount specified in sub. (1) (b). If the total amount of actual expenses paid for a deceased recipient under sub. (1) (b) exceeds the amount specified in sub. (1) (b), the state may not reimburse a county or applicable tribal governing body or organization for such amount unless the department approves the reimbursement due to unusual circumstances.

History: 1973 c. 147, 333; 1975 c. 39, 224; 1979 c. 206; 1981 c. 20; 1985 a 29, 176, 332; 1989 a 31, 239.

A cement grave liner will be considered a funeral and burial expense or a cemetery expense depending on who provides the liner; a liner provided by a funeral home constitutes a funeral and burial expense subject to the statutory payment limit. 79 Atty. Gen. 164.

49.41 Assistance grants exempt from levy. All grants of aid to families with dependent children, payments made for social services, and benefits under ss. 49.032, 49.046 and 49.177 or federal Title XVI, are exempt from every tax, and from execution, garnishment, attachment and every other process and shall be inalienable.

History: 1973 c. 147; 1987 a 27, 399; 1989 a 278.

AFDC money did not lose exemption from garnishment when deposited in checking account. *Northwest Eng. Credit Union v. Jahn*, 120 W (2d) 185, 353 NW (2d) 67 (Ct. App. 1984).

A support order against actual AFDC grants is prohibited, but an order against earned income of one who also receives AFDC is not. *In Support of B, L, T. & K.* 171 W (2d) 617, 492 NW (2d) 350 (Ct. App. 1992).

MEDICAL ASSISTANCE

49.43 Definitions. As used in ss. 49.43 to 49.497 unless the context indicates otherwise:

(1) "Charge" means the customary, usual and reasonable demand for payment as established prospectively, concurrently or retrospectively by the department for services, care or commodities which does not exceed the general level of charges by others who render such service or care, or provide such commodities, under similar or comparable circumstances within the community in which the charge is incurred.

(2) "Cost" means the reasonable cost of services, care or commodities as determined by the principles of reimbursement used under 42 USC 1395 to 1395rr, in effect on April 30, 1980.

(2m) "Cost-effective" has the meaning given in P.L. 101-508, section 4402 (a) (2).

(3) "Dentist" means a person licensed to practice dentistry.

(3m) "Developmentally disabled" has the meaning specified in s. 51.01 (5).

(3r) "Group health plan" has the meaning given in P.L. 101-508, section 4402 (a) (2).

(4) "Home health agency" has the meaning specified in s. 50.49 (1) (a).

(5) "Hospital" means an institution, approved by the appropriate state agency, providing 24-hour continuous nursing service to patients confined therein; which provides standard dietary, nursing, diagnostic and therapeutic facilities; and whose professional staff is composed only of physicians and surgeons, or of physicians and surgeons and doctors of dental surgery.

(6) "Inpatient psychiatric hospital services for individuals 21 years of age or for individuals under 22 years of age who are receiving such service immediately prior to reaching age 21" has the same meaning as provided in section 1905 (h) of the federal social security act.

(6m) "Institution for mental diseases" has the meaning specified in 42 CFR 435.1009.

(7) "Intermediate care facility" means either of the following:

(a) An institution or distinct part thereof, which is:

1. Licensed or approved under state law to provide, on a regular basis, health related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing home is designated to provide but who because of their mental or physical condition require care and services above the level of room and board, which can be made available to them only through institutional facilities; and

2. Qualifies as an "intermediate care facility" within the meaning of Title XIX of the social security act.

(b) A public institution, or distinct part thereof, which is:

1. Licensed or approved under state law for the mentally retarded or persons with related conditions, the primary purpose of which is to provide health or rehabilitative services for mentally retarded individuals according to rules promulgated by the department; and

2. Qualifies as an "intermediate care facility" within the meaning of Title XIX of the social security act.

(8) "Medical assistance" means any services or items under ss. 49.45 to 49.47 and 49.49 to 49.497, or any payment or reimbursement made for such services or items.

(9) "Physician" means a person licensed to practice medicine and surgery, and includes graduates of osteopathic colleges holding an unlimited license to practice medicine and surgery.

(10) "Provider" means a person, corporation, limited liability company, partnership, unincorporated business or professional association and any agent or employe thereof who provides medical assistance under ss. 49.45 to 49.47, 49.49 and 49.495.

(11) "Skilled nursing home" means a facility or distinct part thereof, which:

(a) Is licensed or approved under state law for the accommodation of convalescents or other persons who are not acutely ill and not in need of hospital care;

(b) Employs sufficient registered nursing practitioners for supervision of those giving nursing care to patients; and

(c) Qualifies as a "skilled nursing facility" within the meaning of Title XIX of the social security act.

(12) "Spouse" means the legal husband or wife of the beneficiary, whether or not eligible for medical assistance.

History: 1977 c. 29 ss. 583m, 591; 1977 c. 418 s. 929 (18); 1979 c. 221; 1981 c. 20 s. 2202 (20) (m); 1981 c. 93; 1983 a. 189; 1987 a. 27; 1987 a. 403 s. 256; 1987 a. 413; 1991 a. 39; 1993 a. 27, 99, 112, 437.

49.45 Medical assistance; administration. (1) PURPOSE To provide appropriate health care for eligible persons and obtain the most benefits available under Title XIX of the federal social security act, the department shall administer medical assistance, rehabilitative and other services to help eligible individuals and families attain or retain capability for independence or self-care as hereinafter provided.

(2) DUTIES (a) The department shall:

1. Exercise responsibility relating to fiscal matters, the eligibility for benefits under standards set forth in ss. 49.46 to 49.47 and general supervision of the medical assistance program;

2. Employ necessary personnel under the classified service for the efficient and economical performance of the program and shall supply residents of this state with information concerning the program and procedures;

3. Determine the eligibility of persons for medical assistance, rehabilitative and social services under ss. 49.46, 49.468 and 49.47 and rules and policies adopted by the department and may designate this function to the county department under s. 46.215 or 46.22;

4. To the extent funds are available under s. 20.435 (1) (bm), certify all proper charges and claims for administrative services to

the department of administration for payment and the department of administration shall draw its warrant forthwith;

5. Cooperate with the division for learning support, equity and advocacy in the department of public instruction to carry out the provisions of Title XIX;

6. Appoint such advisory committees as are necessary and proper; and

7. Cooperate with the federal authorities for the purpose of providing the assistance and services available under Title XIX to obtain the best financial reimbursement available to the state from federal funds.

8. Periodically report to the joint committee on finance concerning projected expenditures and alternative reimbursement and cost control policies in the medical assistance program.

9. Periodically set forth conditions of participation and reimbursement in a contract with provider of service under this section.

10. After reasonable notice and opportunity for hearing, recover money improperly or erroneously paid, or overpayments to a provider either by offsetting or adjusting amounts owed the provider under the program, crediting against a provider's future claims for reimbursement for other services or items furnished by the provider under the program, or by requiring the provider to make direct payment to the department or its fiscal intermediary.

11. Establish criteria for the certification of eligible providers of services under Title XIX of the social security act and certify such eligible providers.

12. Decertify or suspend a provider from the medical assistance program, if after giving reasonable notice and opportunity for hearing, the department finds that the provider has violated federal or state law or administrative rule and such violations are by law, regulation or rule grounds for decertification or suspension. No payment may be made under the medical assistance program with respect to any service or item furnished by the provider subsequent to decertification or during the period of suspension.

12r. Notify the medical examining board, or any affiliated credentialing board attached to the medical examining board, of any decertification or suspension of a person holding a license granted by the board or the affiliated credentialing board if the grounds for the decertification or suspension include fraud or a quality of care issue.

13. Impose additional sanctions for noncompliance with the terms of provider agreements under subd. 9. or certification criteria established under subd. 11.

14. Assure due process in implementing subds. 12. and 13. by providing written notice, a fair hearing and a written decision.

15. Routinely provide notification to persons eligible for medical assistance under ss. 49.46 to 49.47, or such persons' guardians, of the department's access to provider records.

16. Notify the joint committee on finance and appropriate standing committees in each house of the legislature prior to renewing, extending or amending the claims processing contract under the medical assistance program.

17. Notify the governor, the joint committee on legislative organization, the joint committee on finance and appropriate standing committees, as determined by the presiding officer of each house, if the appropriation under s. 20.435 (1) (b) is insufficient to provide the state share of medical assistance.

18. Conduct outreach for the early and periodic screening, diagnosis and treatment program as required under 42 CFR 441. This activity is limited to persons under 21 years of age who have been determined to be eligible for medical assistance.

19. Contract with a county department under s. 46.21, 46.23, 51.42 or 51.437 to perform preadmission screening and resident review under sub. (6c).

20. Submit a report, by May 1, 1991, and annually thereafter, to the joint committee on finance on the participation rates of children in the early and periodic screening and diagnosis program.

21. Submit a report, by October 1, 1990, and annually thereafter, on access to obstetric and pediatric services under the medical assistance program, including the effect of medical assistance reimbursement rates.

22. After consulting with counties, independent living centers, consumer organizations and home health agencies, periodically identify those barriers to the provision of personal care services under s. 49.46 (2) (b) 6. j. which lead to a failure to respond to the needs and preferences of individuals who are eligible for these services and act to remove the barriers to the extent possible.

(b) The department may:

1. Direct a county department under s. 46.215, 46.22 or 46.23 to perform other functions, responsibilities and services, including any functions related to health maintenance organizations, limited service health organizations and preferred provider plans.

2. Contract with any organization whether or not organized for profit to administer, in full or in part, the benefits under the medical assistance program including prepaid health care. The department shall accept bids on contracts for administrative services and services evaluating the medical assistance program as provided in ch. 16, but may accept the contract deemed most advantageous for claims processing services; or contract with any insurer authorized under the insurance code of this state to insure the program in full or in part and on behalf of the department. The department shall submit a report each December 31 to the governor, the joint committee on finance and the chief clerk of each house of the legislature, for distribution to the appropriate standing committees under s. 13.172 (3), regarding the effectiveness of the management information system for monitoring and analyzing medical assistance expenditures.

3. Audit all claims filed by any contractor making the payment of benefits paid under ss. 49.46 to 49.47 and make proper fiscal adjustments.

4. Audit claims filed by any provider of medical assistance, and as part of that audit, request of any such provider, and review, medical records of individuals who have received benefits under the medical assistance program, or under s. 49.046.

5. Enter into contracts with providers who donate their services at no charge or who provide services for reduced payments.

(3) PAYMENT (a) Reimbursement shall be made to each county department under ss. 46.215 and 46.22 for the administrative services performed in the medical assistance program on the basis of s. 49.52. For purposes of reimbursement under this paragraph, assessments completed under s. 46.27 (6) (a) are administrative services performed in the medical assistance program.

(am) 1. From the appropriation under s. 20.435 (1) (bm), the department shall make incentive payments to counties to encourage counties to identify medical assistance applicants and recipients who have other health care coverage and the providers of the health care coverage and give that information to the department.

2. The department shall promulgate rules governing the distribution of payments under this paragraph.

(b) 1. The contractor, if any, administering benefits or providing prepaid health care under s. 49.46, 49.465, 49.468 or 49.47 shall be entitled to payment from the department for benefits so paid or prepaid health care so provided or made available when a certification of eligibility is properly on file with the contractor in addition to the payment of administrative expense incurred pursuant to the contract and as provided in sub. (2) (a) 4., but the contractor shall not be reimbursed for benefits erroneously paid where no certification is on file.

2. The contractor, if any, insuring benefits under s. 49.46, 49.465, 49.468 or 49.47 shall be entitled to receive a premium, in an amount and on terms agreed, for such benefits for the persons eligible to receive them and for its services as insurer.

(c) Payment for services provided under this section shall be made directly to the hospital, skilled and intermediate nursing homes, prepaid health care group, other organization or individual

providing such services or to an organization which provides such services or arranges for their availability on a prepayment basis.

(d) No payment may be made for inpatient hospital services, skilled nursing home services, intermediate care facility services, tuberculosis institution services or inpatient mental institution services, unless the facility providing such services has in operation a utilization review program and meets federal regulations governing such utilization review program.

(dm) After distribution of computer software has been made under 1993 Wisconsin Act 16, section 9126 (13h), no payment may be made for home health care services provided to persons who are enrolled in the federal medicare program and are recipients of medical assistance under s. 49.46 or 49.47 unless the provider of the services has in use the computer software to maximize payments under the federal medicare program under 42 USC 1395.

(e) 1. The department may develop, implement and periodically update methods for reimbursing or paying hospitals for allowable services or commodities provided a recipient. The methods may include standards and criteria for limiting any given hospital's total reimbursement or payment to that which would be provided to an economically and efficiently operated facility.

2. A hospital whose reimbursement or payment is determined on the basis of the methods developed and implemented under subd. 1. shall annually prepare a report of cost and other data in the manner prescribed by the department.

3. The department may adopt a prospective payment system under subd. 1 which may include consideration of an average rate per diem, diagnosis-related groups or a hospital-specific prospective rate per discharge.

4. If the department maintains a retrospective reimbursement system under subd. 1 for specific provided services or commodities, total reimbursement for allowable services, care or commodities provided recipients during the hospital's fiscal year may not exceed the lower of the hospital's charges for the services or the actual and reasonable allowable costs to the hospital of providing the services.

7. The daily reimbursement or payment rate to a hospital for services provided to medical assistance recipients awaiting admission to a skilled nursing home, intermediate care facility, community-based residential facility, group home, foster home, treatment foster home or other custodial living arrangement may not exceed the maximum reimbursement or payment rate based on the average adjusted state skilled nursing facility rate, created under sub. (6m). This limited reimbursement or payment rate to a hospital commences on the date the department, through its own data or information provided by hospitals, determines that continued hospitalization is no longer medically necessary or appropriate during a period where the recipient awaits placement in an alternate custodial living arrangement. The department may contract with a peer review organization, established under 42 USC 1320c to 1320c-10, to determine that continued hospitalization of a recipient is no longer necessary and that admission to an alternate custodial living arrangement is more appropriate for the continued care of the recipient. In addition, the department may contract with a peer review organization to determine the medical necessity or appropriateness of physician services or other services provided during the period when a hospital patient awaits placement in an alternate custodial living arrangement.

8. Reimbursement or payment for outpatient hospital services may not exceed reimbursement or payment for comparable services performed by providers not owned or operated by hospitals.

9. Hospital research costs that the department finds to be indirectly related to patient care are not allowable costs in establishing a hospital's reimbursement or payment rate under subd. 1.

10. Hospital procedures on an inpatient basis that could be performed on an outpatient basis shall be reimbursed or paid at the outpatient rate. The department shall determine which procedures this subdivision covers.

(f) 1. Providers of services under this section shall maintain records as required by the department for verification of provider claims for reimbursement. The department may audit such records to verify actual provision of services and the appropriateness and accuracy of claims.

2. The department may deny any provider claim for reimbursement which cannot be verified under subd. 1. or may recover the value of any payment made to a provider which cannot be so verified. The measure of recovery will be the full value of any claim if it is determined upon audit that actual provision of the service cannot be verified from the provider's records or that the service provided was not included in s. 49.46 (2). In cases of mathematical inaccuracies in computations or statements of claims, the measure of recovery will be limited to the amount of the error.

2m. The department shall adjust reimbursement claims for hospital services that are provided during a period when the recipient awaits placement in an alternate custodial living arrangement under par. (e) 7. and that fail to meet criteria the department may establish concerning medical necessity or appropriateness for hospital care. In addition, the department shall deny any provider claim for services that fail to meet criteria the department may establish concerning medical necessity or appropriateness.

3. Contractors under sub. (2) (b) shall maintain records as required by the department for audit purposes. Contractors shall provide the department access to the records upon request of the department, and the department may audit the records.

(g) The secretary may appoint personnel to audit or investigate and report to the department on any matter involving violations or complaints alleging violations of laws, regulations, or rules applicable to Title XIX of the federal social security act or the medical assistance program and to perform such investigations or audits as are required to verify the actual provision of services or items available under the medical assistance program and the appropriateness and accuracy of claims for reimbursement submitted by providers participating in the program. Department employees appointed by the secretary under this paragraph shall be issued and shall possess at all times during which they are performing their investigatory or audit functions under this section identification signed by the secretary which specifically designates the bearer as possessing the authorization to conduct medical assistance investigations or audits. Pursuant to the request of a designated person and upon presentation of that person's authorization, providers and recipients shall accord such person access to any records, books, recipient medical records, documents or other information needed. Authorized employees shall have authority to hold hearings, administer oaths, take testimony and perform all other duties necessary to bring such matter before the department for final adjudication and determination.

(h) 1. For purposes of any audit, investigation, examination, analysis, review or other function authorized by law with respect to the medical assistance program, the secretary shall have the power to sign and issue subpoenas to any person requiring the production of any pertinent books, records, medical records or other information. Subpoenas so issued shall be served by anyone authorized by the secretary by delivering a copy thereof to the person named therein, or by registered mail or certified mail addressed to such person at his or her last-known residence or principal place of business. A verified return by the person so serving the subpoena setting forth the manner of service, or, in the event service is by registered or certified mail, the return post-office receipt signed by the person so served shall constitute proof of service.

2. In the event of contumacy or refusal to obey a subpoena issued under this paragraph and duly served upon any person, any judge in a court of record in the county where the person was served may enforce the subpoena in accordance with s. 885.12.

3. The failure or refusal of a person to purge himself or herself of contempt found under s. 885.12 and perform the act as required by law shall constitute grounds for decertification or suspension

of that person from participation in the medical assistance program and no payment may be made for services rendered by that person subsequent to decertification or during the period of suspension.

(i) The department may not reimburse a provider for certain elective surgical procedures without a 2nd opinion from another provider. Second opinions are required for selected elective surgical procedures for which 2nd opinions disagree with the original opinions at demonstrably high rates. The department shall notify the providers of the surgical procedures for which a 2nd opinion is required.

(j) Reimbursement for administrative contract costs under this section is limited to the funds available under s. 20.435 (1) (bm).

(k) If a physician performs a surgical procedure that is within the scope of practice of a podiatrist, as defined in s. 448.01 (7), the allowable charge for the procedure may not exceed the charge the department determines is reasonable.

(L) 1. In this paragraph:

a. "Designated health service" has the meaning given in 42 USC 1395nn (h) (6).

b. "Medicare" means coverage under Part A or Part B of Title XVIII of the federal social security act, 42 USC 1395 to 1395ccc.

c. "Physician" has the meaning given in s. 448.01 (5).

d. "Referral" has the meaning given in 42 USC 1395nn (h) (5).

2. The department may not pay a provider for a designated health service that is authorized under this section or s. 49.46 or 49.47, that is provided as the result of a referral made to the provider by a physician and that, under 42 USC 1396b (s), if made on behalf of a beneficiary of medicare under the requirements of 42 USC 1395nn, as amended to August 10, 1993, would result in the denial of payment for the service under 42 USC 1395nn.

3. A provider shall submit to the department information concerning the ownership arrangements of the provider or the entity of which the provider is a part that corresponds to the information required of providers under 42 USC 1395nn (f), as amended to August 10, 1993.

4. Any person who fails to comply with subd. 3. may be required to forfeit not more than \$10,000. Each day of continued failure to comply constitutes a separate offense.

5. The department shall administer this paragraph consistently with 42 USC 1395nn and 42 USC 1396b (s).

(4) INFORMATION RESTRICTED. The use or disclosure of any information concerning applicants and recipients of medical assistance not connected with the administration of this section is prohibited.

(5) APPEAL. Any person whose application for medical assistance is denied or is not acted upon promptly or who believes that the payments made in the person's behalf have not been properly determined may file an appeal with the department pursuant to s. 49.50 (8).

(5m) SUPPLEMENTAL FUNDING FOR RURAL HOSPITALS. (a) Notwithstanding sub. (3) (e), from the appropriations under s. 20.435 (1) (b) and (o) the department shall distribute not more than \$2,256,000 in each of fiscal years 1993-94 and 1994-95, to provide supplemental funds to rural hospitals that, as determined by the department, have high utilization of inpatient services by patients whose care is provided from governmental sources, except that the department may not distribute funds to a rural hospital to the extent that the distribution would exceed any limitation under 42 USC 1396b (i) (3).

(b) The supplemental funding under par. (a) shall be based on the utilization, by recipients of medical assistance, of the total inpatient days of a rural hospital in relation to that utilization in other rural hospitals.

(6b) CENTERS FOR THE DEVELOPMENTALLY DISABLED. From the appropriation under s. 20.435 (2) (gk), the department may reimburse the cost of services provided by the centers for the develop-

mentally disabled. Reimbursement to the centers for the developmentally disabled shall be reduced following each placement made under s. 46.275 which involves a relocation from a center for the developmentally disabled, as follows:

(a) Beginning in fiscal year 1994-95, for relocations from the central Wisconsin center for the developmentally disabled, by \$55.77 per day

(b) Beginning in fiscal year 1994-95, for relocations from the northern Wisconsin center for the developmentally disabled, by \$49.06 per day.

(c) Beginning in fiscal year 1994-95, for relocations from the southern Wisconsin center for the developmentally disabled, by \$48.37 per day.

(6c) PREAMMISSION SCREENING AND RESIDENT REVIEW (a) *Definitions.* In this subsection:

1. "Active treatment for developmental disability" means a continuous program for an individual who has a developmental disability that includes aggressive, consistent implementation of specialized and generic training, treatment, health services and related services, that is directed toward the individual's acquiring behaviors necessary for him or her to function with as much self-determination and independence as possible and that is directed toward preventing or decelerating regression or loss of the individual's current optimal functional status. "Active treatment for developmental disability" does not include services to maintain generally independent individuals with developmental disability who are able to function with little supervision or in the absence of active treatment for developmental disability.

2. "Active treatment for mental illness" means the implementation of an individualized plan of care for an individual with mental illness that is developed under and supervised by a physician licensed under ch. 448 and other qualified mental health care providers and that prescribes specific therapies and activities for the treatment of the individual while the individual experiences an acute episode of severe mental illness which necessitates supervision by trained mental health care providers.

3. "County department" means a department under s. 46.21, 46.23, 51.42 or 51.437.

4. "Developmental disability" means any of the following:

a. Significantly subaverage general intellectual functioning that is concurrent with an individual's deficits in adaptive behavior and that manifested during the individual's developmental period.

b. A severe, chronic disability that meets all of the conditions for individuals with related conditions as specified in 42 CFR 435.1009.

5. "Facility" has the meaning given under 42 USC 1396r (a).

6. "Facility care" means services provided in a facility that are in conformity with 42 USC 1396r and that are payable under sub. (6m).

7. "Mental illness" has the meaning given in 42 USC 1396r (e).

(b) *Preadmission screening.* Except as provided in par. (e), beginning on August 9, 1989, every individual who applies for admission to a facility or to an institution for mental diseases shall be screened to determine if the individual has developmental disability or mental illness. Beginning on August 9, 1989, the department or an entity to which the department has delegated authority shall screen every individual who has been identified as having a developmental disability or mental illness to determine if the individual needs facility care. If the individual is determined to need facility care, the department or an entity to which the department has delegated authority shall also assess the individual to determine if he or she requires active treatment for developmental disability or active treatment for mental illness.

(c) *Resident review.* Except as provided in par. (e), by April 1, 1990, and at least annually thereafter, the department or an entity to which the department has delegated authority shall

review every resident of a facility or institution for mental diseases who has a developmental disability or mental illness to determine if any of the following applies:

1. The resident needs facility care.

2. The resident requires active treatment for developmental disability or active treatment for mental illness.

(d) *Payment for facility care.* 1. No payment may be made under sub. (6m) to a facility or to an institution for mental diseases for the care of an individual who is otherwise eligible for medical assistance under s. 49.46 or 49.47, who has developmental disability or mental illness and for whom under par. (b) or (c) it is determined that he or she does not need facility care, unless it is determined that the individual requires active treatment for developmental disability or active treatment for mental illness and has continuously resided in a facility or institution for mental diseases for at least 30 months prior to the date of the determination. If that individual requires active treatment and has so continuously resided, he or she shall be offered the choice of receiving active treatment for developmental disability or active treatment for mental illness in the facility or institution for mental diseases or in an alternative setting. A facility resident who has developmental disability or mental illness, for whom under par. (c) it is determined that he or she does not need facility care and who has not continuously resided in a facility for at least 30 months prior to the date of the determination, may not continue to reside in the facility after December 31, 1993, and shall, if the department so determines, be relocated from the facility after March 31, 1990, and before December 31, 1993. The county department shall be responsible for securing alternative residence on behalf of an individual who is required to be relocated from a facility under this subdivision, and the facility shall cooperate with the county department in the relocation.

2. Payment may be made under sub. (6m) to a facility or institution for mental diseases for the care of an individual who is otherwise eligible for medical assistance under s. 49.46 or 49.47 and who has developmental disability or mental illness and is determined under par. (b) or (c) to need facility care, regardless of whether it is determined under par. (b) or (c) that the individual does or does not require active treatment for developmental disability or active treatment for mental illness.

(e) 1. Payment under sub. (6m) may be made to a facility and no screening under par. (b) or review under par. (c) is required for an individual who is medically diagnosed as having developmental disability or mental illness, and who is not a danger to himself or herself or to others, if, immediately after release from a hospital, the individual enters the facility, as part of a medically prescribed period of recovery, for a period not to exceed 30 days and the admission is approved by the department or an entity to which the department has delegated authority.

2. Payment under sub. (6m) may be made to a facility or institution for mental diseases for an individual who is 65 years of age or older, is medically diagnosed as having developmental disability or mental illness, is not a danger to himself or herself or to others and is competent to make an independent decision, if, following screening under par. (b) or review under par. (c), all of the following apply:

a. It is determined that the individual needs facility care and requires active treatment for developmental disability or active treatment for mental illness.

b. The individual chooses not to participate in active treatment.

(f) *Hearing.* An individual for whom admission to a facility or institution for mental diseases is denied under par. (b) or for whom a determination under par. (c) results in prohibition of payment to a facility or institution for mental diseases under par. (d) and relocation from the facility to a facility or institution for mental diseases may request a hearing from the department.

(g) *Rule making.* The department shall promulgate all of the following rules:

1. Establishing criteria and procedures for a determination by the department under par. (d) that a resident be relocated from a facility after March 31, 1990, and before December 31, 1993.

2. Establishing standards for the conduct of hearings under par. (f).

(6h) LIABILITY FOR DISALLOWANCES If the department or the federal health care financing administration finds a skilled nursing facility or intermediate care facility in this state that provides care to medical assistance recipients for which the facility receives reimbursement under sub. (6m) to be an institution for mental diseases, the facility shall be liable for any retroactive federal medic-aid disallowances for services provided after the date of the finding.

(6j) LIMITATION ON CERTAIN FACILITY COVERAGE The department shall determine, under a method devised by the department, the average population during the period from January 1, 1987, to June 30, 1988, of persons in each skilled nursing facility or an intermediate care facility who are mentally ill and are aged 21 to 64, except persons under 22 years of age who were receiving medical assistance services in the facility prior to reaching age 21 and continuously thereafter. Beginning July 1, 1988, the payment under sub. (6m) for services provided by a facility to persons who are mentally ill and are within the age limitations specified in this subsection may not exceed the payment for the average population of these persons in that facility, as determined by the department.

(6m) PAYMENT TO FACILITIES (a) In this subsection:

1. "Active treatment" has the meaning specified in 42 USC 1396r (e) (7) (G) (iii).

2. "Cost center" means a group of similar facility expenses.

3. "Facility" means a nursing home as defined under s. 50.01 (3) or a community-based residential facility that is licensed under s. 50.03 and that is certified by the department as a provider of medical assistance.

4. "Net property tax" means property tax from which the Wisconsin state property tax credit has been deducted.

(ag) Payment for care provided in a facility under this subsection made under s. 20.435 (1) (b), (o) or (p) shall, except as provided in pars. (bg), (bm) and (br), be determined according to a prospective payment system updated annually by the department. The payment system shall implement standards which are reasonable and adequate to meet the costs which must be incurred by efficiently and economically operated facilities in order to provide care in conformity with this section, with federal regulations authorized under 42 USC 1396a (a) (13) (A), 1396a (a) (30), 1396b (i) (3), 1396L and 1396r (e) and with quality and safety standards established under subch. II of ch. 50 and ch. 150. In administering this payment system, the department shall allow costs it determines are necessary and proper for providing patient care. The payment system shall reflect all of the following:

1. A prudent buyer approach to payment for services, under which a reasonable price recognizing selected factors that influence costs is paid for service that is of acceptable quality.

2. Standards established by the department for costs of economically and efficiently operated facilities that shall be based upon allowable costs incurred by facilities in the state as available from information submitted under par. (c) 3. and compiled by the department.

3m. For state fiscal year 1993-94, rates that shall be set by the department based on information from cost reports for the 1992 fiscal year of the facility and for state fiscal year 1994-95, rates that shall be set by the department based on information from cost reports for the 1993 fiscal year of the facility.

5. Consideration for special needs of facility residents.

6. Standards for capital payment that will be based upon replacement value of a facility as determined by a commercial

estimator with which the department contracts and criteria and limitations as determined by the department.

7. Assurance of an acceptable quality of care for all medical assistance recipients provided nursing home care.

8. Calculation of total payments and supplementary payments to facilities that permits an increase in funds allocated under s. 20.435 (1) (b) and (o) for nursing home care provided medical assistance recipients over that paid for services provided in state fiscal year 1992-93 of no more than 3.58% during state fiscal year 1993-94 and over that paid for services provided in state fiscal year 1993-94 of no more than 3.57% during state fiscal year 1994-95, excluding increases in total payments attributable to increases in recipient utilization of facility care, payments for the provision of active treatment to facility residents with developmental disability or chronic mental illness and payments for preadmission screening of facility applicants and annual reviews of facility residents required under 42 USC 1396r (e).

(am) In determining payments for a facility under the payment system in par. (ag), the department shall consider all of the following cost centers:

1. Allowable direct care costs, including, if provided, any of the following:

a. Personal comfort supplies.

b. Medical supplies.

d. Services of facility medical personnel that are not separately billable under medical assistance requirements.

e. Nonbillable services of a registered nurse, licensed practical nurse, nursing assistant, ward clerk, activity person, recreation person, social worker, volunteer coordinator, teacher for residents aged 22 and older, vocational counselor for residents aged 22 and older, religious person, therapy aide, therapy assistant and counselor on resident living.

2. Allowable support service costs, including the following allowable facility expenses:

a. Dietary service for the provision of meals to facility residents.

b. Environmental service for the provision of maintenance, housekeeping, laundry and security service.

3. Allowable fuel and utility costs, including the facility expenses that the department determines are allowable for the provision of:

a. Electrical service.

b. Water and sewer services.

c. Heat.

4. Net property tax or allowable municipal service costs incurred by the owner of the facility for the facility.

5. Allowable administrative and general costs, including costs related to the facility's overall management and administration and allowable expenses that are not recognized or reimbursed in other cost centers.

6. Capital payment necessary for the provision of service over time, including allowable facility expenses for suitable space, furnishings, property insurance and movable equipment for patient care.

(ar) In determining payments for a facility under par. (ag), the department may establish minimum patient day occupancy standards for determining costs per patient day and shall apply the following methods to calculate amounts payable for the rate year for the cost centers described under par. (am):

1. For direct care costs:

a. The department shall establish standards for payment of allowable direct care costs that are at least 110% of the median for direct care costs for facilities that do not primarily serve the developmentally disabled and separate standards for payment of allowable direct care costs that are at least 110% of the median for direct

care costs for facilities primarily serving the developmentally disabled. The standards shall be adjusted by the department for regional labor cost variations. The department may decrease the percentage established for the standards only if amounts available under par. (ag) (intro.) are insufficient to provide total payment under par. (am), less capital costs under subd. 6.

b. The department shall establish the direct care component of the facility rate for each facility by comparing actual allowable direct care cost information of that facility adjusted for inflation to the standards established under subd. 1. a.

c. If a facility has an approved program for provision of service to emotionally disturbed or mentally retarded residents, residents dependent upon ventilators, or residents requiring supplemental skilled care due to complex medical conditions, a supplement to the direct care component of the facility rate under subd. 1. b. may be made to that facility according to a method developed by the department.

cm. Notwithstanding the limitations under par. (ag) 8, funding distributed to facilities for the provision of active treatment to residents with a diagnosis of developmental disability shall be distributed in accordance with a method developed by the department which is consistent with a prudent buyer approach to payment for services.

2. For support service costs:

a. The department shall establish one or more standards for the payment of support service costs that are not less than the median of support service costs for a sample of all facilities within the state.

b. The department shall establish the support service component of the facility rate for each facility by comparing actual allowable support service cost information of that facility, adjusted for inflation, to the applicable standard established under subd. 2. a.

d. The department may provide an efficiency incentive payment to a facility whose allowable support service costs are less than the standards set forth under subd. 2. a. and a cost share payment to a facility whose allowable support service costs are greater than the standards set forth under subd. 2. a.

3. For fuel and utility costs:

a. The department shall establish standards, adjusted for heating degree day variations in the state, for payment of fuel and utility costs that are not less than the median of heating fuel and utility costs for a sample of all facilities within the state.

b. The department shall establish the fuel and utility component of the facility rate for each facility by comparing actual allowable fuel and utility cost information of that facility, adjusted for inflation, to the standard established under subd. 3. a.

c. The department may provide an efficiency incentive payment to a facility whose allowable heating fuel and utility costs are less than the standard set forth under subd. 3. a. and a cost share payment to a facility whose allowable heating fuel and utility costs are greater than the standards set forth under subd. 3. a.

4. For net property taxes or municipal services, payment shall be made for those costs that range from the amount of the previous calendar year's tax or the amount of municipal service costs for a period specified by the department to a maximum limit as determined by the department.

5. For administrative and general costs:

a. The department shall establish one or more standards for the payment of administrative and general costs that are not less than the median of administrative and general costs for a sample of all facilities within the state.

b. The department shall establish the administrative and general component of the facility rate for each facility by comparing actual allowable administrative and general cost information of that facility, adjusted for inflation, to the applicable standard established under subd. 5. a.

c. The department may provide an efficiency incentive payment to a facility whose allowable administrative and general costs are less than the standards set forth under subd. 5. a.

6. Capital payment shall be based on a replacement value for a facility, as determined by a commercial estimator with which the department has contracted for service, and subject to limitations determined by the department, except that the department may not reduce final capital payment of a facility by more than \$3.50 per patient day.

(av) 1. The department shall calculate a payment rate for a facility by applying the criteria set forth under pars. (ag) 1. to 5., 7. and 8., (am) 1. to 5. and (ar) 1. to 5. to information from cost reports submitted by the facility.

2. The department shall compile an average payment rate for each facility based on that facility's rates for cost centers described under par. (am) 1. to 5. that were in effect on June 30 of the previous year. The department may develop a method for adjusting the facility's rate for the cost center under par. (am) 1. in compiling the average payment rate under this subdivision.

3. The department shall calculate the facility's projected cost per patient day, based on that facility's cost centers under par. (am) 1. to 5., adjusted for inflation.

4. If the facility's payment rate under subd. 1. is a decrease from its average payment rate from the previous year under subd. 2., and if the figure calculated under subd. 3. exceeds the payment rate for the facility under subd. 1., the facility's average payment rate shall be the greater of its average payment rate under subd. 2. or its rate under subd. 1.

5. If subd. 4. does not apply, the facility's payment rate shall be the payment rate calculated under subd. 1.

5m. Notwithstanding the limitations under par. (ag) 8., the rate under subd. 1., 4. or 5. may be adjusted by the department to reflect payments for the provision of active treatment to facility residents with a diagnosis of developmental disability.

6. The total payment rate for a facility as calculated under subd. 1., 4., 5. or 5m. shall be the sum of the rate so calculated, plus capital payment calculated under pars. (am) 6. and (ar) 6. and payment for ancillary services and materials under par. (b) and for nonprescription drugs under par. (bc).

(b) The charges for ancillary materials and services that would be incurred by a prudent buyer may be included as an adjustment to the rate determined by par. (av) when so determined by the department. The department may not authorize any adjustments to the rate established under par. (av) to pay for a cost overrun that the department fails to approve under s. 150.11 (3). Ancillary materials and services for which payment may be made include, if provided, oxygen, medical transportation and laboratory and X-ray services. Payment for these services and materials shall not exceed medical assistance limitations for reimbursement of the services and materials. For services in a facility for which the department may make payment to a service provider other than a facility, the department may make payment to the facility but not in excess of the estimated amount of payment available if a separate service provider provided the service. The department may promulgate rules setting forth conditions of and limitations to this paragraph.

(bc) The department may include charges for nonprescription drugs approved by the department as an adjustment to the rate determined under par. (av).

(bg) The department shall determine payment levels for the provision of skilled, intermediate, limited, personal or residential care or care for the mentally retarded in the state centers for the developmentally disabled and in the Wisconsin veterans home at King separately from the payment principles, applicable costs and methods established under this subsection.

(bm) Except as provided in par. (bo), the department may establish payment methods for a facility for which any of the following apply:

1. The facility is newly constructed.
 2. The total of licensed beds for the facility has significantly increased or decreased prior to calculation of its rate under the payment system.
 3. The facility has undergone a change in certification or licensure level.
 4. The facility has implemented or discontinued an approved program for provision of service to emotionally disturbed residents.
 5. The facility has received approval or disapproval for provision of service to residents requiring supplemental skilled care due to complex medical conditions.
 6. The facility has received approval or been disapproved for provision of service to residents who have any of the following:
 - a. Brain injury, as defined in s. 51.01 (2g).
 - b. A diagnosis of acquired immunodeficiency syndrome.
 - c. An HIV infection, as defined in s. 252.01 (2), and illness or injury associated with the development of acquired immunodeficiency syndrome.
- (bo) The department may establish payment methods for capital payment for a newly constructed facility that first provided services after June 30, 1984.
- (bp) Notwithstanding pars. (ag) 3m., (am) 6. and (ar) 6., the department may establish payment methods based on actual costs for capital payment for a facility to which, after December 31, 1982, any of the following applies:
1. The facility was constructed.
 2. The facility was purchased.
 3. The facility incurred annual remodeling costs of more than \$600,000.
 4. The facility incurred remodeling costs necessary to meet physical plant requirements under 42 USC 1396a (a) (13) (A).
- (br) If the federal department of health and human services disallows use of the allocation of matching federal medical assistance funds under applicable federal acts or programs for the reduction of operation deficits under sub. (6u), all of the following apply:
1. Notwithstanding s. 20.435 (3) (cd), (4) (de) or (eb) or (7) (b), the department shall reduce allocations of funds to counties in the amount of the disallowance from the appropriations under s. 20.435 (3) (cd), (4) (de) or (eb) or (7) (b) in accordance with s. 16.544 to the extent applicable.
 2. If a city, village or town owns and operates a facility that has received funds to reduce an operating deficit, the city, village or town shall reimburse the county in which the city, village or town is located in the amount of funds so received.
- (c) As a condition of payment under this section a facility shall:
1. Meet the staffing standard requirements for direct care costs including the supplement, if any, made under par. (ar) 1. c. and maintain such records as prescribed by the department to document that such level of care was actually provided.
 2. Provide at the time of a patient's admission to a home, for the development and implementation of a rehabilitation plan including the development of an alternate care plan for the patient.
 3. Provide, upon request, cost information relating to the overall financial operation of the facility, including, but not limited to wages and hours worked; costs of food, housekeeping, maintenance and administration.
 4. Agree to admit patients 7 days of the week.
 5. Admit only patients assessed or who waive or are exempt from the requirement of assessment under s. 46.27 (6) (a).
- (d) The department shall:
2. Terminate payment to a facility for a patient, unless a utilization review team established pursuant to federal regulations upon review of the patient's needs and the implementation of a rehabilitation plan for that patient determines that the patient's

need for care and services can only be provided in a facility and determines the appropriate level of care.

3. Establish, maintain, and periodically update a patient needs evaluation system to be used in determining the need and level of care at a facility, which shall include the social and rehabilitative needs of the patient, provide levels of care to correspond to the actual staff time required to provide such care, and define the contents of the services to be provided.

4. Periodically audit all nursing homes and intermediate care facilities receiving funds under this paragraph, and recover payments made where the home is not meeting the conditions under which the payment was made as specified in par. (c) 1. and 2. Erroneous information provided under par. (c) 3. shall constitute grounds for recovery.

5. Beginning October 1, 1989, deny payment to a facility for a patient who is admitted to the facility after the department has provided newspaper notice and notice under s. 50.03 (2m) (b) that the facility violates 42 USC 1396 to 1396s and before the date, if any, that the department determines that the facility is in substantial compliance with 42 USC 1396 to 1396s.

(e) The department shall establish an appeals mechanism within the department to review petitions from facilities providing skilled, intermediate, limited, personal or residential care or providing care for the mentally retarded for modifications to any payment under this subsection. The department may, upon the presentation of facts, modify a payment if demonstrated substantial inequities exist for the period appealed. Upon review of the department's decision the secretary may grant the modifications, which may exceed maximum payment levels allowed under this subsection but may not exceed federal maximum reimbursement levels. The department shall develop specific criteria and standards for granting payment modifications, and shall take into account the following, without limitation because of enumeration, in reviewing petitions for modification:

1. The efficiency and effectiveness of the facility if compared with facilities providing similar services and if valid cost variations are considered.
2. The effect of rate modifications upon compliance with federal regulations authorized under 42 USC 1396 to 1396p.
3. The need for additional revenue to correct licensure and certification deficiencies.
4. The relationship between total revenue and total costs for all patients.
5. The existence and effectiveness of specialized programs for the chronically mentally ill or developmentally disabled.
6. Exceptional patient needs.
7. Demonstrated experience in providing high quality patient care.

(g) Payment under this section to a facility may not include the cost of care reimbursable for persons eligible for medicare benefits under 42 USC 1395 to 1395zz. Medical assistance recipients are not liable for these costs. The department may require that a facility recover these costs from the appropriate agencies. The department may, by rule, require medicare certification under 42 USC 1395 to 1395zz, in whole or in part, of skilled nursing facilities. Any intermediate care facility or skilled nursing facility is subject to a fine of not less than \$10 nor more than \$100 for each day it refuses to recover costs or refuses to obtain the required certification.

(h) The department may require by rule that all claims for payment of services provided facility residents under this chapter be submitted or countersigned by the respective facility administrator. The department may specify those categories of services for which payment will be made only if the services are rendered or authorized in writing by a primary health care provider designated by the recipient for the particular category of services.

(i) 1. On or after October 1, 1981, medical assistance payment for inpatient nursing care may only be provided for persons

receiving skilled, intermediate or limited levels of nursing care as these levels are defined under s. HSS 132.13, Wis. adm. code.

2. Payment for personal or residential care is available for a person in a facility certified under 42 USC 1396 to 1396p only if the person entered a facility before the date specified in subd. 1. and has continuously resided in a facility since the date specified in subd. 1. If the person has a primary diagnosis of developmental disabilities or chronic mental illness, payment for personal or residential care is available only if the person entered a facility on or before November 1, 1983.

(j) The department may develop a separate rate of payment, under this subsection, for persons requiring intense skilled nursing care, as defined by the department.

(k) Notwithstanding pars. (ag) to (b), (bp) and (br), the department may participate in a demonstration project on case mix nursing home reimbursement authorized under 42 USC 1315 (a) and may modify the payment system under this section, on an experimental basis, as necessary for participation in the demonstration project.

(6r) ASSESSMENTS TO PROVIDERS. (a) In this section:

1. "Ambulatory surgery center" has the meaning given under 42 CFR 416.2.

1g. "Facility" means a nursing home as defined in s. 50.01 (3) or a community-based residential facility that is licensed under s. 50.03 and that is certified by the department as a provider of medical assistance.

1m. "Provider" means a facility or an ambulatory surgery center, except that "provider" does not include a facility or ambulatory surgery center that is state-owned or state-operated, federally owned or federally operated or located outside the state.

1r. "Services" means services or items under this section that the provider directly provides and does not reimburse a 3rd party for providing.

2. "State share" means that portion of the medical assistance payments made to a provider under this section for the provision of authorized services that is not reimbursed by federal funds, unless no federal financial participation is available for these services. If no federal financial participation is available for a service that is payable under this section, "state share" means that portion of the payments that would be the state share if federal financial participation were available.

(b) For the privilege of doing business in this state, there is imposed on a provider an assessment at the rate of 6.98% in fiscal year 1991-92 and 13.10% in fiscal year 1992-93 that shall be deposited in the general fund. The assessment shall be made on the state share of payments made to a provider for services provided beginning on July 1, 1991, except that assessments imposed on ambulatory surgery centers shall be made for services provided beginning on January 1, 1992.

(c) The department shall send an invoice to each provider on October 31, 1991, for the amount due for the 3 months preceding that month and shall, thereafter, send an invoice to each provider by the end of every month for the amount due, which shall be based on payments received for services to which the assessment is applicable for the month preceding the month during which the invoice is sent, except that, for an ambulatory surgery center, the department shall first send an invoice by February 29, 1992. Each provider shall pay the amount shown on the invoice on or before the last day of the month after the month in which the invoice is sent. The department may provide to a provider an alternative to payment by invoice under which a provider may elect to have the assessment amounts deducted from net payments made for services.

(d) The interest and penalty provisions under ss. 71.82 (1) (a) and (b) and (2) (a) and (b), 71.83 (1) (a) 1., 2. and 7. and (b) 1., (2) (a) 1. to 3. and (b) 1. to 3. and (3) and 71.85 as they apply to the taxes under ch. 71 and to the department of revenue apply to the assessment under this section and to the department.

(e) The department shall levy, enforce and collect the assessment under this subsection.

(f) Sections 71.74 (1) to (3), (6), (7) and (9) to (15), 71.75 (1), (2), (4), (5) and (6) to (10), 71.76, 71.77, 71.78 (1) to (8), 71.80 (1) (a) to (d), (3), (3m), (6), (8) to (12), (14) and (18), 71.87, 71.88, 71.89, 71.90, 71.91 and 71.93 as they apply to the taxes under ch. 71 and to the department of revenue apply to the assessment under this subsection and to the department.

(g) This subsection does not apply after September 30, 1992.

(6u) FACILITY OPERATING DEFICIT REDUCTION. Except as provided in par. (g), from the appropriation under s. 20.435 (1) (o), for reduction of operating deficits, as defined under criteria developed by the department, incurred by a facility, as defined under sub. (6m) (a) 2., that is established under s. 49.14 (1) or that is owned and operated by a city, village or town, the department shall distribute to these facilities not more than \$18,600,000 in each fiscal year, as determined by the department, and shall perform all of the following:

(a) Estimate the availability of federal medical assistance funds that may be matched to county funds or funds of a city, village or town for the reduction of operating deficits incurred by the facility.

(b) Based on the amount estimated available under par. (a), develop a method to distribute this allocation to the individual facilities that have incurred operating deficits that shall include:

1. Development of criteria for determining operating deficits.

2. Agreement by the county in which is located the facility established under s. 49.14 (1) and agreement by the city, village or town that owns and operates the facility that the applicable county, city, village or town shall provide funds to match federal medical assistance matching funds under this subsection.

2m. Identification by the county in which is located the facility established under s. 49.14 (1) of all county funds expended in each calendar year to operate the facility, and certification by the county to the department of this amount.

3. Consideration of the size of a facility's operating deficit.

(c) Distribute the allocation under the distribution method that is developed, unless a county has failed to comply with par. (b) 2m.

(d) If the federal department of health and human services approves for state expenditure in a fiscal year amounts under s. 20.435 (1) (o) that result in a lesser allocation amount than that allocated under this subsection, allocate not more than the lesser amount so approved by the federal department of health and human services.

(e) If the federal department of health and human services approves for state expenditure in a fiscal year amounts under s. 20.435 (1) (o) that result in a lesser allocation amount than that allocated under this subsection, submit a revision of the method developed under par. (b) for approval by the joint committee on finance in that state fiscal year.

(f) If the federal department of health and human services disallows use of the allocation of matching federal medical assistance funds distributed under par. (c), the requirements under sub. (6m) (br) shall apply.

(g) If a facility that is otherwise eligible for an allocation of funds under this section is found by the federal health care financing administration or the department to be an institution for mental diseases, as defined under 42 CFR 435.1009, the department may not allocate to that facility funds under this section after the date on which the finding is made.

(6v) (a) "Facility" has the meaning given in sub. (6m) (a) 3.

(b) The department shall, by September 1 of each year, submit to the joint committee on finance a report that provides information on the utilization of beds by recipients of medical assistance in facilities for the immediate prior 2 consecutive fiscal years.

(c) If the report specified in par. (b) indicates that utilization of beds by recipients of medical assistance in facilities decreased during the most recently completed fiscal year from the utilization of beds by recipients of medical assistance in facilities in the next most recently completed fiscal year, the department shall multiply the difference between the number of days of care provided in each of the immediate prior 2 consecutive fiscal years by the average daily costs of care in such facilities. The average daily costs of care shall be calculated by dividing the total medical assistance expenditures for care in facilities by the total number of days of care provided in facilities in that fiscal year.

(d) If par. (c) applies, the department's report under par. (b) shall include a proposal to transfer the amount calculated under par. (c) from the appropriation under s. 20.435 (1) (b) to the appropriation under s. 20.435 (7) (bd) for the purpose of increasing funding for the community options program under s. 46.27. The secretary shall transfer the amount identified under the proposal if within 14 working days after the submission of the proposal the joint committee on finance does not schedule a meeting for the purpose of reviewing the proposed action.

(e) The joint committee on finance may approve or modify any proposal submitted by the department under this subsection.

(6w) HOSPITAL OPERATING DEFICIT REDUCTION. From the appropriation under s. 20.435 (1) (o), for reduction of operating deficits, as defined under criteria developed by the department, incurred by a hospital, as defined under s. 50.33 (2) (a) and (b), that is operated by the state, established under s. 49.16 or owned and operated by a city or village, the department shall allocate up to \$3,300,000 in each fiscal year to these hospitals, as determined by the department, and shall perform all of the following:

(a) For the reduction of operating deficits incurred by the hospital, estimate the availability of federal medicaid funds that may be matched to any of the following:

1. State general purpose revenues, for a hospital operated by the state.
2. County funds, for a hospital established under s. 49.16.
3. Funds of a city or village, for a hospital owned and operated by a city or village.

(b) Based on the amount estimated available under par. (a), develop a method to distribute this allocation to the individual hospitals that have incurred operating deficits that shall include:

1. Development of criteria for determining operating deficits.
2. With respect to funds to match federal medicaid matching funds under this section, any of the following, as applicable:

a. Provision by the state of matching funds from general purpose revenues for a hospital operated by the state.

b. Agreement to provide matching funds by the county in which is located a hospital established under s. 49.16.

c. Agreement to provide matching funds by the city or village that owns and operates a hospital.

3. Consideration of the size of a hospital's operating deficit.

(c) Except as provided in par. (d), distribute the allocation under the distribution method that is developed.

(d) If the federal department of health and human services approves for state expenditure in a fiscal year amounts under s. 20.435 (1) (o) that result in a lesser allocation amount than that allocated under this subsection or disallows use of the allocation of federal medicaid funds under par. (c), reduce allocations under this subsection and distribute on a prorated basis, as determined by the department.

(6x) FUNDING FOR ESSENTIAL ACCESS CITY HOSPITAL. (a) Notwithstanding sub. (3) (e), from the appropriations under s. 20.435 (1) (b) and (o) the department shall distribute not more than \$4,748,000 in each of fiscal years 1993-94 and 1994-95, to provide funds to an essential access city hospital, except that the department may not allocate funds to an essential access city hospital to the extent that the allocation would exceed any limitation under 42 USC 1396b (i) (3).

(b) The department shall develop procedures for solicitation and review of requests for funds and a method to distribute the funds under par. (a) to an individual hospital that shall include establishment of criteria for the designation as an essential access city hospital.

(c) Except as provided in par. (d), the department shall distribute the funds under par. (a) under the distribution method that is developed under par. (b).

(d) If the federal department of health and human services approves for state expenditure in any state fiscal year amounts under s. 20.435 (1) (o) that result in a lesser distribution amount than that distributed under this subsection or disallows use of federal medicaid funds under par. (a), the department of health and social services shall reduce the distributions under this subsection.

(e) The department need not promulgate as rules under ch. 227 the procedures, method of distribution and criteria required for distribution under this subsection.

(6y) SUPPLEMENTAL FUNDING FOR COUNTY HOSPITALS. (a) Notwithstanding sub. (3) (e), from the appropriations under s. 20.435 (1) (b) and (o) the department shall distribute funding in each fiscal year to provide supplemental payment to county hospitals and to county mental health complexes, as determined by the department, for inpatient hospital services that are not in excess of the hospitals' customary charges for the services, as limited under 42 USC 1396b (i) (3).

(b) The department need not promulgate as rules under ch. 227 the procedures, methods of distribution and criteria required for distribution under par. (a).

(6z) SUPPLEMENTAL FUNDING FOR HOSPITALS SERVING LOW-INCOME PATIENTS. (a) Notwithstanding sub. (3) (e), from the appropriations under s. 20.435 (1) (b) and (o) the department shall distribute funding in each fiscal year to supplement payment for inpatient services to county hospitals and county mental health complexes that, as determined by the department, serve a disproportionate number of low-income patients with special needs, except that the department may not distribute funds under this subsection to the extent that the distribution would do any of the following:

1. Be inconsistent with 42 USC 1396r-4 (c) (3).
2. Exceed the limitation on payment under 42 USC 1396r-4 (f) (B) in any fiscal year.

(b) The department need not promulgate as rules under ch. 227 the procedures, methods of distribution and criteria required for distribution under par. (a).

(7) PERSONAL FUNDS. (a) A recipient who is a patient in a public medical institution or an accommodated person and has a monthly income exceeding the payment rates established under 42 USC 1382 (e) may retain \$40 unearned income or the amount of any pension paid under 38 USC 3203 (f), whichever is greater, per month for personal needs. Except as provided in s. 49.455 (4) (a), the recipient shall apply income in excess of \$40 or the amount of any pension paid under 38 USC 3203 (f), whichever is greater, less any amount deducted under rules promulgated by the department, toward the cost of care in the facility.

(b) Where a facility participating in the medical assistance program has been delegated in writing by a resident within that facility to manage and control the personal funds of the resident including but not limited to those funds identified in par. (a) the facility shall establish for the resident a personal fund account. All deposits and withdrawals of funds shall be documented by the facility to indicate the amount and date of deposit and amount, date and purpose of withdrawal. Such documentation shall be maintained in the resident's records.

(c) Upon the removal of a resident from the facility as a result of death or permanent transfer, the facility shall transfer the balance of the resident's trust account to the personal representative of the resident's estate, the legal guardian of the resident or if appropriate to the resident personally. A copy of the trust account records shall be transferred with the funds. No facility or any of

its employes or representatives may benefit from the distribution of a deceased resident's personal funds unless they are specifically named in the resident's will or constitute an heir at law.

(d) 1. The department shall accept from any person a verified complaint concerning any violation of this subsection. The department shall forward to the accused within 10 days a copy of such complaint. The department, upon such investigation as it deems necessary, may dismiss the complaint or may find probable cause to believe that a violation of this subsection has occurred.

2. If the department finds probable cause to believe that a violation of this subsection has occurred, it may assess a forfeiture of not less than \$25 nor more than \$500 for each occurrence, and in addition may order that any amount illegally charged against a resident's account be restored. The department shall immediately inform the complainant and respondent of any such decision and the amount of forfeiture or repayment, if any. If the department is not notified in writing that a party wishes to contest a decision within 15 working days after the parties are informed of such decision, the department's determination shall be deemed final and may not be appealed to a court.

3. The department shall inform the nursing home administrators examining board of all decisions made under this paragraph.

4. The department's determination of serious misconduct under this subsection shall be cause for terminating the facility's participation in the state-funded portion of the medical assistance program under ss. 49.45 to 49.47.

(e) Nursing homes shall adopt a uniform accounting system prescribed by the department for purposes of managing residents personal fund accounts.

(8) HOME HEALTH SERVICES REIMBURSEMENT. (a) In this subsection:

1. "Home health aide" has the meaning given in s. 146.40 (1) (bm).

2. "Licensed practical nurse" has the meaning given in s. 146.40 (1) (c).

3. "Occupational therapist" has the meaning given in s. 448.01 (2g).

4. "Patient care visit" means a personal contact with a patient in a patient's home that is made by a registered nurse, licensed practical nurse, home health aide, physical therapist, occupational therapist or speech-language pathologist who is on the staff of or under contract or arrangement with a home health agency, or by a registered nurse or licensed practical nurse practicing independently, to provide a service that is covered under s. 49.46 or 49.47. "Patient care visit" does not include time spent by a nurse, therapist or home health aide on case management, care coordination, travel, record keeping or supervision that is related to the patient care visit.

5. "Physical therapist" has the meaning given in s. 448.50 (3).

6. "Registered nurse" has the meaning given in s. 146.40 (1) (f).

7. "Speech-language pathologist" means an individual engaged in the practice of speech-language pathology, as regulated under ch. 459.

(b) Reimbursement under s. 20.435 (1) (b) and (o) for home health services provided by a certified home health agency or independent nurse shall be made at the home health agency's or nurse's usual and customary fee per patient care visit, subject to a maximum allowable fee per patient care visit that is established under par. (c).

(c) The department shall establish a maximum statewide allowable fee per patient care visit, for each type of visit with respect to provider, that may be no greater than the cost per patient care visit, as determined by the department from cost reports of home health agencies, adjusted for costs related to case management, care coordination, travel, record keeping and supervision.

(8m) RATES FOR RESPIRATORY CARE SERVICES Notwithstanding a determination by the department of a maximum rate under

sub. (8), the rates under sub. (8) and rates charged by providers under s. 49.46 (2) (a) 4. d. that are not home health agencies, for reimbursement for respiratory care services for ventilator-dependent individuals under ss. 49.46 (2) (b) 6. m. and 49.47 (6) (a) 1., shall be as follows:

(a) For visits subsequent to an initial visit and for extended visits by a licensed registered nurse, \$30 per hour.

(b) For visits subsequent to an initial visit and for extended visits by a licensed practical nurse, \$20 per hour.

(8r) PAYMENT FOR CERTAIN OBSTETRIC AND GYNECOLOGICAL CARE. The rate of payment for obstetric and gynecological care provided in primary care health professional shortage areas, as defined in s. 560.184 (1) (c), or provided to recipients of medical assistance who reside in primary care health professional shortage areas, that is equal to 125% of the rates paid under this section to primary care physicians in primary care health professional shortage areas, shall be paid to all certified primary care providers who provide obstetric or gynecological care to those recipients.

(9) FREE CHOICE. Any person eligible for medical assistance under ss. 49.46, 49.468 and 49.47 may use the physician, chiropractor, dentist, pharmacist, hospital, skilled nursing home, health maintenance organization, limited service health organization, preferred provider plan or other licensed, registered or certified provider of health care of his or her choice, except that free choice of a provider may be limited by the department if the department's alternate arrangements are economical and the recipient has reasonable access to health care of adequate quality. The department may also require a recipient to designate, in any or all categories of health care providers, a primary health care provider of his or her choice. After such a designation is made, the recipient may not receive services from other health care providers in the same category as the primary health care provider unless such service is rendered in an emergency or through written referral by the primary health care provider. Alternate designations by the recipient may be made in accordance with guidelines established by the department. Nothing in this subsection shall vitiate the legal responsibility of the physician, chiropractor, dentist, pharmacist, skilled nursing home, hospital, health maintenance organization, limited service health organization, preferred provider plan or other licensed, registered or certified provider of health care to patients. All contract and tort relationships with patients shall remain, notwithstanding a written referral under this section, as though dealings are direct between the physician, chiropractor, dentist, pharmacist, skilled nursing home, hospital, health maintenance organization, limited service health organization, preferred provider plan or other licensed, registered or certified provider of health care and the patient. No physician, chiropractor, pharmacist or dentist may be required to practice exclusively in the medical assistance program.

(9m) REFERRALS. The department may, consistent with sub. (9), specify services for which reimbursement will be made only if the services are provided in accordance with a referral, in writing, which specifies the services to be rendered and the duration of such services. The referral form shall describe the referred services as required by the department.

(9s) DISCLOSURE. Any person who is an employe of, or an owner, partner, member, stockholder or investor in, any legal entity providing services which are reimbursed under this section, shall notify the department, on forms provided by the department for that purpose, if such person is an employe of, or an owner, partner, member, stockholder or investor in, any other legal entity providing services which are reimbursed under this section.

(10) RULE-MAKING POWERS. The department is authorized to promulgate such rules as are consistent with its duties in administering medical assistance.

(11) PENALTY. Any person who receives or assists another in receiving assistance under this section, to which the recipient is not entitled, shall be subject to the penalties under s. 49.12.

(12) MACHINE-READABLE MEDICAL ASSISTANCE CARDS. (a) The department shall assist the commissioner of insurance to conduct the study of health insurance identification cards under s. 601.57 (1).

(b) If the commissioner of insurance promulgates rules under s. 601.57 (2) establishing a health insurance identification card system and its computerized support system, the department shall develop a plan to coordinate a system of machine-readable identification cards for medical assistance recipients with the systems established by the commissioner and shall submit the plan to the governor, and to the legislature under s. 13.172 (2), before issuing a request for proposals under par. (c).

(c) The department shall request proposals for a system of machine-readable identification cards for medical assistance recipients and a computerized support system for the cards that will accept and respond to electronically conveyed requests from health care providers for information related to medical assistance recipients, such as eligibility, coverages and authorizations. The request for proposals shall specify that the systems are to be operating by January 1, 1996.

(13) FINANCIAL REPORTS. (a) The department may require service providers to prepare and submit cost reports or financial reports for purposes of rate certification under Title XIX, cost verification, fee schedule determination or research and study purposes. These financial reports may include independently audited financial statements which shall include balance sheets and statements of revenues and expenses. The department may withhold reimbursement or may decrease or not increase reimbursement rates if a provider does not submit the reports required under this paragraph or if the costs on which the reimbursement rates are based cannot be verified from the provider's cost or financial reports or records from which the reports are derived.

(b) The department may require any provider who fails to submit a cost report or financial report under par. (a) within the period specified by the department to forfeit not less than \$10 nor more than \$100 for each day the provider fails to submit the report.

(15) COMMUNITY CARE ORGANIZATION PROJECT GUARANTEE. Upon termination of the community care organization demonstration projects in Barron, La Crosse and Milwaukee counties, any client who was receiving services through any of those projects may continue to receive the full range of community care organization services. The cost of the services shall continue to be paid by medical assistance.

(16) CERTIFICATION. On or after January 1, 1984, the department may only continue to certify as a medical assistance provider a community-based residential facility that is so certified on December 31, 1983. On or after January 1, 1984, no community-based residential facility may be certified for more beds than the number for which it was certified on December 31, 1983.

(18) RECIPIENT COST SHARING. Except as provided in pars. (a) to (d), any person eligible for medical assistance under s. 49.46, 49.468 or 49.47 shall pay up to the maximum amounts allowable under 42 CFR 447.53 to 447.58 for purchases of services provided under s. 49.46 (2). The service provider shall collect the allowable copayment, coinsurance or deductible. The department shall reduce payments to each provider by the amount of the allowable copayment, coinsurance or deductible. No provider may deny care or services because the recipient is unable to share costs, but an inability to share costs specified in this subsection does not relieve the recipient of liability for these costs. Liability under this subsection is limited by the following provisions:

(a) No person is liable under this subsection for services provided through prepayment contracts.

(b) The following services are not subject to recipient cost sharing under this subsection:

1. Any service provided to a person receiving care as an inpatient in a skilled nursing home or intermediate care facility certified under 42 USC 1396 to 1396k.

2. Any service provided to a person who is less than 18 years old.

3. Any service provided under s. 49.46 (2) to a pregnant woman, if the service relates to the pregnancy or to other conditions that may complicate the pregnancy.

4. Emergency services.

5. Family planning services.

6. Transportation by common carrier or private motor vehicle, if authorized in advance by a county department under s. 46.215 or 46.22, or by specialized medical vehicle.

7. Home health services or, if a home health agency is unavailable, nursing services.

11. Personal care services.

12. Case management services.

(c) The department may limit any medical assistance recipient's liability under this subsection for services it designates.

(d) No person who designates a pharmacy or pharmacist as his or her sole provider of prescription drugs and who so uses that pharmacy or pharmacist is liable under this subsection for more than \$5 per month for prescription drugs received.

(19) ESTABLISHING PATERNITY AND ASSIGNING SUPPORT RIGHTS.

(a) As a condition of eligibility for medical assistance, a person shall:

1. Fully cooperate in efforts directed at establishing the paternity of a nonmarital child and obtaining support payments or any other payments or property to which the person and the dependent child or children may have rights. This cooperation shall be in accordance with federal law and regulations applying to paternity establishment and collection of support payments.

2. Notwithstanding other provisions of the statutes, be deemed to have assigned to the state, by applying for or receiving medical assistance, any rights to medical support or other payment of medical expenses from any other person, including rights to unpaid amounts accrued at the time of application for medical assistance as well as any rights to support accruing during the time for which medical assistance is paid.

(b) If a person charged with the care and custody of a dependent child or children does not comply with the requirements of this subsection, the person is ineligible for medical assistance. In this case, medical assistance payments shall continue to be made on behalf of the eligible child or children.

(bm) The county department under s. 46.215 or 46.22 shall notify applicants of the requirements of this subsection at the time of application.

(c) If the mother of a child was enrolled in a health maintenance organization or other prepaid health care plan under medical assistance at the time of the child's birth, birth expenses that may be recovered by the state under this subsection are the birth expenses incurred by the health maintenance organization or other prepaid health care plan.

(20) EXEMPTION FROM CONTINUATION REQUIREMENTS. An insurer, as defined in s. 632.897 (1) (d), with which the department contracts under sub. (2) (b) 2. for the provision of health care to medical assistance recipients is exempt from the continuation of group coverage requirements of s. 632.897 with regard to those recipients, their spouses and dependents.

(21) TRANSFER OF BUSINESS, LIABILITY FOR REPAYMENTS. (a) If any provider liable for repayment of improper or erroneous payments or overpayments under ss. 49.43 to 49.497 sells or otherwise transfers ownership of his or her business or all or substantially all of the assets of the business, the transferor and transferee are each liable for the repayment. Prior to final transfer, the transferee is responsible for contacting the department and ascertaining if the transferor is liable under this paragraph.

(b) If a transfer occurs and the applicable amount under par. (a) has not been repaid, the department may proceed against either the transferor or the transferee. Within 30 days after receiving

notice from the department, the transferor or the transferee shall pay the amount in full. Upon failure to comply, the department may bring an action to compel payment. If a transferor fails to pay within 90 days after receiving notice from the department, the department may proceed under sub. (2) (a) 12.

(c) The department may enforce this subsection within 4 years following a transfer.

(d) This subsection supersedes any provision of chs. 180, 181 and 185.

(22) MEDICAL ASSISTANCE SERVICES PROVIDED BY HEALTH MAINTENANCE ORGANIZATIONS If the department contracts with health maintenance organizations for the provision of medical assistance it shall give special consideration to health maintenance organizations that provide or that contract to provide comprehensive, specialized health care services to pregnant teenagers.

(24) PRIMARY CARE PROVIDER PILOT The department may request a waiver from the secretary of the federal department of health and human services under 42 USC 1396n (b) (1) to permit the establishment of a primary care provider pilot project. If the waiver is granted, the department may establish a primary care provider pilot project under which primary care providers act as case managers for medical assistance beneficiaries. If the department establishes a primary care provider pilot project, it shall reimburse a case manager for the allowable charges for case management services provided to a beneficiary participating in the pilot project.

(24m) HOME HEALTH CARE AND PERSONAL CARE PILOT PROGRAM From the appropriations under s. 20.435 (1) (b) and (c), in order to test the feasibility of instituting a system of reimbursement for providers of home health care and personal care services for medical assistance recipients that is based on competitive bidding, the department shall:

(a) By September 1, 1990, select a county in this state and solicit bids from providers of home health care and personal care services in that county for the provision, on a contractual basis, of home health and personal care services authorized under ss. 49.46 (2) (a) 4. d. and (b) 6. j. and 49.47 (6) (a) 1.

(b) Award contracts for the provision of home health care and personal care services from the bids received under par. (a) only if the department determines that the contracts would result in a lower cost alternative to fee-for-service reimbursement.

(25) CASE MANAGEMENT SERVICES (a) In this subsection, "severely emotionally disturbed child" means an individual under 21 years of age who has emotional and behavioral problems that:

1. Are severe in degree;
2. Are expected to persist for at least one year;
3. Substantially interfere with the individual's functioning in his or her family, school or community and with his or her ability to cope with the ordinary demands of life; and
4. Cause the individual to need services from 2 or more agencies or organizations that provide social services or services or treatment for mental health, juvenile justice, child welfare, special education or health.

(am) Except as provided under pars. (be) and (bg) and sub. (24), case management services under s. 49.46 (2) (b) 9 are reimbursable under medical assistance only if provided to a medical assistance beneficiary who receives case management services from or through a certified case management provider in a county, city, village or town that elects, under par. (b), to make the services available and who has a developmental disability, as defined under s. 51.01 (5) (a), chronic mental illness, as defined under s. 51.01 (3g), or Alzheimer's disease, as defined under s. 46.87 (1) (a), is alcoholic, as defined under s. 51.01 (1), or drug dependent, as defined under s. 51.01 (8), is physically disabled, as defined by the department, is a severely emotionally disturbed child, is age 65 or over or, after December 31, 1991, has HIV infection, as defined in s. 252.01 (2).

(b) A county, city, village or town may elect to make case management services under this subsection available in the county, city, village or town to one or more of the categories of beneficiaries under par. (am) through the medical assistance program. A county, city, village or town that elects to make the services available shall reimburse a case management provider for the amount of the allowable charges for those services under the medical assistance program that is not provided by the federal government.

(be) A private nonprofit agency that is a certified case management provider may elect to provide case management services to medical assistance beneficiaries who have HIV infection, as defined in s. 252.01 (2). The amount of the allowable charges for those services under the medical assistance program that is not provided by the federal government shall be paid from the appropriation under s. 20.435 (1) (am).

(bg) An independent living center, as defined in s. 46.96 (1) (a), that is a certified case management provider may elect to provide case management services to one or more of the categories of medical assistance beneficiaries specified under par. (am). The amount of allowable charges for the services under the medical assistance program that is not provided by the federal government shall be paid from nonfederal, public funds received by the independent living center from a county, city, village or town or from funds distributed under the appropriation under s. 20.435 (5) (bm) or as a grant under s. 46.96.

(bm) Case management services under this subsection may not be provided to a person under the category of severely emotionally disturbed child unless any of the following is true:

1. A team of mental health experts appointed by the case management provider determines that the person is a severely emotionally disturbed child. The team shall consist of at least 3 members. The case management provider shall appoint at least one member of the team who is a licensed psychologist or a physician specializing in psychiatry. The case management provider shall appoint at least 2 members of the team who are members of the professions of school psychologist, school social worker, registered nurse, social worker, child care worker, occupational therapist or teacher of emotionally disturbed children. The case management provider shall appoint as a member of the team at least one person who personally participated in a psychological evaluation of the child.

2. A service coordination agency has determined under s. 46.56 (8) (d) that the person is a child with emotional and behavioral disabilities that meet the requirements under s. 46.56 (1) (c) 1. to 4.

(c) Except as provided in pars. (be) and (bg), the department shall reimburse a provider of case management services under this subsection only for the amount of the allowable charges for those services under the medical assistance program that is provided by the federal government.

(d) This subsection does not apply to case management services provided under sub. (15) or s. 49.46 (2) (a) 2. or through a community support program under s. 49.46 (2) (b) 6. L.

(26) MANAGED CARE SYSTEM The department shall study alternatives for a system to manage the usage of alcohol and other drug abuse services, including day treatment services, provided under the medical assistance program. On or before September 1, 1988, the department shall submit a plan for a medical assistance alcohol and other drug abuse managed care system to the joint committee on finance. If the cochairpersons of the committee do not notify the department that the committee has scheduled a meeting for the purpose of reviewing the proposed plan within 14 working days after the date of the department's submittal, the department may implement the plan. If within 14 working days after the date of the department's submittal the cochairpersons of the committee notify the department that the committee has scheduled a meeting for the purpose of reviewing the proposed

plan, the department may not implement the plan until it is approved by the committee, as submitted or as modified. If a waiver from the secretary of the federal department of health and human services is necessary to implement the proposed plan, the department of health and social services may request the waiver, but it may not implement the waiver until it is authorized to implement the plan, as provided in this subsection.

(27) ELIGIBILITY OF ALIENS. A person who is not a U.S. citizen or an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law may not receive medical assistance benefits except as provided under 8 USC 1255a (h) (3) or 42 USC 1396b (v).

(29) HOSPICE REIMBURSEMENT. The department shall promulgate rules limiting aggregate payments made to a hospice under ss. 49.46 and 49.47.

(30) SERVICES PROVIDED BY COMMUNITY SUPPORT PROGRAMS. (a) A county shall provide the portion of the cost of services under s. 49.46 (2) (b) 6. L. that is not provided by the federal government.

(b) The department shall reimburse a provider of services under s. 49.46 (2) (b) 6. L. only for the amount of the allowable charges for those services that is provided by the federal government.

(30m) CERTAIN SERVICES FOR DEVELOPMENTALLY DISABLED. A county shall provide the portion of the services under s. 51.06 (1) (d) to individuals who are eligible for medical assistance that is not provided by the federal government.

(31) ELIGIBILITY FOR LONG-TERM CARE INSURANCE BENEFICIARIES. The department shall seek federal approval of, and federal financial participation in, a pilot project under which a person who is the beneficiary of a long-term care insurance policy that satisfies criteria established by the department may become eligible for medical assistance while exceeding the usual medical assistance resource limits.

(32) COMMUNITY CARE FOR THE ELDERLY. The department may request a waiver under 42 USC 1315 to permit the establishment of a community care for the elderly demonstration project to provide medical care, case management services, adult day care and other support services that promote independence and enhance the quality of life of frail elderly persons. If the waiver is approved, the department may establish the community care for the elderly demonstration project and pay a fixed per person fee for the services.

(34) MEDICAL ASSISTANCE MANUAL. The department shall prepare a medical assistance manual that is clear, comprehensive and consistent with ss. 49.43 to 49.47 and 42 USC 1396a to 1396u and shall, no later than July 1, 1992, provide the manual to counties for use by county employes who administer the medical assistance program.

(35) TRAINING FOR NONPROFIT ORGANIZATIONS. The department shall provide training to employes and volunteers of private nonprofit organizations concerning medical assistance eligibility under s. 49.47 of persons whose incomes exceed the levels under s. 49.47 (4) (am) and (c) 1. before consideration, under s. 49.47 (4) (c) 2., of the level of those persons' medical expenses.

(35m) COMPUTER SYSTEM REDESIGN. The department shall ensure that any redesign or replacement of the computer network that is used by counties on May 12, 1992, to determine eligibility for medical assistance includes the capability of determining eligibility for medical assistance under s. 49.47 (4) (c) 2.

(36) HOMELESS BENEFICIARIES. A county department under s. 46.215, 46.22 or 46.23 may not place the word "homeless" on the medical assistance identification card of any person who is determined to be eligible for medical assistance benefits and who is homeless.

(37) PLANS OF CARE. The department may seek a waiver of the requirement under 42 USC 1396n (c) (1) that the department review and approve every written plan of care developed for each

individual who receives, under 42 USC 1396n (c) (1), home or community-based services under ss. 49.46 (2) (b) 8. and 49.47 (6) (a) 1. The waiver of the requirement, if granted, shall apply to those county departments or private nonprofit agencies that administer the services and that the department finds and certifies have implemented effective quality assurance systems for service plan development and implementation. If the federal health care financing administration approves the department's request for waiver of the requirement, the department shall, in evaluating a quality assurance system for certification, consider all of the following:

(a) The adequacy, safety and comprehensiveness of plans of care developed for individuals and of the services provided to them.

(b) Opportunities for individuals to exercise choice and be involved in the provision of services.

(c) Overall conformance to required state and federal quality assurance standards.

(d) Factors in addition to those in pars. (a) to (c) that are required by the federal health care financing administration, if any.

(38) HOME OR COMMUNITY-BASED SERVICES FOR DISABLED WORKERS. The department shall request a waiver from the secretary of the federal department of health and human services to authorize federal financial participation for medical assistance coverage of persons described in ss. 49.46 (1) (a) 14. and 49.47 (4) (as).

History: 1971 c. 40 s. 93; 1971 c. 42, 125; 1971 c. 213 s. 5; 1971 c. 215, 217, 307; 1973 c. 62, 90, 147; 1973 c. 333 ss. 106g, 106h, 106j, 201w; 1975 c. 39; 1975 c. 223 s. 28; 1975 c. 224 ss. 54h, 56 to 59m; 1975 c. 383 s. 4; 1975 c. 411; 1977 c. 29, 418; 1979 c. 34 ss. 837f to 838, 2102 (20) (a); 1979 c. 102, 177, 221, 355; 1981 c. 20, 418; 839 to 854, 2202 (20) (r); 1981 c. 93, 317; 1983 a. 27 ss. 1046 to 1062m, 2200 (42); 1983 a. 245, 447, 527; 1985 a. 29 ss. 1026m to 1031d, 3200 (23), (56), 3202 (27); 1985 a. 120, 176, 269; 1985 a. 332 ss. 91, 251 (5), 253; 1985 a. 340; 1987 a. 27 ss. 989r to 1000s, 2247, 3202 (24); 1987 a. 186, 307, 339, 399; 1987 a. 403 s. 256; 1987 a. 413; 1989 a. 6; 1989 a. 31 ss. 1402 to 1452g, 2909g, 2909i; 1989 a. 107, 173, 310, 336, 351, 359; 1991 a. 22, 39, 80, 250, 269, 315, 316; 1993 a. 16 ss. 1362g to 1403, 3883; 1993 a. 27, 107, 112, 183, 212, 246, 269, 335, 356, 437, 446, 469.

A contract between the trustees of a nursing home and a medical clinic for exclusive medical services under the medical assistance act for residents of such home violates public policy of this state. 59 Atty Gen 68

Medical Assistance & Divestment Canellos Wis Law Aug 1991.

49.453 Divestment of assets. (1) DEFINITIONS. In this section and in s. 49.454:

(a) "Assets" has the meaning given in 42 USC 1396p (e) (1).

(am) "Covered individual" means an individual who is an institutionalized individual or a noninstitutionalized individual.

NOTE: Par. (am) is shown as amended eff. 4-1-95 by 1993 Wis. Act 437. Prior to 4-1-95 it reads:

(am) "Covered individual" means an institutionalized individual.

(b) "Disabled" has the meaning given in 42 USC 1382c (a) (3).

(c) "Expected value of the benefit" means the amount that an irrevocable annuity will pay to the annuitant during his or her expected lifetime as determined under sub. (4) (c).

(d) "Income" has the meaning given in 42 USC 1396p (e) (2).

(e) "Institutionalized individual" has the meaning given in 42 USC 1396p (e) (3).

(f) "Look-back date" means for a covered individual, the date that is 36 months before, or with respect to payments from a trust or portions of a trust that are treated as assets transferred by the covered individual under s. 49.454 (2) (c) or (3) (b) the date that is 60 months before:

1. For a covered individual who is an institutionalized individual, the first date on which the covered individual is both an institutionalized individual and has applied for medical assistance.

2. For a covered individual who is a noninstitutionalized individual, the date on which the covered individual applies for medical assistance or, if later, the date on which the covered individual, his or her spouse, or another person acting on behalf of the covered

individual or his or her spouse, transferred assets for less than fair market value.

NOTE: Subd. 2. is created eff. 4-1-95 by 1993 Wis. Act 437.

(fm) "Noninstitutionalized individual" has the meaning given in 42 USC 1396p (e) (4).

NOTE: Par. (fm) is created eff. 4-1-95 by 1993 Wis. Act 437.

(g) "Reasonable compensation" means the prevailing local market rate of compensation for the service or care provided.

(h) "Relative" means an individual who is related to another by blood, marriage or adoption.

(i) "Resources" has the meaning given in 42 USC 1396p (e) (5).

(j) "Trust" has the meaning given in 42 USC 1396p (d) (6).

(2) **INELIGIBILITY FOR MEDICAL ASSISTANCE FOR CERTAIN SERVICES.** (a) *Institutionalized individuals.* Except as provided in sub. (8), if an institutionalized individual or his or her spouse, or another person acting on behalf of the institutionalized individual or his or her spouse, transfers assets for less than fair market value on or after the institutionalized individual's look-back date, the institutionalized individual is ineligible for medical assistance for the following services for the period specified under sub. (3):

1. For nursing facility services.
2. For a level of care in a medical institution equivalent to that of a nursing facility.
3. For services under a waiver under 42 USC 1396n.

(b) *Noninstitutionalized individuals.* Except as provided in sub. (8), if a noninstitutionalized individual or his or her spouse, or another person acting on behalf of the noninstitutionalized individual or his or her spouse, transfers assets for less than fair market value on or after the noninstitutionalized individual's look-back date, the noninstitutionalized individual is ineligible for medical assistance for the following services for the period specified under sub. (3):

1. Services that are described in 42 USC 1396d (a) (7), (22) or (24).
2. Other long-term care services specified by the department by rule.

NOTE: Par. (b) is created eff. 4-1-95 by 1993 Wis. Act 437.

(3) **PERIOD OF INELIGIBILITY.** (a) The period of ineligibility under this subsection begins on the first day of the first month beginning on or after the look-back date during or after which assets have been transferred for less than fair market value and that does not occur in any other periods of ineligibility under this subsection.

(b) The department shall determine the number of months of ineligibility as follows:

1. The department shall determine the total, cumulative uncompensated value of all assets transferred by the covered individual or his or her spouse on or after the look-back date.
2. The department shall determine the average monthly cost to a private patient of nursing facility services in the state at the time that the covered individual applied for medical assistance.
3. The number of months of ineligibility equals the number determined by dividing the amount determined under subd. 1. by the amount determined under subd. 2.

(c) If the spouse of an individual makes a transfer of assets that results in a period of ineligibility under this section and otherwise becomes eligible for medical assistance, the department shall apportion the period of ineligibility between the individual and the spouse. The department shall promulgate rules establishing a reasonable methodology for apportioning a period of ineligibility under this paragraph.

(4) **IRREVOCABLE ANNUITIES.** (a) For the purposes of sub. (2), whenever a covered individual or his or her spouse, or another person acting on behalf of the covered individual or his or her spouse, transfers assets to an irrevocable annuity in an amount that exceeds the expected value of the benefit, the covered individual or his or her spouse transfers assets for less than fair market value.

(b) The amount of assets that is transferred for less than fair market value under par. (a) is the amount by which the transferred amount exceeds the expected value of the benefit.

(c) The department shall promulgate rules specifying the method to be used in calculating the expected value of the benefit, based on 26 CFR 1.72-1 to 1.72-18, and specifying the criteria for adjusting the expected value of the benefit based on a medical condition diagnosed by a physician before the assets were transferred to the annuity.

(5) **CARE OR PERSONAL SERVICES.** For the purposes of sub. (2), whenever a covered individual or his or her spouse, or another person acting on behalf of the covered individual or his or her spouse, transfers assets to a relative as payment for care or personal services that the relative provides to the covered individual, the covered individual or his or her spouse transfers assets for less than fair market value unless the care or services directly benefit the covered individual, the amount of the payment does not exceed reasonable compensation for the care or services that the relative performs and, if the amount of the payment exceeds 10% of the community spouse resource allowance limit specified in s. 49.455 (6) (b) 1., the agreement to pay the relative is specified in a notarized written agreement that exists at the time that the relative performs the care or services.

(6) **COMMON OWNERSHIP.** For purposes of sub. (2), if a covered individual holds an asset in common with another person in a joint tenancy, tenancy in common, or similar arrangement, the asset, or the affected portion of the asset, is considered to be transferred by the covered individual when an action is taken, either by the covered individual or by any other person, that reduces or eliminates the covered individual's ownership or control of the asset.

(7) **CERTAIN AUTHORIZATIONS.** For the purposes of sub. (2), if a covered individual or his or her spouse authorizes another person to transfer, encumber, lease, consume or otherwise act with respect to an asset as though the asset belonged to that other person; if that other person exercises the authority in a way that causes the asset to be unavailable for the support and maintenance of the covered individual or his or her spouse; and if the covered individual does not receive fair market value for the asset, then the covered individual or his or her spouse transfers assets for less than fair market value at the time that the other person exercises the authority.

(8) **INAPPLICABILITY.** Subsections (2) and (3) do not apply to transfers of assets if the assets are exempt under 42 USC 1396p (c) (2) or if the department determines that application of this section would work an undue hardship. The department shall promulgate rules concerning the transfer of assets exempt under 42 USC 1396p (c) (2).

History: 1993 a 437 ss. 74 to 92

49.454 Treatment of trust amounts. (1) **APPLICABILITY.** (a) Except as provided in sub. (4), this section applies to an individual with respect to a trust if assets of the individual or the individual's spouse were used to form all or part of the corpus of the trust and if any of the following persons established the trust other than by will:

1. The individual.
2. The individual's spouse.
3. A person, including a court or administrative body with legal authority to act in place of or on behalf of the individual or the individual's spouse.
4. A person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

(b) If the corpus of a trust under par. (a) includes assets of a person other than the individual or the individual's spouse, this section applies only with respect to the portion of the trust attributable to the assets of the individual or the individual's spouse.

(2) **TREATMENT OF REVOCABLE TRUST AMOUNTS.** For purposes of determining an individual's eligibility for, or amount of benefits under, medical assistance:

(a) The corpus of a revocable trust is considered a resource available to the individual.

(b) Payments from a revocable trust to or for the benefit of the individual are considered income of the individual.

(c) Other payments from a revocable trust are considered transfers of assets by the individual subject to s. 49.453.

(3) **TREATMENT OF IRREVOCABLE TRUST AMOUNTS.** For purposes of determining an individual's eligibility for, or amount of benefits under, medical assistance:

(a) If there are circumstances under which payment from an irrevocable trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to or for the benefit of the individual could be made is considered a resource available to the individual, and payments from that portion of the corpus or income:

1. To or for the benefit of the individual, are considered income of the individual.

2. For any other purpose, are considered transfers of assets by the individual subject to s. 49.453.

(b) Any portion of an irrevocable trust from which, or any income on the corpus from which, no payment could under any circumstances be made to or for the benefit of the individual, is considered to be an asset transferred by the individual subject to s. 49.453. The asset is considered to be transferred as of the date of the establishment of the trust, or, if later, the date on which payment to the individual was foreclosed. The value of the trust shall be determined for purposes of s. 49.453 by including the amount of any payments made from that portion of the trust after that date.

(4) **INAPPLICABILITY.** This section does not apply to any trust described in 42 USC 1396p (d) (4) or if the department determines, pursuant to procedures established by the department by rule, that the application of this section would work an undue hardship on an individual.

History: 1993 a. 437

49.455 Protection of income and resources of couple for maintenance of community spouse. (1) DEFINITIONS. In this section:

(a) "Community spouse" means an individual who is married to an institutionalized spouse.

(b) "Consumer price index" means the consumer price index for all urban consumers, U.S. city average, as determined by the U.S. department of labor.

(c) "Family member" means a minor or dependent child, dependent parent or dependent sibling of an institutionalized or community spouse who resides with the community spouse.

(d) "Institutionalized spouse" means either an individual who is in a medical institution or nursing facility and is married to an individual who is not in a medical institution or nursing facility or an individual who receives services under a waiver under 42 USC 1396n (c) or (d) and is married to an individual who is not in a medical institution or nursing facility and does not receive services under a waiver under 42 USC 1396n (c) or (d).

(e) "Resources" does not include items excluded under 42 USC 1382b (a) or (d) or items that would be excluded under 42 USC 1382b (a) (2) (A) but for the limitation on total value established under that provision.

(2) **APPLICABILITY.** The department shall use the provisions of this section in determining the eligibility for medical assistance under s. 49.46 or 49.47 and the required contribution toward care of an institutionalized spouse.

(3) **ATTRIBUTION OF INCOME.** (a) Except as provided in par. (b), no income of a spouse is considered to be available to the other spouse during any month in which that other spouse is an institutionalized spouse.

(b) Notwithstanding ch. 766, for the purposes of sub. (4), the following criteria apply in determining the income of an institutionalized spouse or a community spouse:

1. Except as determined under subd. 2. or 3., unless the instrument providing the income specifically provides otherwise:

a. Income paid solely in the name of one spouse is considered to be available only to that spouse.

b. Income paid in the names of both spouses is considered to be available one-half to each spouse.

c. Income paid in the name of either or both spouses and to one or more other persons is considered to be available to each spouse in proportion to the spouse's interest or, if payment is made to both spouses and each spouse's individual interest is not specified, one-half of the joint interest is considered to be available to each spouse.

2. Except as provided in subd. 3., if there is no trust or other instrument establishing ownership, income received by a couple is considered to be available one-half to each spouse.

3. Subdivisions 1. and 2. do not apply to income other than income from a trust if the institutionalized spouse establishes, by a preponderance of the evidence, that the ownership interests in the income are other than as provided in subds. 1. and 2.

(4) **PROTECTING INCOME FOR COMMUNITY SPOUSE.** (a) After an institutionalized spouse is determined to be eligible for medical assistance, in determining the amount of that institutionalized spouse's income that must be applied monthly to payment for the costs of care in the institution, the department shall deduct the following amounts in the following order from the institutionalized spouse's income:

1. The personal needs allowance under s. 49.45 (7) (a).

2. The community spouse monthly income allowance calculated under par. (b) or the amount of income of the institutionalized spouse that is actually made available to, or for the benefit of, the community spouse, whichever is less.

3. A family allowance for each family member equal to one-third of the amount by which the family member's monthly income is exceeded by the following:

a. Beginning on September 30, 1989, and ending on June 30, 1991, 122% of one-twelfth of the poverty line for a family of 2 persons.

b. Beginning on July 1, 1991, and ending on June 30, 1992, 133% of one-twelfth of the poverty line for a family of 2 persons.

c. Beginning on July 1, 1992, 150% of one-twelfth of the poverty line for a family of 2 persons.

4. The amount incurred as expenses for medical or remedial care for the institutionalized spouse.

(b) The community spouse monthly income allowance equals the greater of the following:

1. The minimum monthly maintenance needs allowance determined under par. (c) or the amount determined at a fair hearing under sub. (8) (c), if such an amount has been determined, minus the amount of monthly income otherwise available to the community spouse.

2. The amount of monthly support which a court orders the institutionalized spouse to pay for the support of the community spouse.

(c) The minimum monthly maintenance needs allowance is \$1,500 in 1989. For a calendar year after 1989, the minimum monthly maintenance needs allowance is \$1,500 increased by the same percentage as the percentage increase in the consumer price index between September 1988 and September of the year before the calendar year involved.

(5) **RULES FOR TREATMENT OF RESOURCES.** (a) 1. The department shall determine the total value of the ownership interest of the institutionalized spouse plus the ownership interest of the community spouse in resources as of the beginning of the first continuous period of institutionalization beginning after Septem-

ber 29, 1989. The spousal share of resources equals one-half of that total value.

2. At the beginning of the first continuous period of institutionalization beginning after September 29, 1989, upon the request of an institutionalized spouse or a community spouse and the receipt of necessary documentation, the department shall assess and document the total value of resources under subd. 1. and shall provide a copy of the assessment and documentation to each spouse and retain a copy for departmental use. If the request is not part of an application for medical assistance, the department may charge a fee not exceeding the reasonable expenses of providing and documenting the assessment. When the department provides a copy of an assessment, it shall provide notice that a spouse has the right to a fair hearing under sub. (8) after an application for medical assistance is filed.

(b) Notwithstanding ch. 766, in determining the resources of an institutionalized spouse at the time of application for medical assistance, the amount of resources considered to be available to the institutionalized spouse equals the value of all of the resources held by either or both spouses minus the greatest of the amounts determined under sub. (6) (b) 1. to 4.

(c) The amount of resources determined under par. (b) to be available for the cost of care does not cause an institutionalized spouse to be ineligible for medical assistance, if any of the following applies:

1. The institutionalized spouse has assigned to the state any rights to support from the community spouse.

2. The institutionalized spouse lacks the ability to execute an assignment under subd. 1. due to a physical or mental impairment but the state has the right to bring a support proceeding against the community spouse without an assignment.

3. The department determines that denial of eligibility would work an undue hardship.

(d) During a continuous period of institutionalization, after an institutionalized spouse is determined to be eligible for medical assistance, no resources of the community spouse are considered to be available to the institutionalized spouse.

(6) PERMITTING TRANSFER OF RESOURCES TO COMMUNITY SPOUSE (a) Notwithstanding s. 49.453 (2), an institutionalized spouse may transfer an amount of resources equal to the community spouse resource allowance determined under par. (b) to, or for the sole benefit of, the community spouse without becoming ineligible for medical assistance for the period of ineligibility under s. 49.453 (3) as a result of the transfer. The institutionalized spouse shall make the transfer as soon as practicable after the initial determination of eligibility for medical assistance, taking into account the amount of time that is necessary to obtain a court order under par. (c).

(b) The community spouse resource allowance equals the amount by which the amount of resources otherwise available to the community spouse is exceeded by the greatest of the following:

1. In 1989, \$60,000; in a calendar year after 1989, \$60,000 increased by the same percentage as the percentage increase in the consumer price index between September 1988 and September of the year before the calendar year involved.

3. The amount established in a fair hearing under sub. (8) (d).

4. The amount transferred under a court order under par. (c).

(c) If a court has entered a support order against a community spouse, s. 49.453 does not apply to resources transferred under the order for the support of the community spouse or a family member.

(7) NOTICE The department shall notify both spouses upon a determination of medical assistance eligibility of an institutionalized spouse, or shall notify the spouse making the request upon a request by either an institutionalized spouse or a community spouse, of all of the following:

(a) The amount of the community spouse monthly income allowance calculated under sub. (4) (b).

(b) The amount of any family allowances under sub. (4) (a) 3.

(c) The method for computing the amount of the community spouse resource allowance under sub. (6) (b).

(d) The spouse's right to a fair hearing under sub. (8) concerning ownership or availability of income or resources and the determination of the community spouse monthly income or resource allowance.

(8) FAIR HEARING (a) An institutionalized spouse or a community spouse is entitled to a departmental fair hearing concerning any of the following:

1. The determination of the community spouse monthly income allowance under sub. (4) (b).

2. The determination of the amount of monthly income otherwise available to the community spouse used in the calculation under sub. (4) (b).

3. After an application for medical assistance benefits is filed, the computation of the spousal share of resources under sub. (5) (a) 1.

4. The attribution of resources under sub. (5) (b).

5. The determination of the community spouse resource allowance under sub. (6) (b).

(b) If the institutionalized spouse has made an application for medical assistance, and a fair hearing is requested under par. (a) concerning the determination of community spouse resource allowance, the department shall hold the hearing within 30 days after the request.

(c) If either spouse establishes at a fair hearing that, due to exceptional circumstances resulting in financial duress, the community spouse needs income above the level provided by the minimum monthly maintenance needs allowance determined under sub. (4) (c), the department shall determine an amount adequate to provide for the community spouse's needs and use that amount in place of the minimum monthly maintenance needs allowance in determining the community spouse monthly income allowance under sub. (4) (b).

(d) If either spouse establishes at a fair hearing that the community spouse resource allowance determined under sub. (6) (b) without a fair hearing does not generate enough income to raise the community spouse's income to the minimum monthly maintenance needs allowance under sub. (4) (c), the department shall establish an amount to be used under sub. (6) (b) 3. that results in a community spouse resource allowance that generates enough income to raise the community spouse's income to the minimum monthly maintenance needs allowance under sub. (4) (c). Except in exceptional cases which would result in financial duress for the community spouse, the department may not establish an amount to be used under sub. (6) (b) 3. unless the institutionalized spouse makes available to the community spouse the maximum monthly income allowance permitted under sub. (4) (b) or, if the institutionalized spouse does not have sufficient income to make available to the community spouse the maximum monthly income allowance permitted under sub. (4) (b), unless the institutionalized spouse makes all of his or her income, except for an amount equal to the sum of the personal needs allowance under sub. (4) (a) 1. and any family allowances under sub. (4) (a) 3. paid by the institutionalized spouse and the amount incurred as expenses for medical or remedial care for the institutionalized spouse under sub. (4) (a) 4., available to the community spouse as a community spouse monthly income allowance under sub. (4) (b).

History: 1989 a. 31, 81; 1991 a. 39, 269; 1993 a. 16, 437.

Medical Assistance & Divestment. Canellos Wis. Law. Aug. 1991.

49.46 Medical assistance; recipients of social security aids. (1) **ELIGIBILITY** (a) The following shall receive medical assistance under this section:

1. Any person included in the grant of aid to families with dependent children and any person who does not receive such aid solely because of the application of s. 49.19 (11) (a) 7.

1m. Any pregnant woman who meets the resource and income limits under s. 49.19 (4) (bm) and (es) and whose pregnancy is medically verified. Eligibility continues to the last day of the month in which the 60th day after the last day of the pregnancy falls.

3. Any essential person.

4. Any person receiving benefits under s. 49.177 or federal Title XVI.

5. Any child in an adoption assistance, foster care or treatment foster care placement under ch. 48, as determined by the department.

6. Any person not described in pars. (c) to (e) who is considered, under federal law, to be receiving aid to families with dependent children or supplemental security income for the purpose of determining eligibility for medical assistance.

9. Any pregnant woman not described under subd. 1. or 1m. whose family income does not exceed 133% of the poverty line for a family the size of the woman's family.

10. Any child not described under subd. 1. who is under 6 years of age and whose family income does not exceed 133% of the poverty line for a family the size of the child's family.

11. Any child not described under subd. 1. who was born after September 30, 1983, who has attained the age of 6 but has not attained the age of 19 and whose family income does not exceed 100% of the poverty line for a family the size of the child's family.

12. Any child not described under subd. 1. who is under 19 years of age and who meets the resource and income limits under s. 49.19 (4).

13. Any child who is under one year of age, whose mother was determined to be eligible under subd. 9. and who lives with his or her mother.

14. Any person who would meet the financial and other eligibility requirements for home or community-based services under s. 46.27 (11) or 46.277 but for the fact that the person engages in substantial gainful activity under 42 USC 1382c (a) (3), if a waiver under s. 49.45 (38) is in effect or federal law permits federal financial participation for medical assistance coverage of the person and if funding is available for the person under s. 46.27 (11) or 46.277.

(am) 1. If the change requested under subd. 2. in the approved state plan for services under 42 USC 1396 is approved by the federal department of health and human services, the department shall disregard income from the following individuals, in an amount sufficient for the individual to become eligible for medical assistance under this section:

a. A pregnant woman whose family income, before any income is disregarded under this paragraph, does not exceed, in state fiscal year 1994-95, 155% of the poverty line for a family the size of the woman's family; and, in each state fiscal year after the 1994-95 state fiscal year, 185% of the poverty line for a family the size of the woman's family.

b. A child who is under 6 years of age and whose family income, before any income is disregarded under this paragraph, does not exceed, in state fiscal year 1994-95, 155% of the poverty line for a family the size of the child's family; and, in each state fiscal year after the 1994-95 state fiscal year, 185% of the poverty line for a family the size of the child's family.

c. A child who is under one year of age, whose mother was determined to be eligible under subd. 1. a. and who lives with his or her mother.

2. The department shall request a change in the approved state plan for services under 42 USC 1396 to allow, pursuant to the authority granted under 42 USC 1396a (r) (2), the use of federal matching funds to provide medical assistance coverage to individuals under subd. 1., beginning on July 1, 1994.

(b) Any person shall be considered a recipient of aid for 3 months prior to the month of application if the proper agency determines eligibility existed during such prior month.

(c) Except as provided under pars. (co) and (cs), a family that becomes ineligible for aid to families with dependent children under s. 49.19 because of increased income from employment or increased hours of employment or because of the expiration of the time during which the disregards under s. 49.19 (5) (a) 4. or 4m. or (am) apply shall receive medical assistance for:

1. Six calendar months following the month in which the family becomes ineligible for aid to families with dependent children if all of the following apply:

a. The family is eligible for aid to families with dependent children for at least 3 of the 6 months immediately preceding the month in which the family becomes ineligible.

b. The family continues to include a child who is, or would be if needy, a dependent child under s. 49.19.

c. The family complies with reporting requirements established by the department by rule.

2. Six calendar months following the 6 months under subd. 1. if all of the following apply:

a. The family chooses to continue to receive medical assistance.

b. The family continues to include a child who is, or would be if needy, a dependent child under s. 49.19.

c. The family complies with reporting requirements established by the department by rule.

d. The caretaker relative has earnings in each month of the period unless the caretaker lacks earnings because of illness, involuntary loss of employment or other good cause as determined by the department.

e. The family's average gross monthly earnings, less the cost of child care necessary for the employment of the caretaker relative, during the immediately preceding 3-month period do not exceed 185% of the poverty line for a family the size of the family.

(cg) Except as provided in par. (cs), medical assistance shall be provided to a dependent child, a relative with whom the child is living or the spouse of the relative, if the spouse meets the requirements of s. 49.19 (1) (c) 2. a. or b., for 4 calendar months beginning with the month in which the child, relative or spouse is ineligible for aid to families with dependent children because of the collection or increased collection of maintenance or support, if the child, relative or spouse received aid to families with dependent children in 3 or more of the 6 months immediately preceding the month in which that ineligibility begins.

(co) 1. Except as provided under subd. 2. and par. (cs), medical assistance shall be provided to a family for 12 consecutive calendar months following the month in which the family becomes ineligible for aid to families with dependent children because of increased income from employment, because the family no longer receives the earned income disregard under s. 49.19 (5) (a) 4. or 4m. or (am) due to the expiration of the time limit during which the disregards are applied or because of the application of the monthly employment time eligibility limitation under 45 CFR 233.100 (a) (1) (i).

2. If a waiver under subd. 3. is granted, the department may select individuals to receive medical assistance benefits as provided under par. (c), rather than under subd. 1., as a control group for part or all of the period during which the waiver is in effect.

3. The department shall request a waiver from the secretary of the federal department of health and human services to permit the extension of medical assistance benefits under subs. 1. and 2. Subdivision 1. does not apply unless a federal waiver is in effect. If a waiver is received, the department shall implement subs. 1. and 2. no later than the first day of the 6th month beginning after the waiver is approved.

(cr) Except as provided in par. (cs), medical assistance shall be provided for 9 consecutive calendar months to a family that

ceased to receive aid to families with dependent children after September 30, 1981, and prior to October 1, 1984, solely because of the loss of the disregards for earned income under s. 49.19 (5) (a) 4., after receiving the disregards for 4 consecutive months, if the family:

1. Applies for the medical assistance no later than the last day of the 6th month commencing after the month in which the secretary of the federal department of health and human services promulgates final regulations under 42 USC 602 (a) (37).

2. Discloses in the application under subd. 1. any health insurance possessed by a member of the family.

3. Demonstrates that, but for the loss of the disregards for earned income under s. 49.19 (5) (a) 4., the family was continuously eligible for aid to families with dependent children from the date of that loss until the date of the application made under subd. 1.

(cs) Medical assistance shall be provided to members of a work-not-welfare group, as defined in s. 49.27 (1) (c), that is eligible for transitional medical assistance coverage under s. 49.27 (8) (c). If the person is or was a member of a work-not-welfare group, as defined in s. 49.27 (1) (c), and if the period of ineligibility under s. 49.27 (4) (f) and (g) for that work-not-welfare group has not yet expired, the person is not eligible for medical assistance under par. (c), (cg), (co) or (cr), unless the person was a dependent child, as defined in s. 49.19 (1) (a), at the time that he or she was a member of the work-not-welfare group.

(d) For the purposes of this section:

1. Children who are placed in licensed foster homes or licensed treatment foster homes by the department and who would be eligible for payment of aid to families with dependent children in foster homes or treatment foster homes except that their placement is not made by a county department under s. 46.215, 46.22 or 46.23 will be considered as recipients of aid to families with dependent children.

2. Any accommodated person or any patient in a public medical institution shall be considered a recipient for purposes of this section if such person or patient would have inadequate means to meet his or her need for care and services if living in his or her usual living arrangement.

3. Any child adopted under s. 48.48 (12) shall be considered a recipient for any medical condition which exists at the time of the adoption or develops subsequent to the adoption.

4. A child who meets the conditions under 42 USC 1396a (e) 3. shall be considered a recipient of benefits under s. 49.177 or federal Title XVI.

(e) If an application under s. 49.47 (3) shows that the person has income and resources within the limitations of s. 49.19, federal Title XVI or s. 49.177, or that the person is an essential person, an accommodated person or a patient in a public medical institution, the person shall be granted the benefits enumerated under sub. (2) whether or not the person requests or receives a grant of any of such aids.

(j) An individual determined to be eligible for benefits under par. (a) 9. remains eligible for benefits under par. (a) 9. for the balance of the pregnancy and to the last day of the month in which the 60th day after the last day of the pregnancy falls without regard to any change in the individual's family income.

(k) 1. If a child eligible for benefits under par. (a) 10. is receiving inpatient services covered under sub. (2) on the day before the birthday on which the child attains the age of 6 and, but for attaining that age, the child would remain eligible for benefits under par. (a) 10., the child remains eligible for benefits until the end of the stay for which the inpatient services are furnished.

2. If a child eligible for benefits under par. (a) 11. is receiving inpatient services covered under sub. (2) on the day before the birthday on which the child attains the age of 19 and, but for attaining that age, the child would remain eligible for benefits under par. (a) 11., the child remains eligible for benefits until the end of the stay for which the inpatient services are furnished.

(L) For the purposes of par. (a) 9 to 12., "income" includes income that would be used in determining eligibility for aid to families with dependent children under s. 49.19, except to the extent that that determination is inconsistent with 42 USC 1396a (a) 17., and excludes income that would be excluded in determining eligibility for aid to families with dependent children under s. 49.19. For the purposes of par. (am), "income" shall be determined in accordance with the approved state plan for services under 42 USC 1396.

(m) 1. Except as provided in subd. 2., any individual who is otherwise eligible under this subsection and who is eligible for enrollment in a group health plan shall, as a condition of eligibility for medical assistance and if the department determines it is cost-effective to do so, apply for enrollment in the group health plan, except that, for a minor, the parent of the minor shall apply on the minor's behalf.

2. If a parent of a minor fails to enroll the minor in a group health plan in accordance with subd. 1., the failure does not affect the minor's eligibility under this subsection.

(2) BENEFITS (a) Except as provided in par. (be), the department shall audit and pay allowable charges to certified providers for medical assistance on behalf of recipients for the following federally mandated benefits:

1. Physicians' services, excluding services provided under par. (b) 6. f.

2. Early and periodic screening and diagnosis, including case management services, of persons under 21 years of age and all medical treatment and dentists' services specified in par. (b) 1. found necessary by this screening and diagnosis.

3. Rural health clinic services.

4. The following medical services if prescribed by a physician:

a. Inpatient hospital services other than services in an institution for mental diseases, including psychiatric and alcohol or other drug abuse treatment services.

b. Services specified in this paragraph, provided by any hospital on an outpatient basis.

c. Skilled nursing home services other than in an institution for mental diseases, except as limited under s. 49.45 (6c).

d. Home health services or nursing services if a home health agency is unavailable.

e. Laboratory and X-ray services.

f. Family planning services and supplies.

g. Nurse midwifery services.

6. Premiums, deductibles and coinsurance and other cost-sharing obligations for items and services otherwise paid under this subsection that are required for enrollment in a group health plan, as specified in sub. (1) (m), except that, if enrollment in the group health plan requires enrollment of family members who are not eligible under this subsection, the department shall pay, if it is cost-effective, for an ineligible family member only the premium that is required for enrollment in the group health plan.

(b) Except as provided in par. (be), the department shall audit and pay allowable charges to certified providers for medical assistance on behalf of recipients for the following services:

1. Dentists' services, limited to basic services within each of the following categories:

a. Diagnostic services.

b. Preventive services.

c. Restorative services.

d. Endodontic services.

e. Periodontic services.

f. Oral and maxillofacial surgery services.

g. Emergency treatment of dental pain.

h. Removable prosthodontic services.

i. Fixed prosthodontic services.

2. Optometrists' or opticians' services.

3. Transportation by emergency medical vehicle to obtain emergency medical care; transportation by specialized medical vehicle to obtain medical care including the unloaded travel of the specialized medical vehicle necessary to provide that transportation or, if authorized in advance by the county department under s. 46.215 or 46.22, transportation by common carrier or private motor vehicle to obtain medical care.

4. Chiropractors' services.

5. Eyeglasses.

6. The following services if prescribed by a physician:

a. Intermediate care facility services other than in an institution for mental diseases.

b. Physical and occupational therapy.

c. Speech, hearing and language disorder services.

d. Medical supplies and equipment.

e. Inpatient hospital, skilled nursing facility and intermediate care facility services for patients of any institution for mental diseases who are under 21 years of age, are under 22 years of age and who were receiving these services immediately prior to reaching age 21, or are 65 years of age or older.

f. Medical day treatment services, mental health services and alcohol and other drug abuse services, including services provided by a psychiatrist.

g. Nursing services, including services performed by a nurse practitioner, as defined in rules that the department shall promulgate.

h. Legend drugs, as listed in the Wisconsin medical assistance drug index.

i. Over-the-counter drugs listed by the department in the Wisconsin medical assistance drug index.

j. Personal care services.

k. Alcohol and other drug abuse day treatment services. This subd. 6. k. does not apply after June 30, 1995, or the day after publication of the 1995-97 biennial budget act, whichever is later.

L. Mental health and psychosocial rehabilitative services, including case management services, provided by the staff of a community support program certified under s. 49.45 (2) (a) 11.

m. Respiratory care services for ventilator-dependent individuals.

8. Home or community-based services, if provided under s. 46.27 (11), 46.275, 46.277 or 46.278.

9. Case management services, as specified under s. 49.45 (24) or (25).

10. Hospice care as defined in 42 USC 1396d (o) (1).

11. Podiatrists' services.

12. Care coordination for women with high-risk pregnancies.

13. Care coordination and follow-up of persons having lead poisoning or lead exposure, as defined in s. 254.11 (9), including lead inspections.

(be) Benefits for an individual eligible under sub. (1) (a) 9. are limited to those services under par. (a) or (b) that are related to pregnancy, including postpartum and family planning services, or related to other conditions which may complicate pregnancy.

(c) 1. In this paragraph and par. (cm):

a. "Entitled to coverage under part A of medicare" means eligible for and enrolled in part A of medicare under 42 USC 1395c to 1395f.

b. "Entitled to coverage under part B of medicare" means eligible for and enrolled in part B of medicare under 42 USC 1395j to 1395l.

2. For an individual who is entitled to coverage under part A of medicare, entitled to coverage under part B of medicare, meets the eligibility criteria under sub. (1) and meets the limitation on income under subd. 6., medical assistance shall include payment of the deductible and coinsurance portions of medicare services

under 42 USC 1395 to 1395zz which are not paid under 42 USC 1395 to 1395zz, including those medicare services that are not included in the approved state plan for services under 42 USC 1396; the monthly premiums payable under 42 USC 1395v; the monthly premiums, if applicable, under 42 USC 1395i-2 (d); and the late enrollment penalty, if applicable, for premiums under part A of medicare. Payment of coinsurance for a service under part B of medicare under 42 USC 1395j to 1395w may not exceed the allowable charge for the service under medical assistance minus the medicare payment.

3. For an individual who is only entitled to coverage under part A of medicare, meets the eligibility criteria under sub. (1) and meets the limitation on income under subd. 6., medical assistance shall include payment of the deductible and coinsurance portions of medicare services under 42 USC 1395 to 1395i which are not paid under 42 USC 1395 to 1395i, including those medicare services that are not included in the approved state plan for services under 42 USC 1396; the monthly premiums, if applicable, under 42 USC 1395i-2 (d); and the late enrollment penalty, if applicable, for premiums under part A of medicare.

4. For an individual who is entitled to coverage under part A of medicare, entitled to coverage under part B of medicare and meets the eligibility criteria for medical assistance under sub. (1), but does not meet the limitation on income under subd. 6., medical assistance shall include payment of the deductible and coinsurance portions of medicare services under 42 USC 1395 to 1395zz which are not paid under 42 USC 1395 to 1395zz, including those medicare services that are not included in the approved state plan for services under 42 USC 1396. Payment of coinsurance for a service under part B of medicare under 42 USC 1395j to 1395w may not exceed the allowable charge for the service under medical assistance minus the medicare payment.

5. For an individual who is only entitled to coverage under part A of medicare and meets the eligibility criteria for medical assistance under sub. (1), but does not meet the limitation on income under subd. 6., medical assistance shall include payment of the deductible and coinsurance portions of medicare services under 42 USC 1395 to 1395i which are not paid under 42 USC 1395 to 1395i, including those medicare services that are not included in the approved state plan for services under 42 USC 1396.

5m. For an individual who is only entitled to coverage under part B of medicare and meets the eligibility criteria under sub. (1), but does not meet the limitation on income under subd. 6., medical assistance shall include payment of the deductible and coinsurance portions of medicare services under 42 USC 1395j to 1395w, including those medicare services that are not included in the approved state plan for services under 42 USC 1396. Payment of coinsurance for a service under part B of medicare may not exceed the allowable charge for the service under medical assistance minus the medicare payment.

6. The income limitation under this paragraph is income that is equal to or less than 100% of the poverty line, as established under 42 USC 9902 (2).

(cm) 1. Beginning on January 1, 1993, for an individual who is entitled to coverage under part A of medicare, is entitled to coverage under part B of medicare, meets the eligibility criteria under sub. (1) and meets the limitation on income under subd. 2., medical assistance shall pay the monthly premiums under 42 USC 1395r.

2. Benefits under subd. 1. are available for an individual whose income is greater than 100% of the poverty line but less than 120% of the poverty line.

(d) Benefits authorized under this subsection may not include payment for that part of any service payable through 3rd party liability or any federal, state, county, municipal or private benefit system to which the beneficiary is entitled. "Benefit system" does not include any public assistance program such as, but not limited

to, Hill-Burton benefits under 42 USC 291c (e), in effect on April 30, 1980, or general relief.

(dm) Benefits under this section may not include payment for services to individuals aged 21 to 64 who are residents of an institution for mental diseases and who are otherwise eligible for medical assistance, except for individuals under 22 years of age who were receiving these services immediately prior to reaching age 21 and continuously thereafter and except for services to individuals who are on convalescent leave or are conditionally released from the institution for mental diseases. For purposes of this paragraph, the department shall define "convalescent leave" and "conditional release" by rule.

(f) Benefits under this subsection may not include payment for gastric bypass surgery or gastric stapling surgery unless it is performed because of a medical emergency.

History: 1971 c. 125, 211, 215; 1973 c. 90, 147; 1975 c. 39; 1977 c. 29 ss. 592m, 1656 (18); 1977 c. 389, 418; 1979 c. 34, 221; 1981 c. 20, 93, 317; 1983 a. 27; 1983 a. 189 s. 329 (5); 1983 a. 245 ss. 10, 15; 1983 a. 538; 1985 a. 29, 120, 176, 253; 1987 a. 27, 307, 339, 399, 413; 1989 a. 9; 1989 a. 31 ss. 1454d to 1460 and 2909g, 2909i; 1989 a. 122, 173, 333, 336, 351; 1991 a. 39, 178, 269, 316; 1993 a. 16, 99, 269, 277, 446, 450, 491.

Categorically needy person applying for assistance under this section need not comply with divestment of assets provisions under 49.47 (4) (d). *Sinclair v. H&SS Department*, 77 W (2d) 322, 253 NW (2d) 245.

States need not fund nontherapeutic abortions. *Beal v. Doe*, 432 US 438.

49.465 Presumptive medical assistance eligibility.

(1) In this section, "qualified provider" means a provider which satisfies the requirements under 42 USC 1396r-1 (b) (2), as determined by the department.

(2) A pregnant woman is eligible for medical assistance benefits, as provided under sub. (3), during the period beginning on the day on which a qualified provider determines, on the basis of preliminary information, that the woman's family income does not exceed the highest level for eligibility for benefits under s. 49.46 (1) or 49.47 (4) (am) or (c) 1. and ending as follows:

(a) If the woman applies for benefits under s. 49.46 or 49.47 within the time required under sub. (4), the day on which the department or the county department under s. 46.215, 46.22 or 46.23 determines whether the woman is eligible for benefits under s. 49.46 or 49.47.

(c) If the woman does not apply for benefits under s. 49.46 or 49.47 within the time required under sub. (4), the last day of the month following the month in which the provider makes the determination under this subsection.

(3) The department shall audit and pay allowable charges to a provider certified under s. 49.45 (2) (a) 11. for medical assistance on behalf of a recipient under this section only for ambulatory prenatal care covered under s. 49.46 (2).

(4) A woman who is determined to be eligible under this section shall apply for benefits under s. 49.46 or 49.47 on or before the last day of the month following the month in which the qualified provider makes that determination.

(5) A qualified provider which determines that a woman is eligible under this section shall do all of the following:

(a) Notify the department of that determination within 5 working days after the day the determination is made.

(b) Notify the woman of the requirement under sub. (4).

(6) The department shall provide qualified providers with application forms for medical assistance under ss. 49.46 and 49.47 and information on how to assist women in completing the forms.

History: 1987 a. 27, 307, 413; 1989 a. 9; 1989 a. 31 ss. 1460p, 2909g, 2909i; 1991 a. 269.

49.468 Expanded medicare buy-in. (1) (a) In this subsection and sub. (1m):

1. "Disabled" means blind, as defined under 42 USC 1382c (a) (2) and disabled, as defined under 42 USC 1382c (a) (3).

2. "Elderly" means 65 years of age or older.

3. "Entitled to coverage under part A of medicare" means eligible for and enrolled in part A of medicare under 42 USC 1395c to 1395f.

4. "Entitled to coverage under part B of medicare" means eligible for and enrolled in part B of medicare under 42 USC 1395j to 1395L.

(b) For an elderly or disabled individual who is entitled to coverage under part A of medicare, entitled to coverage under part B of medicare and who does not meet the eligibility criteria for medical assistance under s. 49.46 (1), 49.465 or 49.47 (4) but meets the limitations on income and resources under par. (d), medical assistance shall pay the deductible and coinsurance portions of medicare services under 42 USC 1395 to 1395zz which are not paid under 42 USC 1395 to 1395zz, including those medicare services that are not included in the approved state plan for services under 42 USC 1396; the monthly premiums payable under 42 USC 1395v; the monthly premiums, if applicable, under 42 USC 1395i-2 (d); and the late enrollment penalty, if applicable, for premiums under part A of medicare. Payment of coinsurance for a service under part B of medicare under 42 USC 1395j to 1395w may not exceed the allowable charge for the service under medical assistance minus the medicare payment.

(c) For an elderly or disabled individual who is only entitled to coverage under part A of medicare and who does not meet the eligibility criteria for medical assistance under s. 49.46 (1), 49.465 or 49.47 (4) but meets the limitations on income and resources under par. (d), medical assistance shall pay the deductible and coinsurance portions of medicare services under 42 USC 1395 to 1395i which are not paid under 42 USC 1395 to 1395i, including those medicare services that are not included in the approved state plan for services under 42 USC 1396; the monthly premiums, if applicable, under 42 USC 1395i-2 (d); and the late enrollment penalty for premiums under part A of medicare, if applicable.

(d) Benefits under par. (b) or (c) are available for an individual who has resources that are equal to or less than 200% of the allowable resources as determined under 42 USC 1381 to 1385 and income that is equal to or less than 100% of the poverty line.

(e) In determining under this subsection the income of an individual who is entitled to a monthly social security benefit under 42 USC 401 to 433, the department shall exclude, from December until the month after the month in which the annual revision of the poverty line is published, the amount of the social security benefit attributable to a cost-of-living increase under 42 USC 415 (i).

(1m) (a) Beginning on January 1, 1993, for an elderly or disabled individual who is entitled to coverage under part A of medicare and is entitled to coverage under part B of medicare, does not meet the eligibility criteria for medical assistance under s. 49.46 (1), 49.465 or 49.47 (4) but meets the limitations on income and resources under par. (b), medical assistance shall pay the monthly premiums under 42 USC 1395r.

(b) Benefits under par. (a) are available for an individual who has resources that are equal to or less than 200% of the allowable resources determined under 42 USC 1381 to 1385 and income that is greater than 100% of the poverty line but less than 120% of the poverty line.

(2) (a) Beginning on January 1, 1991, for a disabled working individual who is entitled under P.L. 101-239, section 6012 (a), to coverage under part A of medicare and who does not meet the eligibility criteria for medical assistance under s. 49.46 (1), 49.465 or 49.47 (4) but meets the limitations on income and resources under par. (b), medical assistance shall pay the monthly premiums for the coverage under part A of medicare, including late enrollment fees, if applicable.

(b) Benefits under par. (a) are available for an individual who has resources that are equal to or less than 200% of the allowable resources under 42 USC 1381 to 1385 and income that is equal to or less than 200% of the poverty line.

History: 1989 a. 31, 336; 1991 a. 39, 269; 1993 a. 16.

49.47 Medical assistance; medically indigent.

(1) **PURPOSE.** Medical assistance as set forth herein shall be provided to persons over 65, all children under 18 and, if the child is "dependent" pursuant to s. 49.19, the relatives enumerated in s.

49.19 with whom the child is living, or blind or disabled if eligible under this section.

(2) **DEFINITIONS** As used in this section, unless the context indicates otherwise:

(a) "Beneficiary" means a person eligible for, and a recipient of, medical assistance under this section.

(b) "Illness" means a bodily disorder, bodily injury, disease or mental disease. All illnesses existing simultaneously which are due to the same or related causes shall be considered "one illness." Successive periods of illness less than 6 months apart, which are due to the same or related causes, shall also be considered "one illness."

(3) **APPLICATION** (a) At any time any resident of this state who believes himself or herself medically indigent and qualified for aid under this section may make application, on forms prescribed by the department. If eligibility is questionable by reason of the information contained on the application or is incomplete, further investigation shall be made to determine eligibility.

(b) The agency shall promptly review the application and shall issue a certificate to the individual showing eligibility when eligibility has been established.

(c) The department shall simplify applications for benefits for pregnant women and children under sub. (4) and shall make the simplified applications available in the offices of health care providers.

(4) **ELIGIBILITY** (a) Any individual who meets the limitations on income and resources under pars. (b) and (c) and who complies with par. (cm) shall be eligible for medical assistance under this section if such individual is:

1. Under 18 years of age or, if the person resides in an intermediate care facility, skilled nursing facility or inpatient psychiatric hospital, under 21 years of age.

2. Pregnant and the woman's pregnancy is medically verified. Eligibility continues to the last day of the month in which the 60th day after the last day of the pregnancy falls.

3. 65 years of age or older.

4. Blind or totally and permanently disabled as defined under federal Title XVI.

(am) An individual who does not meet the limitation on income in par. (c) is eligible for medical assistance under this section if the individual is one of the following:

1. A pregnant woman whose family income does not exceed 155% of the poverty line for a family the size of the woman's family, except that if a waiver under par. (j) or a change in the approved state plan under s. 49.46 (1) (am) 2. is in effect, the income limit is 185% of the poverty line for a family the size of the woman's family in each state fiscal year after the 1994-95 state fiscal year.

2. A child who is under 6 years of age and whose family income does not exceed 155% of the poverty line for a family the size of the child's family, except that if a waiver under par. (j) or a change in the approved state plan under s. 49.46 (1) (am) 2. is in effect, the income limit is 185% of the poverty line for a family the size of the child's family in each state fiscal year after the 1994-95 state fiscal year.

3. A child who is under one year of age, whose mother was determined to be eligible under subd. 1. and who lives with his or her mother.

(as) A person is eligible for benefits under this section if all of the following apply:

1. The person would meet the financial and other eligibility requirements for home or community-based services under s. 46.27 (11) or 46.277 but for the fact that the person engages in substantial gainful activity under 42 USC 1382c (a) (3).

2. A waiver under s. 49.45 (38) is in effect or federal law authorizes federal financial participation for medical assistance coverage of the person.

3. Funding is available for the person under s. 46.27 (11) or 46.277.

(b) Eligibility exists if the applicant's property does not exceed the following:

1. A home and the land used and operated in connection therewith or in lieu thereof a mobile home if the home or mobile home is used as the person's or his or her family's place of abode.

2. Household and personal possessions.

2m. One or more motor vehicles as specified in this subdivision.

a. For persons who are eligible under par. (a) 1. or 2., one vehicle is exempt from consideration as an asset. A 2nd vehicle is exempt from consideration as an asset only if the department determines that it is necessary for the purpose of employment or to obtain medical care. The equity value of any nonexempt vehicles owned by the applicant is an asset for the purposes of determining eligibility for medical assistance under this section.

b. For persons who are eligible under par. (a) 3. or 4., motor vehicles are exempt from consideration as an asset to the same extent as provided under 42 USC 1381 to 1385.

2r. For a person who is eligible under par. (a) 3. or 4., the value of any burial space or agreement representing the purchase of a burial space held for the purpose of providing a place for the burial of the person or any member of his or her immediate family.

2w. For a person who is eligible under par. (a) 3. or 4., life insurance with cash surrender values if the total face value of all life insurance policies is not more than \$1,500.

3. For a person who is eligible under par. (a) 3. or 4., funds set aside to meet the burial and related expenses of the person and his or her spouse in an amount not to exceed \$1,500 each, minus the sum of the cash value of any life insurance excluded under subd. 2w. and the amount in any irrevocable burial trust under s. 445.125 (1).

3g. Liquid assets for a single person limited to:

a. In 1985, \$1,600.

b. In 1986, \$1,700.

c. In 1987, \$1,800.

d. In 1988, \$1,900.

e. After December 31, 1988, \$2,000.

3m. Liquid assets for a family of 2, limited to:

a. In 1985, \$2,400.

b. In 1986, \$2,550.

c. In 1987, \$2,700.

d. In 1988, \$2,850.

e. In 1989, \$3,000.

3r. Liquid assets limited to \$300 for each legal dependent in addition to a family of 2.

4. Additional tangible personal property of reasonable value, considering the number of members in the family group, used in the production of income.

(c) 1. Except as provided in par. (am) and as limited by subd. 3., eligibility exists if income does not exceed 133 1/3% of the maximum aid to families with dependent children payment under s. 49.19 (11) for the applicant's family size or the combined benefit amount available under supplemental security income under 42 USC 1381 to 1383c and state supplemental aid under s. 49.177 whichever is higher. In this subdivision "income" includes earned or unearned income that would be included in determining eligibility for the individual or family under s. 49.177 or 49.19, or for the aged, blind or disabled under 42 USC 1381 to 1385. "Income" does not include earned or unearned income which would be excluded in determining eligibility for the individual or family under s. 49.177 or 49.19, or for the aged, blind or disabled individual under 42 USC 1381 to 1385.

2. Whenever an applicant has excess income under subd. 1. or par. (am), no certification may be issued until the excess income above the applicable limits has been obligated or expended for medical care or for any other type of remedial care recognized under state law or for personal health insurance premiums or both.

3. Except as provided in par. (am), no person is eligible for medical assistance under this section if the person's income exceeds the maximum income levels that the U.S. department of health and human services sets for federal financial participation under 42 USC 1396b (f).

(cm) 1. Except as provided in subd. 2., any individual who is otherwise eligible under this subsection and who is eligible for enrollment in a group health plan shall, as a condition of eligibility for medical assistance and if the department determines it is cost-effective to do so, apply for enrollment in the group health plan, except that, for a minor, the parent of the minor shall apply on the minor's behalf.

2. If a parent of a minor fails to enroll the minor in a group health plan in accordance with subd. 1., the failure does not affect the minor's eligibility under this subsection.

(d) An individual is eligible for medical assistance under this section for 3 months prior to the month of application if the individual met the eligibility criteria under this section during those months.

(e) Temporary absence of a resident from the state shall not be grounds for denying the certificate or for the cancellation of an existing certificate.

(f) An individual determined to be eligible for benefits under par. (am) 1. remains eligible for benefits under par. (am) 1. for the balance of the pregnancy and to the last day of the first month which ends at least 60 days after the last day of the pregnancy without regard to any change in the individual's family income.

(g) If a child eligible for benefits under par. (am) 2. is receiving inpatient services covered under sub. (6) on the day before the birthday on which the child attains the age of 6 and, but for attaining that age, the child would remain eligible for benefits under par. (am) 2., the child remains eligible for benefits until the end of the stay for which the inpatient services are furnished.

(h) For the purposes of par. (am), "income" includes income that would be used in determining eligibility for aid to families with dependent children under s. 49.19 and excludes income that would be excluded in determining eligibility for aid to families with dependent children under s. 49.19.

(i) 1. The department shall request a waiver from the secretary of the federal department of health and human services to permit the application of subd. 2. The waiver shall request approval to implement the waiver on a statewide basis, unless the department of health and social services determines that statewide implementation of the waiver would present an obstacle to the approval of the waiver by the secretary of the federal department of health and human services, in which case the waiver shall request approval to implement the waiver in 48 pilot counties to be selected by the department of health and social services. Within 30 days after August 12, 1993, the department of regulation and licensing shall notify funeral directors licensed under ch. 445, cemetery associations, as defined in s. 157.061 (1r), and cemetery authorities, as defined in s. 157.061 (2), of the terms of the waiver required to be requested under this subdivision. If the waiver is approved by the secretary of the federal department of health and human services and if the waiver remains in effect, subd. 2. shall apply.

2. Notwithstanding par. (b) 2r. and 3., a person who is described in par. (a) 3. or 4. is not eligible for benefits under this section if any of the following criteria is met:

a. For the person or his or her spouse, the sum of the following, less the cash value of any life insurance excluded under par. (b) 2w. that was obtained after July 1, 1993, exceeds \$8,000: the value of any burial space or agreement described in par. (b) 2r. that was acquired after July 1, 1993; the amount in any irrevocable burial trust under s. 445.125 (1) that was acquired after July 1, 1993; and any funds set aside after July 1, 1993, to meet the burial and related expenses under par. (b) 3.

b. The value of any burial space or agreement described in par. (b) 2r. that is held for any other member of the person's im-

mediate family and that was acquired after July 1, 1993, exceeds \$8,000.

c. For the person or his or her spouse, the value of amounts set aside under par. (b) 3. for cemetery property and fees to open and close grave sites, including mausoleum spaces, exceeds \$1,000.

(j) If the change in the approved state plan under s. 49.46 (1) (am) 2. is denied, the department shall request a waiver from the secretary of the federal department of health and human services to allow the use of federal matching funds to provide medical assistance coverage under par. (am) 1. and 2. to individuals whose family incomes do not exceed 185% of the poverty line in each state fiscal year after the 1994-95 state fiscal year.

(5) INVESTIGATION BY DEPARTMENT. The department may make additional investigation of eligibility:

(a) When there is reasonable ground for belief that an applicant may not be eligible or that the beneficiary may have received benefits to which the beneficiary is not entitled; or

(b) Upon the request of the secretary of the U.S. department of health and human services.

(6) BENEFITS (a) The department shall audit and pay charges to certified providers for medical assistance on behalf of the following:

1. Except as provided in subds. 6 to 7., all beneficiaries, for all services under s. 49.46 (2) (a) and (b).

6. a. In this subdivision: 1) "entitled to coverage under part A of medicare" means eligible for and enrolled in part A of medicare under 42 USC 1395c to 1395f; 2) "entitled to coverage under part B of medicare" means eligible for and enrolled in part B of medicare under 42 USC 1395j to 1395L; and 3) "income limitation" means income that is equal to or less than 100% of the poverty line, as established under 42 USC 9902 (2).

b. An individual who is entitled to coverage under part A of medicare, entitled to coverage under part B of medicare, meets the eligibility criteria under sub. (4) (a) and meets the income limitation, the deductible and coinsurance portions of medicare services under 42 USC 1395 to 1395zz which are not paid under 42 USC 1395 to 1395zz, including those medicare services that are not included in the approved state plan for services under 42 USC 1396; the monthly premiums payable under 42 USC 1395v; the monthly premiums, if applicable, under 42 USC 1395i-2 (d); and the late enrollment penalty, if applicable, for premiums under part A of medicare. Payment of coinsurance for a service under part B of medicare under 42 USC 1395j to 1395w may not exceed the allowable charge for the service under medical assistance minus the medicare payment.

c. An individual who is only entitled to coverage under part A of medicare, meets the eligibility criteria under sub. (4) (a) and meets the income limitation, the deductible and coinsurance portions of medicare services under 42 USC 1395 to 1395i which are not paid under 42 USC 1395 to 1395i, including those medicare services that are not included in the approved state plan for services under 42 USC 1396; the monthly premiums, if applicable, under 42 USC 1395i-2 (d); and the late enrollment penalty, if applicable, for premiums under part A of medicare.

d. An individual who is entitled to coverage under part A of medicare, entitled to coverage under part B of medicare and meets the eligibility criteria for medical assistance under sub. (4) (a) but does not meet the income limitation, the deductible and coinsurance portions of medicare services under 42 USC 1395 to 1395zz which are not paid under 42 USC 1395 to 1395zz, including those medicare services that are not included in the approved state plan for services under 42 USC 1396. Payment of coinsurance for a service under part B of medicare under 42 USC 1395j to 1395w may not exceed the allowable charge for the service under medical assistance minus the medicare payment.

e. An individual who is only entitled to coverage under part A of medicare and meets the eligibility criteria for medical assist-

ance under sub. (4) (a), but does not meet the income limitation, the deductible and coinsurance portions of medicare services under 42 USC 1395 to 1395i, including those services that are not included in the approved state plan for services under 42 USC 1396.

f. For an individual who is only entitled to coverage under part B of medicare and meets the eligibility criteria under sub. (4), but does not meet the income limitation, medical assistance shall include payment of the deductible and coinsurance portions of medicare services under 42 USC 1395j to 1395w, including those medicare services that are not included in the approved state plan for services under 42 USC 1396. Payment of coinsurance for a service under part B of medicare may not exceed the allowable charge for the service under medical assistance minus the medicare payment.

6m. An individual who is entitled to coverage under part A of medicare, as defined in subd. 6. a. is entitled to coverage under part B of medicare, as defined in subd. 6. a. and meets the eligibility criteria under sub. (4) (a) and whose income is greater than 100% of the poverty line but less than 120% of the poverty line for the monthly premiums under 42 USC 1395r.

7. Beneficiaries eligible under sub. (4) (a) 2. or (am) 1., for services under s. 49.46 (2) (a) and (b) that are related to pregnancy, including postpartum and family planning services, or related to other conditions which may complicate pregnancy.

(b) In no event may payments be made for medical assistance rendered during a period when the beneficiary would not have been eligible for benefits under this section.

(c) Benefits shall not include any payment with respect to:

1. Care or services in any private or public institution, unless the institution has been approved by a standard-setting authority responsible by law for establishing and maintaining standards for such institution.

2. That part of any service otherwise authorized under this section which is payable through 3rd party liability or any federal, state, county, municipal or private benefit systems, to which the beneficiary may otherwise be entitled.

3. Care or services for an individual who is an inmate of a public institution, except as a patient in a medical institution or a resident in an intermediate care facility.

4. Services to individuals aged 21 to 64 who are residents of an institution for mental diseases and who are otherwise eligible for medical assistance, except for individuals under 22 years of age who were receiving these services immediately prior to reaching age 21 and continuously thereafter and except for services to individuals who are on convalescent leave or are conditionally released from the institution for mental diseases. For purposes of this subdivision, the department shall define "convalescent leave" and "conditional release" by rule.

(d) No payment under this subsection may include care for services rendered earlier than 3 months preceding the month of application.

(7) REDUCTION OF BENEFITS If the funds appropriated become or are estimated to be insufficient to make full payment of benefits provided under this section, all charges for service so authorized shall be prorated on the basis of funds available or by limiting the benefits provided.

(8) ENROLLMENT FEE As long as an enrollment fee or premium is required for persons receiving benefits under Title XIX of the social security act, the department shall charge the minimum enrollment fee or premium required under federal law. The fee or premium so charged shall be related to the beneficiary's income, in accordance with guidelines established by the secretary of the U.S. department of health and human services.

(9m) ELIGIBILITY FOR LONG-TERM CARE INSURANCE BENEFICIARIES. (a) In this subsection, "long-term care insurance" has the meaning given in s. 146.91 (1).

(b) A person who meets the eligibility requirements for medical assistance under sub. (4) except that the person has liquid assets in excess of the limits under sub. (4) (b) is eligible for medical assistance under this section if all of the following conditions are satisfied:

1. The person is 65 years of age or older.

2. The person is the beneficiary of a long-term care insurance policy that is certified to meet the standards set by the department by rule.

3. The long-term care insurance policy paid for institutional or community-based long-term care services, or both, up to the limits specified in the long-term care insurance policy.

4. The person required the services paid for under the long-term care insurance policy because of a severe limitation in activities of daily living or because of medical necessity, as defined by the department by rule.

5. The amount of liquid assets retained by the person does not exceed the amount paid under the policy or the actual charges, whichever is lower, for the following services provided to the beneficiary that are reimbursed under the medical assistance program:

- a. Skilled nursing home services under s. 49.46 (2) (a) 4. c.
- b. Home health services under s. 49.46 (2) (a) 4. d.
- c. Intermediate care facility services under s. 49.46 (2) (b) 6. a.
- d. Nursing services under s. 49.46 (2) (b) 6. g.
- e. Home or community-based services under s. 49.46 (2) (b) 8.
- f. Case management services under s. 49.46 (2) (b) 9.

(c) A person who seeks benefits under this subsection shall apply to an office of the department designated by the department.

(d) Paragraphs (b) and (c) do not apply unless the federal department of health and human services approves a waiver of federal medical assistance eligibility limits that authorizes federal financial participation in providing medical assistance benefits to persons eligible under par. (b). If a waiver is approved, the department shall implement pars. (b) and (c) no later than 3 months after the date on which it is notified of that approval.

History: 1971 c. 125; 1971 c. 213 s. 5; 1971 c. 215; 1973 c. 90, 147, 333; 1977 c. 29 ss. 593, 1656 (18); 1977 c. 105 s. 59; 1977 c. 273, 418; 1979 c. 34; 1981 c. 20, 93; 1981 c. 314 s. 144; 1983 a. 27, 245; 1985 a. 29; 1987 a. 27, 307, 399, 413; 1989 a. 9; 1989 a. 31 ss. 1462k to 1466d, 2909c to 2909i; 1989 a. 173, 336, 351; 1991 a. 39, 178, 269, 316; 1993 a. 16, 269, 277, 437.

Spent-down requirements discussed. *Swanson v. HSS*, 105 W (2d) 78, 312 NW (2d) 833 (Ct. App. 1981).

Five-step process for evaluating disability claims applied. *Clauer v. DHSS*, 174 W (2d) 344, 497 NW (2d) 738 (Ct. App. 1993).

Regulation which "deemed" resources of one spouse to be "available" to the other was valid. *Schweiker v. Gray Panthers*, 453 US 34 (1981).

49.475 Information about medical assistance beneficiaries. (1) DEFINITIONS In this section:

(a) "Disability insurance policy" has the meaning given in s. 632.895 (1) (a).

(b) "Insurer" has the meaning given in s. 600.03 (27).

(2) DISCLOSURE TO DEPARTMENT. An insurer that issues or delivers a disability insurance policy that provides coverage to a resident of this state shall provide to the department, upon the department's request, information contained in the insurer's records regarding all of the following:

(a) Information that the department needs to identify beneficiaries of medical assistance who satisfy any of the following:

1. Are eligible for benefits under a disability insurance policy.
2. Would be eligible for benefits under a disability insurance policy if the beneficiary were enrolled as a dependent of a person insured under the disability insurance policy.

(b) Information required for submittal of claims under the insurer's disability insurance policy.

(c) The types of benefits provided by the disability insurance policy.

(3) **WRITTEN AGREEMENT** Upon requesting an insurer to provide the information under sub. (2), the department shall enter into a written agreement with the insurer that satisfies all of the following:

- (a) Identifies in detail the information to be disclosed.
- (b) Includes provisions that adequately safeguard the confidentiality of the information to be disclosed.
- (c) Specifies how the insurer's reimbursable costs under sub. (5) will be determined and specifies the manner of payment.

(4) **DEADLINE FOR RESPONSE; ENFORCEMENT** (a) An insurer shall provide the information requested under sub. (2) within 180 days after receiving the department's request if it is the first time that the department has requested the insurer to disclose information under this section.

(b) An insurer shall provide the information requested under sub. (2) within 30 days after receiving the department's request if the department has previously requested the insurer to disclose information under this section.

(c) If an insurer fails to comply with par. (a) or (b), the department may notify the commissioner of insurance, and the commissioner of insurance may initiate enforcement proceedings against the insurer under s. 601.41 (4) (a).

(5) **REIMBURSEMENT OF COSTS** From the appropriations under s. 20.435 (1) (bm) and (p), the department shall reimburse an insurer that provides information under this section for the insurer's reasonable costs incurred in providing the requested information, including its reasonable costs, if any, to develop and operate automated systems specifically for the disclosure of information under this section.

History: 1991 a. 39.

49.48 Aid for treatment of kidney disease. (1) DECLARATION OF POLICY The legislature finds that effective means of treating kidney failure are available, including dialysis or artificial kidney treatment or transplants. It further finds that kidney disease treatment is prohibitively expensive for the overwhelming portion of the state's citizens. It further finds that public and private insurance coverage is inadequate in many cases to cover the cost of adequate treatment at the proper time in modern facilities. The legislature finds, in addition, that the incidence of the disease in the state is not so great that public aid may not be provided to alleviate this serious problem for a relatively modest investment. Therefore, it is declared to be the policy of this state to assure that all persons are protected from the destructive cost of kidney disease treatment by one means or another.

(1m) In this section, "recombinant human erythropoietin" means a bioengineered glycoprotein that has the same biological effects in stimulating red blood cell production as does the glycoprotein erythropoietin that is produced by the human body.

(2) **DUTIES OF DEPARTMENT** The department shall:

- (a) Promulgate rules setting standards for operation and certification of dialysis and renal transplantation centers and home dialysis equipment and suppliers.
- (b) Promulgate rules setting standards for acceptance and certification of patients into the treatment phase of the program.
- (c) Promulgate rules concerning reasonable cost and length of treatment programs.

(d) Aid in preparing educational programs and materials informing the public as to chronic renal disease and the prevention and treatment thereof.

(3) **AID TO KIDNEY DISEASE PATIENTS.** (a) Any permanent resident of this state who suffers from chronic renal disease may be accepted into the dialysis treatment phase of the renal disease control program if the resident meets standards set by rule under sub. (2) and s. 49.487.

(b) The state shall pay the cost of medical treatment required as a direct result of chronic renal disease of certified patients from the date of certification, including the cost of administering recombinant human erythropoietin to appropriate patients, whether the treatment is rendered in an approved facility in the state or in a dialysis or transplantation center which is approved as such by a contiguous state, subject to the conditions specified under par. (d). Approved facilities may include a hospital in-center dialysis unit or a nonhospital dialysis center which is closely affiliated with a home dialysis program supervised by an approved facility. Aid shall also be provided for all reasonable expenses incurred by a potential living-related donor, including evaluation, hospitalization, surgical costs and postoperative follow-up to the extent that these costs are not reimbursable under the federal medicare program or other insurance. In addition, all expenses incurred in the procurement, transportation and preservation of cadaveric donor kidneys shall be covered to the extent that these costs are not otherwise reimbursable. All donor-related costs are chargeable to the recipient and reimbursable under this subsection.

(c) Disbursement and collection of all funds under this subsection shall be by the department or by a fiscal intermediary, in accordance with a contract with a fiscal intermediary. The costs of the fiscal intermediary under this paragraph shall be paid from the appropriation under s. 20.435 (1) (a).

(d) 1. No aid may be granted under this subsection unless the recipient has no other form of aid available from the federal medicare program or from private health, accident, sickness, medical and hospital insurance coverage. If insufficient aid is available from other sources and if the recipient has paid an amount equal to the annual medicare deductible amount specified in subd. 2., the state shall pay the difference in cost to a qualified recipient. If at any time sufficient federal or private insurance aid becomes available during the treatment period, state aid shall be terminated or appropriately reduced. Any patient who is eligible for the federal medicare program shall register and pay the premium for medicare medical insurance coverage where permitted, and shall pay an amount equal to the annual medicare deductible amounts required under 42 USC 1395e and 1395L (b), prior to becoming eligible for state aid.

2. Aid under this subsection is only available after the patient pays an annual amount equal to the annual deductible amount required under the federal medicare program. This subdivision requires an inpatient who seeks aid first to pay an annual deductible amount equal to the annual medicare deductible amount specified under 42 USC 1395e and requires an outpatient who seeks aid first to pay an annual deductible amount equal to the annual medicare deductible amount specified under 42 USC 1395L (b).

(e) State aids for services provided under this section shall be equal to the allowable charges under the federal medicare program. In no case shall state rates for individual service elements exceed the federally defined allowable costs. The rate of charges for services not covered by public and private insurance shall not exceed the reasonable charges as established by medicare fee determination procedures. The state may not pay for the cost of travel, lodging or meals for persons who must travel to receive inpatient and outpatient dialysis treatment for kidney disease. This paragraph shall not apply to donor related costs as defined in par. (b).

History: 1973 c. 308; 1975 c. 39; 1977 c. 29; 1981 c. 314; 1983 a. 27; 1985 a. 332 s. 251 (1); 1989 a. 311; 1991 a. 316; 1993 a. 16, 449, 491.

49.483 Cystic fibrosis aids. (1) The department may provide financial assistance for costs of medical care of persons over the age of 18 years with the diagnosis of cystic fibrosis who meet financial requirements established by the department by rule under s. 49.487 (1).

(2) Approved costs for medical care under sub. (1) shall be paid from the appropriation under s. 20.435 (1) (e).

History: 1973 c 300; Stats 1973 s 146.35; 1973 c 336 s 55; Stats 1973 s 146.36; 1975 c 39; 1979 c 34 s 2102 (43) (a); 1983 a 27 s 1562; Stats 1983 s 49.483; 1993 a 16, 449

49.485 Hemophilia treatment services. (1) DEFINITIONS. In this section:

(a) "Comprehensive hemophilia treatment center" means a center, and its satellite facilities, approved by the department, which provide services, including development of the maintenance program, to persons with hemophilia and other related congenital bleeding disorders.

(c) "Hemophilia" means a bleeding disorder resulting from a genetically determined clotting factor abnormality or deficiency.

(d) "Home care" means the self-infusion of a clotting factor on an outpatient basis by the patient or the infusion of a clotting factor to a patient on an outpatient basis by a person trained in such procedures.

(e) "Maintenance program" means the individual's therapeutic and treatment regimen, including medical, dental, social and vocational rehabilitation including home health care.

(f) "Net worth" means the sum of the value of liquid assets, real property, after excluding the first \$10,000 of the full value of the home derived by dividing the assessed value by the assessment ratio of the taxation district.

(g) "Physician director" means the medical director of the comprehensive hemophilia treatment center which is directly responsible for an individual's maintenance program.

(2) **ASSISTANCE PROGRAM.** The department shall establish a program of financial assistance to persons suffering from hemophilia and other related congenital bleeding disorders. The program shall assist such persons to purchase the blood derivatives and supplies necessary for home care. The program shall be administered through the comprehensive hemophilia treatment centers.

(4) **ELIGIBILITY.** Any permanent resident of this state who suffers from hemophilia or other related congenital bleeding disorder may participate in the program if that person meets the requirements of this section and s. 49.487 and the standards set by rule under this section and s. 49.487. The person shall enter into an agreement with the comprehensive hemophilia treatment center for a maintenance program to be followed by that person as a condition for continued eligibility. The physician director or a designee shall, at least once in each 6-month period, review the maintenance program and verify that the person is complying with the program.

(5) **RECOVERY FROM OTHER SOURCES.** The department is responsible for payments for blood products and supplies used in home care by persons participating in the program. The department may enter into agreements with comprehensive hemophilia treatment centers under which the treatment center assumes the responsibility for recovery of the payments from a 3rd party, including any insurer.

(6) **PAYMENTS.** (a) The department shall, by rule, establish a reasonable cost for blood products and supplies used in home care as a basis of reimbursement under this section.

(b) Reimbursement shall not be made under this section for any blood products or supplies which are not purchased from or provided by a comprehensive hemophilia treatment center, or a source approved by the treatment center. Reimbursement shall not be made under this section for any portion of the costs of blood products or supplies which are payable under any other state or federal program or under any grant, contract and any other contractual arrangement.

(c) The reasonable cost, determined under par. (a), of blood products and supplies used in home care for which reimbursement is not prohibited under par. (b), shall be reimbursed under this sec-

tion after deduction of the patient's liability, determined under sub. (7).

(7) **PATIENT'S LIABILITY.** (a) 1. The percentage of the patient's liability for the reasonable costs for blood products and supplies which are determined to be eligible for reimbursement under sub. (6) shall be based upon the income and the size of the person's family unit, according to standards to be established by the department under s. 49.487.

2. In determining income, only the income of the patient and persons responsible for the patient's support under s. 49.90 may be considered.

4. In determining family size, only persons who are related to the patient as parent, spouse, legal dependent or, if under the age of 18, as brother or sister may be considered.

5. In determining net worth, only the net worth of the patient and persons responsible for the patient's support under s. 49.90 will be considered.

(b) Individual liability shall be determined at the time of initial treatment and shall be redetermined annually or upon the patient's notification to the department of a change in family size or financial condition.

(8) **DEPARTMENT'S DUTIES.** The department shall:

(a) Extend financial assistance under this section to eligible persons suffering from hemophilia or other related congenital bleeding disorders.

(b) Employ administrative personnel to implement this section.

(c) Promulgate all rules necessary to implement this section.

History: 1977 c. 213; 1979 c 32; 1983 a 27; 1983 a 189 s 329 (10); 1983 a 544 s 47 (1); 1985 a 29 s 3202 (23), (46); 1987 a 27; 1987 a 312 s 17; 1993 a 16, 449.

49.486 AZT and pentamidine reimbursement program. (1) DEFINITIONS. In this section:

(a) "AIDS" means acquired immunodeficiency syndrome.

(am) "AZT" means the drug azidothymidine.

(b) "Gross income" means all income, from whatever source derived and in whatever form realized, whether in money, property or services.

(c) "HIV" means any strain of human immunodeficiency virus, which causes acquired immunodeficiency syndrome.

(d) "HIV infection" means the pathological state produced by a human body in response to the presence of HIV.

(e) "Physician" has the meaning specified in s. 448.01 (5).

(f) "Residence" means the concurrence of physical presence with intent to remain in a place of fixed habitation. Physical presence is prima facie evidence of intent to remain.

(g) "Validated test result" means a result of a test for the presence of HIV, antigen or nonantigenic products of HIV or an antibody to HIV that meets the validation requirements determined to be necessary by the state epidemiologist.

(2) **REIMBURSEMENT.** From the appropriation under s. 20.435 (1) (am), the department shall distribute not more than \$375,600 in fiscal year 1993-94 and not more than \$491,500 in fiscal year 1994-95 to reimburse or supplement the reimbursement of the cost of AZT, the drug pentamidine and any drug approved for reimbursement under sub. (4) (c) for an applying individual who has HIV infection.

(3) **ELIGIBILITY.** An individual is eligible to receive the reimbursement specified under sub. (2) if he or she meets all of the following criteria:

(a) Has residence in this state.

(b) Has an infection that is certified by a physician to be an HIV infection.

(c) Has a prescription issued by a physician for AZT, for pentamidine or for a drug approved for reimbursement under sub. (4) (c).

(d) Has applied for coverage under and has been denied eligibility for medical assistance within 12 months prior to application for reimbursement under sub. (2).

(e) Has no insurance coverage for AZT, the drug pentamidine or any drug approved for reimbursement under sub. (4) (c) or, if he or she has insurance coverage, the coverage is inadequate to pay the full cost of the individual's prescribed dosage of AZT, the drug pentamidine or any drug approved for reimbursement under sub. (4) (c).

(f) Is an individual with an annual gross income of \$40,000 or less.

(4) DEPARTMENTAL DUTIES The department shall do all of the following:

(a) Determine the eligibility of individuals applying for reimbursement, or a supplement to the reimbursement, of the costs of AZT or the drug pentamidine.

(b) Within the limits of sub. (5) and of the funds specified under sub. (2) and under a schedule that the department shall establish based on the ability of individuals to pay, reimburse or supplement the reimbursement of the eligible individuals.

(c) After consulting with individuals, including those not employed by the department, with expertise in issues relative to drugs for the treatment of HIV infection and AIDS, determine which, if any, drugs that are cost-effective alternatives to AZT and pentamidine may also have costs reimbursed under this section.

(5) REIMBURSEMENT LIMITATION Reimbursement may not be made under this section for any portion of the costs of AZT, the drug pentamidine or any drug approved for reimbursement under sub. (4) (c) which are payable by an insurer, as defined in s. 600.03 (27).

History: 1989 a 31; 1991 a 39; 1993 a 16

49.487 Disease aids; patient financial and liability requirements. (1) The department shall promulgate rules that require a person who is eligible for benefits under s. 49.48, 49.483 or 49.485 and whose current income exceeds specified limits to obligate or expend specified portions of the income for medical care for treatment of kidney disease, cystic fibrosis or hemophilia before receiving benefits under s. 49.48, 49.483 or 49.485.

(2) The department shall develop and implement a sliding scale of patient liability for kidney disease aid under s. 49.48, cystic fibrosis aid under s. 49.483 and hemophilia treatment under s. 49.485, based on the patient's ability to pay for treatment. To ensure that the needs for treatment of patients with lower incomes receive priority within the availability of funds under s. 20.435 (1) (e), the department shall revise the sliding scale for patient liability by January 1, 1994, and shall, every 3 years thereafter by January 1, review and, if necessary, revise the sliding scale.

History: 1983 a 27; 1989 a 56; 1991 a 39; 1993 a 16, 449

49.49 Medical assistance offenses. (1) **FRAUD** (a) *Prohibited conduct.* No person, in connection with a medical assistance program, may:

1. Knowingly and wilfully make or cause to be made any false statement or representation of a material fact in any application for any benefit or payment.

2. Knowingly and wilfully make or cause to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment.

3. Having knowledge of the occurrence of any event affecting the initial or continued right to any such benefit or payment or the initial or continued right to any such benefit or payment of any other individual in whose behalf he or she has applied for or is receiving such benefit or payment, conceal or fail to disclose such event with an intent fraudulently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized.

4. Having made application to receive any such benefit or payment for the use and benefit of another and having received it,

knowingly and wilfully convert such benefit or payment or any part thereof to a use other than for the use and benefit of such other person.

(b) *Penalties.* Violators of this subsection may be punished as follows:

1. In the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing by that person of items or services for which medical assistance is or may be made, a person convicted of violating this subsection may be fined not more than \$25,000 or imprisoned for not more than 5 years or both.

2. In the case of such a statement, representation, concealment, failure, or conversion by any other person, a person convicted of violating this subsection may be fined not more than \$10,000 or imprisoned for not more than one year in the county jail or both.

(c) *Damages.* If any person is convicted under this subsection, the state shall have a cause of action for relief against such person in an amount 3 times the amount of actual damages sustained as a result of any excess payments made in connection with the offense for which the conviction was obtained. Proof by the state of a conviction under this section in a civil action shall be conclusive regarding the state's right to damages and the only issue in controversy shall be the amount, if any, of the actual damages sustained. Actual damages shall consist of the total amount of excess payments, any part of which is paid by state funds. In any such civil action the state may elect to file a motion in expedition of the action. Upon receipt of the motion, the presiding judge shall expedite the action.

(2) **KICKBACKS, BRIBES AND REBATES** (a) *Solicitation or receipt of remuneration.* Any person who solicits or receives any remuneration, including any kickback, bribe, or rebate, directly or indirectly, overtly or covertly, in cash or in kind, in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a medical assistance program, or in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under a medical assistance program, may be fined not more than \$25,000 or imprisoned for not more than 5 years or both.

(b) *Offer or payment of remuneration.* Whoever offers or pays any remuneration including any kickback, bribe, or rebate directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under a medical assistance program, or to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service or item for which payment may be made in whole or in part under a medical assistance program, may be fined not more than \$25,000 or imprisoned for not more than 5 years or both.

(c) *Exceptions.* This subsection shall not apply to:

1. A discount or other reduction in price obtained by a provider of services or other entity under chs. 46 to 51 and 58 if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under a medical assistance program.

2. Any amount paid by an employer to an employee who has a bona fide employment relationship with such employer for employment in the provision of covered items or services.

(3) **FRAUDULENT CERTIFICATION OF FACILITIES** No person may knowingly and wilfully make or cause to be made, or induce or seek to induce the making of, any false statement or representation of a material fact with respect to the conditions or operation of any institution or facility in order that such institution or facility may qualify either upon initial certification or upon recertification as a hospital, skilled nursing facility, intermediate care facility, or home health agency. Violators of this subsection may be fined not

more than \$25,000 or imprisoned for not more than 5 years or both.

(3m) PROHIBITED PROVIDER CHARGES (a) No provider may knowingly impose upon a recipient charges in addition to payments received for services under ss. 49.45 to 49.47 or knowingly impose direct charges upon a recipient in lieu of obtaining payment under ss. 49.45 to 49.47 except under the following conditions:

1. Benefits or services are not provided under s. 49.46 (2) and the recipient is advised of this fact prior to receiving the service.

2. If an applicant is determined to be eligible retroactively under s. 49.46 (1) (b) and a provider bills the applicant directly for services and benefits rendered during the retroactive period, the provider shall, upon notification of the applicant's retroactive eligibility, submit claims for reimbursement under s. 49.45 for covered services or benefits rendered during the retroactive period. Upon receipt of payment, the provider shall reimburse the applicant or other person who has made prior payment to the provider. No provider may be required to reimburse the applicant or other person in excess of the amount reimbursed under s. 49.45.

3. Benefits or services for which recipient copayment, coinsurance or deductible is required under s. 49.45 (18), not to exceed maximum amounts allowable under 42 CFR 447.53 to 447.58.

(b) A person who violates this subsection may be fined not more than \$25,000 or imprisoned not more than 5 years or both.

(3p) OTHER PROHIBITED PROVIDER CHARGES No provider may knowingly violate s. 609.91 (2).

(4) PROHIBITED FACILITY CHARGES (a) No person, in connection with the medical assistance program when the cost of the services provided to the patient is paid for in whole or in part by the state, may knowingly and wilfully charge, solicit, accept or receive, in addition to any amount otherwise required to be paid under a medical assistance program, any gift, money, donation or other consideration, other than a charitable, religious or philanthropic contribution from an organization or from a person unrelated to the patient, as a precondition of admitting a patient to a hospital, skilled nursing facility or intermediate care facility, or as a requirement for the patient's continued stay in such a facility.

(b) A person who violates this subsection may be fined not more than \$25,000 or imprisoned not more than 5 years or both.

(4m) PROHIBITED CONDUCT; FORFEITURES (a) No person, in connection with medical assistance, may:

1. Knowingly make or cause to be made any false statement or representation of a material fact in any application for a benefit or payment.

2. Knowingly make or cause to be made any false statement or representation of a material fact for use in determining rights to a benefit or payment.

3. Knowingly conceal or fail to disclose any event of which the person has knowledge that affects his or her initial or continued right to a benefit or payment or affects the initial or continued right to a benefit or payment of any other person in whose behalf he or she has applied for or is receiving a benefit or payment.

(b) A person who violates this subsection may be required to forfeit not less than \$100 nor more than \$15,000 for each statement, representation, concealment or failure.

(5) COUNTY COLLECTION Any county may retain 15% of state medical assistance funds that are recovered due to the efforts of a county employe or officer or, if the county initiates action by the department of justice, due to the efforts of the department of justice under s. 49.495. This subsection applies only to recovery of medical assistance that was provided as a result of fraudulent activity by a recipient or by a provider.

History: 1977 c. 418; 1979 c. 89; 1981 c. 317; 1985 a. 29 s. 3202 (23); 1985 a. 269; 1989 a. 23, 31

The only state of mind required for a violation of sub. (1) (a) 1 is the intentional making or causing the making of a false statement that appears in an application; that anyone actually received a medical assistance benefit need not be proved. *State v. Williams*, 179 W (2d) 80, 505 NW (2d) 468 (Ct. App. 1993)

Nursing home guarantor agreements may violate (4) after resident becomes certified Medicaid eligible. 76 Atty Gen 295.

49.493 Benefits under uninsured health plans.

(1) In this section, "uninsured health plan" means a partially or wholly uninsured plan, including a plan that is subject to 29 USC 1001 to 1461, providing health care benefits.

(2) The providing of medical assistance constitutes an assignment to the department, to the extent of the medical assistance benefits provided, for benefits to which the recipient would be entitled under any uninsured health plan.

(3) An uninsured health plan may not do any of the following:

(a) Exclude a person or a person's dependent from coverage under the uninsured health plan because the person or the dependent is eligible for medical assistance.

(b) Terminate its coverage of a person or a person's dependent because the person or the dependent is eligible for medical assistance.

(c) Provide different benefits of coverage to a person or the person's dependent because the person or the dependent is eligible for medical assistance than it provides to persons and their dependents who are not eligible for medical assistance.

(d) Impose on the department, as assignee of a person or a person's dependent who is covered under the uninsured health plan and who is eligible for medical assistance, requirements that are different from those imposed on any other agent or assignee of a person who is covered under the uninsured health plan.

(4) Benefits provided by an uninsured health plan shall be primary to those benefits provided under medical assistance.

History: 1991 a. 178, 214; 1993 a. 481

49.495 Jurisdiction of the department of justice.

The department of justice or the district attorney may institute, manage, control and direct, in the proper county, any prosecution for violation of criminal laws affecting the medical assistance program including but not limited to laws relating to medical assistance contained in this chapter and laws affecting the health, safety and welfare of recipients of medical assistance. For this purpose the department of justice shall have and exercise all powers conferred upon district attorneys in such cases. The department of justice or district attorney shall notify the medical examining board or the interested affiliated credentialing board of any such prosecution of a person holding a license granted by the board or affiliated credentialing board.

History: 1977 c. 418; 1985 a. 340; 1993 a. 107

49.496 Recovery of correct medical assistance payments. (1) DEFINITIONS In this section:

(a) "Disabled" has the meaning given in s. 49.468 (1) (a) 1.

(b) "Home" means property in which a person has an ownership interest consisting of the person's dwelling and the land used and operated in connection with the dwelling.

(c) "Nursing home" has the meaning given in s. 50.01 (3).

(d) "Recipient" means a person who receives or received medical assistance.

NOTE: Par. (d) is shown as amended eff. 4-1-95 by 1993 Wis. Act 437. Prior to 4-1-95 it reads:

(d) "Recipient" means a person who receives medical assistance.

(2) LIENS ON THE HOMES OF NURSING HOME RESIDENTS (a) Except as provided in par. (b), the department may obtain a lien on a recipient's home if the recipient resides in a nursing home and cannot reasonably be expected to be discharged from the nursing home and return home. The lien is for the amount of medical assistance paid on behalf of the recipient while the recipient resides in a nursing home.

(b) The department may not obtain a lien under this subsection if any of the following persons lawfully reside in the home:

1. The recipient's spouse.

2. The recipient's child who is under age 21 or is disabled.

3. The recipient's sibling who has an ownership interest in the home and who has lived in the home continuously beginning at least 12 months before the recipient was admitted to the nursing home.

(c) Before obtaining a lien on a recipient's home under this subsection, the department shall do all of the following:

1. Notify the recipient in writing of its determination that the recipient cannot reasonably be expected to be discharged from the nursing home, its intent to impose a lien on the recipient's home and the recipient's right to a hearing on whether the requirements for the imposition of a lien are satisfied.

2. Provide the recipient with a hearing if he or she requests one.

(d) The department shall obtain a lien under this subsection by recording a lien claim in the office of the register of deeds of the county in which the home is located.

NOTE: Par. (d) is shown as amended eff. 4-1-95 by 1993 Wis. Act 301 and by 1993 Wis. Act 437. Prior to 4-1-95 it reads:

(d) The department shall obtain a lien under this section by recording a lien claim in the office of the register of deeds of the county in which the home is located.

(e) The department may not enforce a lien under this subsection while the recipient lives unless the recipient sells the home and does not have a living child who is under age 21 or disabled or a living spouse.

(f) The department may not enforce a lien under this subsection after the death of the recipient as long as any of the following survive the recipient:

1. A spouse.

2. A child who is under age 21 or disabled.

3. A child of any age who resides in the home, if that child resided in the home for at least 24 months before the recipient was admitted to the nursing home and provided care to the recipient that delayed the recipient's admission to the nursing home.

4. A sibling who resides in the home, if the sibling resided in the home for at least 12 months before the recipient was admitted to the nursing home.

(g) The department may enforce a lien imposed under this subsection by foreclosure in the same manner as a mortgage on real property.

(h) The department shall file a release of a lien imposed under this subsection if the recipient is discharged from the nursing home and returns to live in the home.

(3) RECOVERY FROM ESTATES (a) Except as provided in par. (b), the department shall file a claim against the estate of a recipient or against the estate of the surviving spouse of a recipient for all of the following unless already recovered by the department under this section:

1. The amount of medical assistance paid on behalf of the recipient while the recipient resided in a nursing home or while the recipient was an inpatient in a medical institution and was required to contribute to the cost of care.

2. The following medical assistance services paid on behalf of the recipient after the recipient attained 55 years of age:

a. Home-based or community-based services under 42 USC 1396d (7) and (8) and under any waiver granted under 42 USC 1396n (c) (4) (B).

b. Related hospital services, as specified by the department by rule.

c. Related prescription drug services, as specified by the department by rule.

NOTE: Par. (a) (intro.) and 1. are shown as renumbered from par. (a) and amended and par. (a) 2. is shown as created eff. 4-1-95 by 1993 Wis. Act 437. Prior to 4-1-95 par. (a) reads:

(a) The department may file a claim against the estate of a recipient or against the estate of the surviving spouse of a recipient for the amount of medical assistance paid on behalf of the recipient while the recipient resided in a nursing home. The affidavit of a person designated by the secretary to administer this subsection is evidence of the amount of the claim.

(ag) The affidavit of a person designated by the secretary to administer this subsection is evidence of the amount of the claim.

NOTE: Par. (ag) is shown as amended from sub. (a) eff. 4-1-95 by 1993 Wis. Act 437.

(am) The court shall reduce the amount of a claim under par. (a) by up to \$3,000 if necessary to allow the recipient's heirs or the beneficiaries of the recipient's will to retain the following personal property:

1. The decedent's wearing apparel and jewelry held for personal use.

2. Household furniture, furnishings and appliances.

3. Other tangible personal property not used in trade, agriculture or other business, not to exceed \$1,000 in value.

(b) A claim under par. (a) is not allowable if the decedent has a surviving child who is under age 21 or disabled or a surviving spouse.

NOTE: Par. (b) is shown as amended eff. 4-1-95 by 1993 Wis. Act 437. Prior to 4-1-95 it reads:

(b) A claim under par. (a) is allowable if the decedent has no surviving child who is under age 21 or disabled and no surviving spouse.

(c) If the department's claim is not allowable because of par. (b) and the estate includes an interest in a home, the court exercising probate jurisdiction shall, in the final judgment, assign the interest in the home subject to a lien in favor of the department for the amount described in par. (a). The personal representative shall record the final judgment as provided in s. 863.29.

(d) The department may not enforce the lien under par. (c) as long as any of the following survive the decedent:

1. A spouse.

2. A child who is under age 21 or disabled.

(e) The department may enforce a lien under par. (c) by foreclosure in the same manner as a mortgage on real property.

(4) ADMINISTRATION. The department may require a county department under s. 46.215 or 46.22 or the governing body of a federally recognized American Indian tribe administering medical assistance to gather and provide the department with information needed to recover medical assistance under this section. The department shall pay to a county department or tribal governing body an amount equal to 5% of the recovery collected by the department relating to a beneficiary for whom the county department or tribal governing body made the last determination of medical assistance eligibility. A county department or tribal governing body may use funds received under this subsection only to pay costs incurred under this subsection and, if any amount remains, to pay for improvements to functions required under s. 46.032. The department may withhold payments under this subsection for failure to comply with the department's requirements under this subsection. The department shall treat payments made under this subsection as costs of administration of the medical assistance program.

(5) USE OF FUNDS. From the appropriation under s. 20.435 (1) (im), the department shall pay the amount of the payments under sub. (4) that is not paid from federal funds, shall pay to the federal government the amount of the funds recovered under this section equal to the amount of federal funds used to pay the benefits recovered under this section and shall spend the remainder of the funds recovered under this section for medical assistance benefits administered under s. 49.45.

(6) APPLICABILITY. (a) The department may recover amounts under this section for medical assistance benefits paid on and after August 15, 1991.

(b) The department may file a claim under sub. (3) only with respect to a recipient who dies after September 30, 1991.

(6m) WAIVER DUE TO HARDSHIP. The department shall promulgate rules establishing standards for determining whether the application of this section would work an undue hardship in individual cases. If the department determines that the application of

this section would work an undue hardship in a particular case, the department shall waive application of this section in that case.

NOTE: Sub. (6m) is created eff. 4-1-95 by 1993 Wis. Act 437.

History: 1991 a. 39, 269; 1993 a. 301, 437, 491

Preserving the Homestead of the Small Estate: Wisconsin's Medical Recovery Law Gilbert. Wis. Law. July 1992

49.497 Recovery of incorrect medical assistance payments. (1) The department may recover any payment made incorrectly for benefits specified under s. 49.46, 49.468 or 49.47 if the incorrect payment results from any misstatement or omission of fact by a person supplying information in an application for benefits under s. 49.46, 49.468 or 49.47. The department may also recover if a medical assistance recipient or any other person responsible for giving information on the recipient's behalf fails to report the receipt of income or assets in an amount that would have affected the recipient's eligibility for benefits. The department's right of recovery is against any medical assistance recipient to whom or on whose behalf the incorrect payment was made. The extent of recovery is limited to the amount of the benefits incorrectly granted. The county department under s. 46.215 or 46.22 or the governing body of a federally recognized American Indian tribe administering medical assistance shall begin recovery actions on behalf of the department according to rules promulgated by the department.

(2) A county or governing body of a federally recognized American Indian tribe may retain 15% of benefits distributed under s. 49.46, 49.468 or 49.47 that are recovered under sub. (1) due to the efforts of an employe or officer of the county or tribe.

(3) Cash assets of medical assistance recipients that exceed asset limitations shall be applied against the cost of medical assistance benefits provided.

History: 1981 c. 20; 1983 a. 27, 192; 1985 a. 176; 1987 a. 27; 1989 a. 31, 173, 359

See note to 767.51 citing In re Paternity of N.L.M., 166 W (2d) 306, 479 NW (2d) 237 (Ct. App. 1991).

49.498 Requirements for skilled nursing facilities.

(1) DEFINITIONS In this section:

(a) "Active treatment for developmental disability" means a continuous program for an individual who has a developmental disability that includes aggressive, consistent implementation of specialized and generic training; treatment, health services and related services, that is directed toward the individual's acquiring behaviors necessary for him or her to function with as much self-determination and independence as possible and that is directed toward preventing or decelerating regression or loss of the individual's current optimal functional status. "Active treatment for developmental disability" does not include services to maintain generally independent individuals with developmental disability who are able to function with little supervision or in the absence of active treatment for developmental disability.

(b) "Active treatment for mental illness" means the implementation of an individualized plan of care for an individual with mental illness that is developed under and supervised by a physician licensed under ch. 448 and other qualified mental health care providers and that prescribes specific therapies and activities for the treatment of the individual while the individual experiences an acute episode of severe mental illness which necessitates supervision by trained mental health care providers

(c) "Developmental disability" means any of the following:

1. Significantly subaverage general intellectual functioning that is concurrent with an individual's deficits in adaptive behavior and that manifested during the individual's developmental period.

2. A severe, chronic disability that meets all of the conditions for individuals with related conditions as specified in 42 CFR 435.1009.

(d) "Licensed health professional" has the meaning given under 42 USC 1396r (b) (5) (G).

(e) "Managing employe" means a general manager, business manager, administrator, director or other individual who exercises operational or managerial control over, or who directly or indirectly conducts, the operation of the facility.

(f) "Medicare" means coverage under part A or part B of Title XVIII of the federal social security act, 42 USC 1395 to 1395zz.

(g) "Mental illness" has the meaning given under 42 USC 1396r (e) (7) (G) (i).

(h) "Nurse's assistant" has the meaning given for "nurse aide" under 42 USC 1396r (b) (5) (F).

(i) "Nursing facility" has the meaning given under 42 USC 1396r (a).

(j) "Physician" has the meaning given under s. 448 01 (5).

(k) "Psychopharmacologic drugs" means drugs that modify psychological functions and mental states.

(L) "Registered professional nurse" means a registered nurse who is licensed under ch. 441.

(m) "Resident" means an individual who resides in a nursing facility.

(2) REQUIREMENTS RELATING TO PROVISION OF SERVICES (a) 1. A nursing facility shall care for its residents in such a manner and in such an environment as will promote maintenance or enhancement of the quality of life of each resident.

2. A nursing facility shall maintain a quality assessment and assurance committee that consists of the director of nursing services, a physician who is designated by the nursing facility and at least 3 other members of the nursing facility staff and that shall do all of the following:

a. Meet at least every 3 months to identify issues with respect to which quality assessment and assurance activities are necessary.

b. Develop and implement appropriate plans of action to correct identified quality deficiencies.

(b) A nursing facility shall provide services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident in accordance with a written plan of care for each resident which:

1. Describes the medical, nursing and psychosocial needs of the resident and how the needs shall be met;

2. Is initially prepared, with participation to the extent practicable of the resident or the resident's family or legal counsel, by a team which includes the resident's attending physician and a registered professional nurse who has responsibility for the resident; and

3. Is periodically reviewed and revised by the team in subd. 2. after the conduct of an assessment under par. (c).

(c) 1. A nursing facility shall conduct a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity that:

a. Describes the resident's capability to perform daily life functions and significant impairments in the resident's functional capacity.

b. Is based on a uniform minimum data set of core elements and common definitions specified as required under 42 USC 1395i-3 (f) (6) (A).

c. Uses an instrument which shall be specified by the department by rule.

d. Includes identification of the resident's medical problems.

2. A registered professional nurse shall conduct or coordinate with the appropriate participation of health professionals, sign and certify the completion of an assessment under subd. 1. Each individual who completes a portion of the assessment shall sign and certify as to the accuracy of that portion of the assessment.

3. No individual may wilfully and knowingly certify under subd. 2. a material and false statement in an assessment.

4. No individual may wilfully and knowingly cause another individual to certify under subd. 2. a material and false statement in an assessment.

5. If the department determines by survey of a nursing facility or otherwise that an individual has knowingly and wilfully certified a false assessment under subd. 2., the department may require that individuals who are independent of the nursing facility and are approved by the department conduct and certify assessments under this paragraph.

6. A nursing facility shall:

a. Conduct an assessment under subd. 1. no later than 4 days after the admission of an individual admitted after September 30, 1990.

b. Conduct all of the assessments under subd. 1. for a resident of the nursing facility by October 1, 1991, for a resident who resides in the facility on that date; promptly after a significant change in a resident's physical or mental condition; and, for every resident, no less often than once every 12 months.

c. Examine a resident no less frequently than once every 3 months and, as appropriate, revise the resident's assessment under subd. 1. to assure the assessment's continuing accuracy.

7. The assessment conducted under subd. 1. shall be used in developing, reviewing and revising a nursing facility resident's plan of care under par. (b).

8. A nursing facility shall coordinate an assessment conducted under this paragraph with the conduct of preadmission screening under s. 49.45 (6c) (b) to the maximum extent practicable in order to avoid duplicative testing and effort.

(d) 1. To the extent needed to fulfill the plans of care required under par. (b), a nursing facility shall provide or arrange for the provision of all of the following, which shall meet professional standards of quality:

a. Nursing services and specialized rehabilitative services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

b. Medically related social services to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident.

c. Pharmaceutical services, including procedures that assure the accurate acquiring, receiving, dispensing and administering of all drugs and biologicals, to meet the needs of each resident.

d. Dietary services that assure that the meals meet the daily nutritional and special dietary needs of each resident.

e. An ongoing program, directed by a qualified professional, of activities designed to meet the interests and the physical, mental and psychosocial well-being of each resident.

f. Routine dental services to the extent covered under the approved state medicaid plan and emergency dental services to meet the needs of each resident.

2. Services specified under subd. 1. a. to d. and f. shall be provided to a resident by qualified persons in accordance with the resident's written plan of care under par. (b).

3. Unless waived under subd. 4., a nursing facility shall:

a. Provide 24-hour per day licensed nursing services which are sufficient to meet the nursing needs of its residents; and

b. Shall use the services of a registered professional nurse at least 8 consecutive hours per day, 7 days per week.

4. Subject to subd. 5., the department may waive the requirement under subd. 3. a. or b. if all of the following apply:

a. The nursing facility demonstrates to the satisfaction of the department that the nursing facility has been unable, despite diligent efforts including offering wages at the community prevailing rate for nursing facilities, to recruit appropriate personnel.

b. The department determines that a waiver of the requirement will not endanger the health or safety of nursing facility residents.

c. The department finds that a registered professional nurse or a physician is obligated to respond immediately to telephone calls from the nursing facility for any periods in which licensed nursing services are not available.

5. A waiver under subd. 4. is subject to annual review by the department and to review by the secretary of the federal department of health and human services. The department may, in granting or reviewing a waiver, require the nursing facility to employ other qualified, licensed personnel.

(e) Except as otherwise provided in s. 146.40, all of the following apply:

1. A nursing facility shall provide, for individuals used as nurse's assistants by the facility as of July 1, 1989, for a competency evaluation program that is approved by the department under s. 146.40 (3m) and for the preparation necessary for the individual to complete the program by January 1, 1990.

2. A nursing facility may not use the individual as a nurse's assistant unless the nursing facility has inquired of the department concerning information about the individual in the registry under s. 146.40 (4g).

3. A nursing facility shall provide the regular performance review and regular in-service education that assures that individuals used as nurse's assistants are competent to perform services as nurse's assistants, including training for individuals to provide nursing and nursing-related services to nursing facility residents with cognitive impairments.

(f) A nursing facility shall do all of the following:

1. Require that the health care of every nursing facility resident be provided under the supervision of a physician.

2. Provide for the availability of a physician to furnish necessary medical care in case of emergency.

3. Maintain clinical records on all nursing facility residents which include all of the following:

a. Written plans of care, as required under par. (b).

b. Assessments, as required under par. (c).

c. Results of any preadmission screening conducted under s. 49.45 (6c) (b).

(g) A nursing facility with more than 120 beds shall employ full-time at least one social worker with at least a bachelor's degree in social work or similar professional qualifications to provide or assure the provision of social services.

(3) RESIDENT'S RIGHTS; GENERAL RIGHTS (a) A nursing facility shall protect and promote the rights of each resident, including each of the following rights:

1. The right to choose a personal attending physician, to be fully informed in advance about care and treatment, to be fully informed in advance of any changes in care or treatment that may affect the resident's well-being, and, except with respect to a resident found incompetent under s. 880.33, to participate in planning care and treatment or changes in care and treatment.

2. The right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for the purpose of discipline or convenience and not required to treat the resident's medical symptoms. Restraints may only be imposed:

a. To ensure the physical safety of the resident or other residents; and

b. Upon the written order of a physician that specifies the duration and circumstances under which the restraints are to be used, except in emergency circumstances until the order could reasonably be obtained.

3. The right to privacy with regard to accommodations, medical treatment, written and telephonic communications, visits, and meetings of family and of resident groups, except that this subdivision may not be construed to require provision of a private room.

4. The right to confidentiality of personal and clinical records.

5. The rights:

a. To reside and receive services with reasonable accommodations of individual needs and preferences, except where the health or safety of the individual or other residents would be endangered; and

b. To receive notice before the room or roommate of the resident in the nursing facility is changed.

6. The right to voice grievances with respect to treatment or care that is or is not furnished, without discrimination or reprisal for voicing the grievances, and the right to prompt efforts by the nursing facility to resolve grievances that the resident may have, including those with respect to the behavior of other residents.

7. The right of the resident to organize and participate in resident groups in the nursing facility and the right of the resident's family to meet in the nursing facility with the families of other residents in the nursing facility.

8. The right of the resident to participate in social, religious and community activities that do not interfere with the rights of other residents in the nursing facility.

9. The right to examine, upon reasonable request, the results of the most recent survey of the facility conducted by the federal department of health and human services or the department with respect to the nursing facility and any plan of correction in effect with respect to the nursing facility.

10. Any other right specified in rules that the department shall promulgate in conformity with federal regulations.

(b) Except as provided in par. (c), a nursing facility shall do all of the following:

1. Inform each resident, orally and in writing at the time of admission to the nursing facility, of the resident's legal rights during the stay at the nursing facility, including a description of the protection of personal funds under sub. (8) and a statement that a resident may file a complaint with the department under s. 146.40 (4r) (a) concerning neglect, abuse or misappropriation of property of a resident.

2. Make available to each resident, upon reasonable request, a written statement of the rights specified in subd. 1. which is updated upon changes in nursing rights.

3. Inform each resident who is entitled to medical assistance:

a. At the time of admission to the nursing facility or, if later, at the time the resident becomes eligible for medical assistance, of the items and services that are included in nursing facility services under the approved state medicaid plan and for which the resident may not be charged, except as permitted, and of other items and services that the nursing facility offers and for which the resident may be charged and the amount of the charges for the items and services; and

b. Of changes in the items and services described in subd. 3. a. and of changes in the charges imposed for items and services described in subd. 3. a.

4. Inform each other resident, in writing before or at the time of admission and periodically during the resident's stay, of services available in the nursing facility and of related charges for the services, including any charges for services not covered under medicare or by the nursing facility's basic per diem charge.

(c) For a resident who is found incompetent under s. 880.33, the rights of a resident under this subsection devolve upon and, to the extent determined necessary by a court of competent jurisdiction, are exercised by the resident's guardian appointed under s. 880.33.

(d) Psychopharmacologic drugs may be administered to a resident only on the orders of a physician and only as part of a plan included in the written plan of care under par. (b) designed to eliminate or modify the symptoms for which the drugs are prescribed and only if, at least annually, an independent, external consultant reviews the appropriateness of the drug plan of each resident receiving the pharmacologic drugs.

(4) RESIDENT'S RIGHTS; TRANSFER AND DISCHARGE RIGHTS. (a) A nursing facility shall permit a resident to remain in the nursing

facility and may not transfer or discharge the resident from the nursing facility unless one of the following applies:

1. The transfer or discharge is necessary to meet the resident's welfare and the resident's welfare cannot be met in the nursing facility, as documented by the resident's physician in the resident's clinical record.

2. The transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the nursing facility, as documented by the resident's physician in the resident's clinical record.

3. The safety of individuals in the nursing facility is endangered, as documented in the resident's clinical record.

4. The health of individuals in the nursing facility would otherwise be endangered, as documented by a physician in the resident's clinical record.

5. The resident has failed, after reasonable and appropriate notice, to pay or have paid on his or her behalf under medical assistance or under medicare for a stay at the nursing facility. If a resident becomes eligible for medical assistance after admission to the nursing facility, only charges that may be imposed under medical assistance may be allowed in enforcement of this subdivision.

6. The nursing facility ceases to operate.

(b) 1. Before effecting a transfer or discharge of a resident a nursing facility shall note in the resident's record and notify the resident and, if known, an immediate family member of the resident or the resident's legal counsel concerning the transfer or discharge and the reasons for it, at least 30 days in advance of the resident's transfer or discharge, except that the nursing facility shall notify as soon as practicable in the circumstances specified in par. (a) 3. or 4; in the circumstance specified in par. (a) 2 in which the resident's health improves sufficiently to permit a more immediate transfer or discharge; in the circumstances specified in par. (a) 1. in which a more immediate transfer or discharge is necessitated by the resident's urgent medical needs; or in the instance in which a resident has resided in the nursing facility fewer than 30 days.

2. Each notice under subd. 1. shall include all of the following:

a. For transfers or discharges effected after September 30, 1990, notice of the resident's right to appeal the transfer or discharge under a mechanism for hearing the appeals that is established by the department by rule.

b. The name, mailing address and telephone number of the long-term care ombudsman program under s. 16.009 (2) (b).

c. For a resident with developmental disability or mental illness, the mailing address and telephone number of the protection and advocacy agency designated under s. 51.62 (2) (a).

(c) A nursing facility shall provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the nursing facility.

(d) 1. Before a resident of a nursing facility is transferred for hospitalization or therapeutic leave, a nursing facility shall provide written information to the resident and an immediate family member or legal counsel concerning all of the following:

a. The provisions of the approved state medicaid plan concerning the period, if any, during which the resident is permitted to return and resume residence in the nursing facility.

b. The policies of the nursing facility regarding subd. 1. a., which shall be consistent with subd. 1. a.

2. At the time of a resident's transfer to a hospital for therapeutic leave, a nursing facility shall provide written notice to the resident and an immediate family member or legal counsel of the duration of the period, if any, specified in subd. 1. a.

3. A nursing facility shall establish and follow a written policy under which a resident, who is eligible for medical assistance for nursing facility services, who is transferred from the nursing facility for hospitalization or therapeutic leave and whose hospitaliza-

tion or therapeutic leave exceeds a period paid for by medical assistance for the resident, shall be permitted to be readmitted to the nursing facility immediately upon the first availability of a bed in a semiprivate room in the nursing facility, if at the time of readmission the resident requires the services provided by the nursing facility.

(5) RESIDENT'S RIGHTS; ACCESS AND VISITATION RIGHTS. A nursing facility shall do all of the following:

(a) Permit immediate access to a resident by the department, by any representative of the secretary of the federal department of health and human services, by a representative of the board on aging and long-term care, by a representative of the protection and advocacy agency designated under s. 51.62 (2) (a) or by the resident's attending physician.

(b) Permit immediate access to a resident by immediate family or other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time.

(c) Permit immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time.

(d) Permit reasonable access to a resident by any entity or individual that provides health, social, legal or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(e) Permit a designated representative of the long-term care ombudsman under s. 16.009 (4), with the permission of the resident or the resident's legal counsel, and in accordance with s. 16.009 (4) (b) 1. d., to examine a resident's clinical records.

(6) EQUAL ACCESS TO QUALITY CARE. (a) A nursing facility shall establish and maintain identical policies and practices regarding transfer, discharge and the provision of services required under the approved state medicaid plan for all individuals regardless of payment.

(b) Paragraph (a) may not be construed to prohibit a nursing facility from charging any amount for services furnished, consistent with the notice required under sub. (3) (b) 3.

(c) Paragraph (a) may not be construed to require the department to provide additional services on behalf of a resident than are otherwise provided under the approved state medicaid plan.

(7) ADMISSIONS POLICY. (a) Except as provided in par. (b), with respect to admissions practices of a nursing facility:

1. A nursing facility may not require individuals applying to reside or residing in the facility to waive their rights to benefits under medical assistance or under medicare.

2. A nursing facility may not require oral or written assurance that individuals applying to reside or residing in the nursing facility are ineligible for or will not apply for medical assistance or medicare.

3. A nursing facility shall prominently display written information in the nursing facility and provide oral and written information to individuals applying to reside or residing in the nursing facility concerning how to apply for and use benefits under medical assistance and how to receive refunds for previous payments covered by these benefits.

4. A nursing facility may not require a 3rd-party guarantee of payment to the nursing facility as a condition of admission or expedited admission to or continued stay in the nursing facility.

5. With respect to an individual who is entitled to medical assistance for nursing facility services, a nursing facility may not charge, solicit, accept or receive, in addition to any amount otherwise required to be paid under the approved state medicaid plan, a gift, money, donation or other consideration as a precondition of admitting or expediting the admission of an individual to the nursing facility or as a requirement for the individual's continued stay in the facility.

(b) Paragraph (a) may not be construed to do any of the following:

1. Prevent the department from prohibiting discrimination against individuals who are entitled to medical assistance under the approved state medicaid plan with respect to admissions practices of nursing facilities.

1m. Permit a county, city, town or village to implement nursing facility admissions policies that conflict with state law.

2. Prevent a nursing facility from requiring an individual who has legal access to a resident's income or resources available to pay for care in the nursing facility, to sign a contract, without incurring personal financial liability, to provide payment from the resident's income or resources for care in the nursing facility.

3. Prevent a nursing facility from charging a resident who is eligible for medical assistance for items or services that the resident has requested and received and that are not included in the approved state medicaid plan.

4. Prohibit a nursing facility from soliciting, accepting or receiving a charitable, religious or philanthropic contribution from an organization or from a person who is unrelated to the resident or potential resident, but only to the extent that the contribution is not a condition of admission, expediting admission or continued stay in the nursing facility.

(8) PROTECTION OF RESIDENT FUNDS. (a) A nursing facility:

1. May not require a resident to deposit his or her personal funds with the nursing facility.

2. Upon the written authorization of a resident, shall hold, safeguard and account for the resident's personal funds under a system established and maintained by the nursing facility that is in accordance with par. (b).

(b) Upon written authorization of a resident under par. (a), the nursing facility shall manage and account for the resident's personal funds deposited with the nursing facility as follows:

1. The nursing facility shall deposit any amount of a resident's personal funds in excess of \$50 in an interest-bearing account that is separate from any of the nursing facility's operating accounts and credits all interest earned on the separate account to the account. The nursing facility shall maintain a resident's personal funds that do not exceed \$50 in a noninterest-bearing account or petty cash fund.

2. The nursing facility shall assure a full and complete separate accounting of the personal funds of each resident for whom the facility has written authorization, maintain a written record of all financial transactions involving the personal funds of the resident deposited with the nursing facility and afford the resident or the resident's legal representative with reasonable access to the record.

3. The nursing facility shall notify each resident receiving medical assistance of all of the following:

a. When the amount in the resident's account is \$200 less than the dollar amount permitted under 42 USC 1381 to 1385.

b. That if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the amount under 42 USC 1382 (a) (3) (B) the resident may lose eligibility for medical assistance or for supplemental security income benefits.

4. Upon the death of a resident with an account under subd. 1., the nursing facility shall promptly convey the resident's personal funds and a final accounting of the funds to the individual administering the resident's estate.

5. The nursing facility shall purchase a surety bond or otherwise provide satisfactory assurance of the security of all personal funds of residents that are deposited with the nursing facility.

6. The nursing facility may not impose a charge against the personal funds of a resident for any item or service for which payment is made by medical assistance or medicare.

(8m) POSTING OF SURVEY RESULTS. A nursing facility shall post in a place that is readily accessible to residents, residents' family members and residents' legal representatives, the results of the most recent survey of the facility conducted under sub. (13).

(9) ADMINISTRATION REQUIREMENTS. (a) A nursing facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, consistent with federal regulations.

(b) If a change occurs in any of the following, the nursing facility shall provide notice to the department, at the time of the change, of the change and the identity of each new person or company under the change:

1. The persons with an ownership or control interest in the nursing facility.

2. The persons who are officers, directors, agents or managing employees of the nursing facility.

3. The corporation, association or other company responsible for the management of the nursing facility.

4. The individual who is the administrator or director of the nursing facility.

(c) The administrator of a nursing facility shall meet standards established under 42 USC 1396r (f) (4).

(10) LICENSING REQUIREMENTS. (a) A nursing facility shall be licensed under s. 50.03 (1).

(b) Except as waived under 42 USC 1396r (d) (2) (B) (i) or found under 42 USC 1396r (d) (2) (B) (ii), a nursing facility shall meet the provisions that are applicable to nursing homes of the edition of the life safety code of the national fire protection association specified in federal regulations.

(11) INFECTION CONTROL. A nursing facility shall do all of the following:

(a) Establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection.

(b) Be designed, constructed, equipped and maintained in a manner so as to protect the health and safety of residents, personnel and the general public.

(12) COMPLIANCE WITH LAWS, REGULATIONS AND PROFESSIONAL STANDARDS. (a) A nursing facility shall operate and provide services in compliance with all applicable state laws and federal regulations and with accepted professional standards and principles that apply to professionals providing services in the nursing facility.

(b) A nursing facility shall meet requirements relating to the health and safety of residents or relating to physical facilities for the health and safety of residents under regulations promulgated by the federal department of health and human services.

(13) ANNUAL STANDARD SURVEY. A nursing facility is subject to a standard survey under 42 USC 1396r (g) (2) (A) (i). No person may notify a nursing facility or cause a nursing facility to be notified of the time or date on which the survey is scheduled to be conducted.

(14) RULE MAKING. The department shall promulgate all of the following rules:

(a) Establishing a fair mechanism meeting the requirements of 42 USC 1396r (e) (3) and (f) (3) for hearing appeals on transfers and discharges of residents from nursing facilities.

(b) Specifying an instrument for use in performing assessments of residents under sub. (2) (c) 1. c.

(c) Establishing criteria for the denial of payment under s. 49.45 (6m) (d) 5., for the imposition of forfeitures under sub. (16) (b), for the placement of a monitor or appointment of a receiver for a facility under sub. (17) and for closure of a facility under sub. (18) that do all of the following:

1. Are consistent with federal regulations promulgated to interpret 42 USC 1396r.

2. Are designed so as to minimize the time between the identification of violations and final imposition of the penalties.

3. Provide incrementally more severe penalties for repeated or uncorrected deficiencies.

(d) Establishing the percentage of interest to be assessed under sub. (16) (d).

(15) CLASSIFICATION OF VIOLATIONS. (a) A class "1" violation is a violation of this section or of the rules promulgated under this section which creates a condition or occurrence relating to the operation and maintenance of a nursing facility presenting a substantial probability that death or serious mental or physical harm to a resident will result therefrom.

(b) A class "2" violation is a violation of this section or of the rules promulgated under this section which creates a condition or occurrence relating to the operation and maintenance of a nursing facility directly threatening to the health, safety or welfare of a resident.

(c) A class "3" violation is a violation of this section or of the rules promulgated under this section which creates a condition or occurrence relating to the operation and maintenance of a nursing facility which does not directly threaten the health, safety or welfare of a resident.

(d) Each day of violation constitutes a separate violation. The department shall have the burden of showing that a violation existed on each day for which a forfeiture is assessed. No forfeiture may be assessed for a condition for which the nursing facility has received a variance or waiver of a standard.

(16) FORFEITURES, PENALTY ASSESSMENTS AND INTEREST. (a) Any operator or owner of a nursing facility which is in violation of this section or any rule promulgated under this section may be subject to the following forfeitures:

1. A class "1" violation may be subject to a forfeiture of not more than \$250 for each violation.

2. A class "2" violation may be subject to a forfeiture of not more than \$125 for each violation.

3. A class "3" violation may be subject to a forfeiture of not more than \$60 for each violation.

(b) In determining whether a forfeiture is to be imposed and in fixing the amount of the forfeiture to be imposed, if any, for a violation, factors shall be considered that are established in rules that shall be promulgated by the department consistent with federal regulations promulgated to interpret 42 USC 1396r.

(c) 1. Whenever the department imposes a forfeiture under par. (a) for a violation of this section or the rules promulgated under this section, the department shall in addition levy a penalty assessment in the following amounts:

a. For a class "1" violation, not less than \$5,100 nor more than \$10,000.

b. For a class "2" violation, not less than \$2,600 nor more than \$5,000.

c. For a class "3" violation, not less than \$100 nor more than \$2,500.

2. Notwithstanding subd. 1., whenever the department imposes a forfeiture under par. (a) for the violation of the following, the department shall levy a penalty assessment in the following amounts:

a. For a violation of sub. (2) (c) 3., \$1,000

b. For a violation of sub. (2) (c) 4., \$5,000.

c. For a violation of sub. (13), \$2,000.

3. If multiple violations are involved, the penalty assessment levied under subd. 1. or 2. shall be based on the total forfeitures for all violations.

(d) If the period of the violation under par. (a) is longer than one day, the penalty assessment shall additionally include interest for each day of the period at a rate established in rules that the department shall promulgate, except that no interest shall be computed for a day in the period between the date on which a request for a hearing, if any, is filed under par. (f) and the date of the con-

clusion of all administrative and judicial proceedings arising out of the imposition of a forfeiture under par. (a).

(dm) In determining whether a forfeiture is to be imposed and in fixing the amount of the forfeiture to be imposed, if any, for a violation, factors shall be considered that are established in rules that shall be promulgated by the department consistent with federal regulations promulgated to interpret 42 USC 1396r.

(e) The department may directly assess forfeitures provided for under par. (a), penalty assessments provided for under par. (c) and interest provided for under par. (d). If the department determines that a forfeiture should be assessed for a particular violation or for failure to correct it, it shall send a notice of assessment to the nursing facility. The notice shall specify the amount of the forfeiture assessed, the amount of the penalty assessment, the violation, the statute or rule alleged to have been violated, and shall inform the licensee of the right to hearing under par. (f).

(f) A nursing facility may contest an assessment of forfeiture, penalty assessment or interest, if any, by sending a written request for hearing under s. 227.44 to the division of hearings and appeals created under s. 15.103 (1). The administrator may designate a hearing examiner to preside over the case and recommend a decision to the administrator under s. 227.46. The decision of the administrator shall be the final administrative decision. The division shall commence the hearing within 30 days of receipt of the request for hearing and shall issue a final decision within 15 days after the close of the hearing. Proceedings before the division are governed by ch. 227. In any petition for judicial review of a decision by the division, the department, if not the petitioner who was in the proceeding before the division, shall be the named respondent.

(g) All forfeitures, penalty assessments and interest, if any, shall be paid to the department within 10 days of receipt of notice of assessment or, if the forfeiture, penalty assessment and interest, if any, are contested under par. (f), within 10 days of receipt of the final decision after exhaustion of administrative review, unless the final decision is appealed and the order is stayed by court order under sub. (19) (b). The department shall remit all forfeitures paid to the state treasurer for deposit in the school fund. The department shall deposit all penalty assessments and interest in the appropriation under s. 20.435 (1) (g).

(h) The attorney general may bring an action in the name of the state to collect any forfeiture, penalty assessment or interest, if any, imposed under par. (e) or (f) if the forfeiture, penalty assessment or interest, if any, has not been paid following the exhaustion of all administrative and judicial reviews. The only issue to be contested in any such action shall be whether the forfeiture, penalty assessment or interest has been paid.

(17) **TEMPORARY MANAGEMENT.** Any nursing facility that is in violation of this section or any rule promulgated under this section may be subject to placement of a monitor or appointment of a receiver, under the procedures and criteria specified in s. 50.05 and under criteria promulgated as rules by the department under sub. (14) (c).

(18) **NURSING FACILITY CLOSURE AND RESIDENT TRANSFER** (a) Any nursing facility that is in violation of this section or any rule promulgated under this section may, in an emergency as determined by the department, be subject to closure by the department or to the transfer of residents of the nursing facility to another nursing facility, or both, under criteria promulgated as rules by the department under sub. (14) (c).

(b) A nursing facility may contest closure of the nursing facility or transfer of residents of the nursing facility, if any, by sending a written request for hearing under s. 227.44 to the division of hearings and appeals created under s. 15.103 (1). The administrator may designate a hearing examiner to preside over the case and recommend a decision to the administrator under s. 227.46. The decision of the administrator shall be the final administrative decision. The division shall commence the hearing within 30 days of receipt of the request for hearing and shall issue a final decision

within 15 days after the close of the hearing. Proceedings before the division are governed by ch. 227. In any petition for judicial review of a decision by the division, the department, if not the petitioner who was in the proceeding before the division, shall be the named respondent.

(19) **JUDICIAL REVIEW.** (a) All administrative remedies shall be exhausted before an agency determination under this section shall be subject to judicial review. Final decisions after hearing shall be subject to judicial review exclusively as provided in s. 227.52, except that any petition for review of department action under this section shall be filed within 15 days after receipt of notice of the final agency determination.

(b) The court may stay enforcement under s. 227.54 of the department's final decision if a showing is made that there is a substantial probability that the party seeking review will prevail on the merits and will suffer irreparable harm if a stay is not granted, and that the nursing facility will meet the requirements of this section and the rules promulgated under this section during such stay. Where a stay is granted the court may impose such conditions on the granting of the stay as may be necessary to safeguard the lives, health, rights, safety and welfare of residents, and to assure compliance by the nursing facility with the requirements of this section.

(c) The attorney general may delegate to the department the authority to represent the state in any action brought to challenge department decisions prior to exhaustion of administrative remedies and final disposition by the division of hearings and appeals created under s. 15.103 (1).

(20) **VIOLATIONS.** If an act forms the basis for a violation of this section and s. 50.04, the department or the attorney general may impose sanctions in conformity with this section or under s. 50.04, but not both.

History: 1989 a 31; 1991 a 32, 39; 1993 a 16.

49.499 Nursing facility resident protection. From the appropriation under s. 20.435 (1) (g), the department shall contribute to the payment of all of the following, as needed by a resident in a nursing facility, as defined in s. 49.498 (1) (i), that is in violation of s. 49.498 or of a rule promulgated under s. 49.498:

(1) The cost of relocating the resident from the nursing facility to another nursing facility.

(2) Maintenance of operation of a nursing facility pending correction of deficiencies or closure of the nursing facility.

(3) Reimbursement of the resident for any personal funds of the resident that were misappropriated by the nursing facility staff or other persons holding an interest in the nursing facility.

History: 1989 a 31

ADMINISTRATION OF SECURITY AIDS

49.50 State supervision. (1) **DEFINITION.** In this section, "child care provider" means a child care provider that is licensed under s. 48.65 (1), certified under s. 48.651 or established or contracted for under s. 120.13 (14).

(2) **RULES; MERIT SYSTEM.** The department shall promulgate rules for the efficient administration of aid to families with dependent children in agreement with the requirement for federal aid, including the establishment and maintenance of personnel standards on a merit basis. The provisions of this section relating to personnel standards on a merit basis supersede any inconsistent provisions of any law relating to county personnel. This subsection shall not be construed to invalidate the provisions of s. 46.22 (1) (d).

(3) **PERSONNEL EXAMINATIONS.** Statewide examinations to ascertain qualifications of applicants in any county department administering aid to families with dependent children shall be given by the administrator of the division of merit recruitment and selection in the department of employment relations. The department of employment relations shall be reimbursed for actual expenditures incurred in the performance of its functions under

this section from the appropriations available to the department of health and social services for administrative expenditures.

(4) **PERSONNEL LISTS.** All persons who are qualified as a result of examinations shall be certified to the counties in which they reside at the time of examination; if there are no resident qualified persons for any class of positions on the list certified to the county, appointments shall be made from available lists without regard to residence within the county.

(5) **COUNTY PERSONNEL SYSTEMS.** Pursuant to rules promulgated under sub. (2), the department where requested by the county shall delegate to that county, without restriction because of enumeration, any or all of the department's authority under sub. (2) to establish and maintain personnel standards including salary levels.

(6) **DEPARTMENT TO ADVISE COUNTIES.** The department shall advise all county officers charged with the administration of such laws of these requirements and shall render all possible assistance in securing compliance therewith, including the preparation of necessary blanks and reports. The department shall also publish such information as it deems advisable to acquaint persons entitled to public assistance and the public generally with the laws governing the same.

(6e) **DAY CARE FUNDS FOR CERTAIN RECIPIENTS OF AID TO FAMILIES OF DEPENDENT CHILDREN** (a) The department shall provide funds to pay child care costs of individuals receiving aid to families with dependent children under s. 49.19 who are participating in self-initiated education or training activities that are approved by the department if the child care is provided by a child care provider.

(b) Within the limits of funds available under s. 20.435 (4) (cn) and (na), the department shall provide funds for individuals who are working and who receive aid to families with dependent children to pay child care costs in excess of the amount of the child care disregard under s. 49.19 (5) (a) and child care costs incurred before the child care disregard under s. 49.19 (5) (a) becomes available if the child care is provided by a child care provider.

(6g) **DAY CARE FUNDS FOR FORMER RECIPIENTS OF AID TO FAMILIES WITH DEPENDENT CHILDREN.** The department shall pay the child care costs of an individual who secures unsubsidized employment and loses eligibility for aid to families with dependent children because of earned income or number of hours worked for up to 12 months following the loss of eligibility if the child care is provided by a child care provider. The department shall establish a formula for assistance based on ability to pay. The rates for child care services under this subsection shall be determined under s. 46.98 (4) (d), or, if a higher rate is established under s. 46.98 (4) (e) and if the child care services meet the quality standards established under s. 46.98 (4) (e), the rates for child care services under this subsection that meet those standards shall be determined under s. 46.98 (4) (e). The department shall promulgate rules for the disbursement of funds under this subsection.

(6k) **ADMINISTRATION OF DAY CARE FUNDS.** (a) County departments under ss. 46.215, 46.22 and 46.23 shall administer the funds appropriated for the purpose of providing child care under subs. (6e) (b) and (6g) for recipients and former recipients of aid under s. 49.19 and under sub. (7) (e) for participants in the learnfare program. The department shall allocate funds to county departments under ss. 46.215, 46.22 and 46.23 for the purposes of this paragraph.

(b) Beginning on January 1, 1994, a county department under s. 46.215, 46.22 or 46.23 may, with the approval of the department, provide payment for, or reimbursement of, child care under s. 49.193 (8) or 49.50 (6e) (a) using funds allocated under par. (a). The department shall approve or disapprove this use of funds under criteria established to maximize state and federal funding available for child care.

(6n) **DAY CARE EXPENDITURE INFORMATION.** The department shall collect information on expenditures for child care for indi-

viduals participating in the employment and training programs under this section.

(7) **LEARNFARE PROGRAM.** (a) In this subsection, "school" means any one of the following:

1. A public school, as described in s. 115.01 (1).
2. A private school, as defined in s. 115.001 (3r).
3. A technical college pursuant to a contract under s. 118.15 (2).
4. A course of study meeting the standards established by the state superintendent of public instruction under s. 115.29 (4) for the granting of a declaration of equivalency of high school graduation.

(e) For an individual who is a recipient of aid under s. 49.19, who is the parent with whom a dependent child lives and who is either required to attend school under par. (g) or is under 20 years of age and wants to attend school, the department shall make a monthly payment to the individual or the child care provider for the month's child care costs in an amount based on need with the maximum amount per child equal to the lesser of the actual cost of the care or the rate established under s. 46.98 (4) (d) or, if a higher rate is established under s. 46.98 (4) (e) and if the child care meets the quality standards established under s. 46.98 (4) (e), in an amount based on need with the maximum amount per child equal to the lesser of the actual cost of the care or the rate established under s. 46.98 (4) (e), if the individual demonstrates the need to purchase child care services in order to attend school and those services are available from a child care provider.

(g) An individual who is a recipient of aid under s. 49.19 shall attend school to meet the participation requirements of the program under this subsection if all of the following apply:

1. Before the first day of the fall 1994 school term, as defined in s. 115.001 (12), the individual is 13 to 19 years of age. Beginning on the first day of the fall 1994 school term, as defined in s. 115.001 (12), the individual is 13 to 19 years of age or the individual lives in a county designated by the department under par. (j) and is required to attend school under that paragraph.
2. The individual has not graduated from a public or private high school or obtained a declaration of equivalency of high school graduation under s. 115.29 (4).
3. The individual is not excused from attending school under s. 118.15 (3).
4. The individual is a parent or is residing with his or her natural or adoptive parent.
5. If the individual is the caretaker of a child, the child is at least 45 days old and child care is available for the child at the school or the school provides an instruction program for the caretaker at home.
6. If child care services are necessary in order for the individual to attend school, child care from a child care provider is available for the child and transportation to and from child care is also available.
7. The individual is not prohibited from attending school while an expulsion under s. 119.25 or 120.13 (1) is pending.
8. If the individual was expelled from a school under s. 119.25 or 120.13 (1), there is another school available which the individual can attend.
9. The individual does not have good cause for failing to attend school, as defined by the department by rule.
10. If the individual is the mother of a child, a physician has not determined that the individual should delay her return to school after giving birth.
11. If the individual is on a waiting list for a children-at-risk program under s. 118.153, a children-at-risk program that is appropriate for the individual is not available.

(gm) The first time that an individual fails to meet the requirements under par. (g), the county department under s. 46.215, 46.22

or 46.23 shall offer case management services described in s. 46.62 to the individual and his or her family.

(h) 1. An individual who is 6 to 12 years of age and who fails to meet the requirements under par. (g) is subject to sanctions as provided by the department by rule only if all of the following apply:

a. The county department under s. 46.215, 46.22 or 46.23 complies with par. (gm).

b. The individual's family fails to cooperate with the case manager or fails to engage in the activities identified by the case manager as being necessary to improve the individual's school attendance.

c. The individual continues to fail to meet the requirements under par. (g).

1m. An individual who is 13 to 19 years of age and fails to meet the requirements under par. (g) is subject to sanctions as provided by the department by rule.

2. If, as a result of the application of sanctions under this paragraph, no child in a family receives payment under s. 49.19, the department shall make a payment to meet only the needs of the parent or parents who would otherwise be eligible for aid under s. 49.19.

(hm) The department may require consent to the release of school attendance records, under s. 118.125 (2) (e), as a condition of eligibility for aid under s. 49.19.

(hr) If an individual required to attend school under par. (g) is enrolled in a public school, communications between the school district and the department or a county department under s. 46.215, 46.22 or 46.23 concerning the individual's school attendance may only be made by a school attendance officer, as defined under s. 118.16 (1) (a).

(i) The department shall request a waiver from the secretary of the federal department of health and human services to permit the application of the school attendance requirement under par. (g). Paragraphs (e) and (g) to (hr) do not apply unless the federal waiver is in effect. If a waiver is received, the department shall implement par. (e) beginning with the fall 1987 school term, as defined under s. 115.001 (12), or on the date the waiver is effective, whichever is later.

(j) The department shall designate 4 counties in which the school attendance requirement under par. (g) will apply to individuals who are 6 to 12 years of age. The department may phase in the requirement by age, beginning on the first day of the fall 1994 school term, as defined in s. 115.001 (12). The department shall conduct or contract for an evaluation of the expansion of the school attendance requirement under this paragraph.

(8) FAIR HEARING AND REVIEW. (a) Any person whose application for aid to families with dependent children is not acted upon by the county department under s. 46.215 or 46.22 or by the federally recognized tribal governing body with reasonable promptness after the filing of the application, or is denied in whole or in part, whose award is modified or canceled, or who believes the award to be insufficient, may petition the department for a review of such action. Review is unavailable if the decision or failure to act arose more than 45 days prior to submission of the petition for a hearing.

(b) 1. Upon receipt of a timely petition under par. (a) the department shall give the applicant or recipient reasonable notice and opportunity for a fair hearing. The department may make such additional investigation as it deems necessary. Notice of the hearing shall be given to the applicant and to the county clerk. The county may be represented at such hearing. The department shall render its decision as soon as possible after the hearing and shall send a certified copy of its decision to the applicant, the county clerk and the county officer charged with administration of such assistance. The decision of the department shall have the same effect as an order of the county officer charged with the administration of such form of assistance. Such decision shall be final, but may be revoked or modified as altered conditions may require.

The department shall deny a petition for a hearing or shall refuse to grant relief if:

a. The petitioner withdraws the petition in writing

b. The sole issue in the petition concerns an automatic grant adjustment or change for a class of recipients as required by state or federal law, unless the issue concerns the incorrect computation of a grant of aid to families with dependent children.

d. The petitioner abandons the petition. Abandonment occurs if the petitioner fails to appear in person or by representative at a scheduled hearing without providing the department with good cause therefor.

2. If a recipient requests a hearing within the timely notice period specified in 45 CFR 205.10, aid shall not be suspended, reduced or discontinued until a decision is rendered after the hearing but may be recovered by the department if the contested decision or failure to act is upheld. Until a decision is rendered after the hearing, the manner or form of aid payment to the recipient shall not change to a protective, vendor or 2-party payment. Aid shall be suspended, reduced or discontinued if:

a. The recipient is contesting a state or federal law or a change in state or federal law and not the recipient's grant computation.

b. The recipient is notified of a change in his or her grant while the hearing decision is pending but the recipient fails to request a hearing on the change.

3. The recipient shall be promptly informed in writing if aid is to be suspended, reduced or terminated pending the hearing decision.

(9) HEARING TO INSURE PROPER ADMINISTRATION. (a) The department may at any time terminate payment of state or federal aid on any grant of aid to families with dependent children which may have been improperly allowed or which is no longer warranted due to altered conditions. Such action shall be taken only after thorough investigation and after fair notice and hearing. Such notice shall be given to the recipient of the assistance, the county clerk, and the county officer charged with the administration of such assistance, and their statements may be presented either orally or in writing, or by counsel.

(b) Any decision of the department terminating the payment of state and federal aid shall be transmitted to the county treasurer. After receipt of such notice the county treasurer shall not include any payments thereafter made in such case in the certified statement of the expenditures of the county for which state or federal aid is claimed.

(10) ELIGIBILITY VERIFICATION. Proof shall be provided for each person included in an application for public assistance, except for a child who is eligible for medical assistance under s. 49.46 or 49.47 because of 42 USC 1396a (e) (4), of his or her social security number or that an application for a social security number has been made.

(11) PERIODIC EARNINGS CHECK BY DEPARTMENT. The department shall make a periodic check of the amounts earned by recipients of medical assistance under s. 49.46, 49.468 or 49.47, aid to families with dependent children under s. 49.19 and food stamps under 7 USC 2011 to 2029 through a check of the amounts credited to the recipient's social security number. The department shall make an investigation into any discrepancy between the amounts credited to a social security number and amounts reported as income on the declaration application and take appropriate action under s. 49.12 when warranted. The department shall use the state wage reporting system developed by the department of industry, labor and human relations under 1985 Wisconsin Act 17, section 65 (1), when the system is implemented, to make periodic earnings checks. The department of industry, labor and human relations shall cooperate with the department in supplying this information.

History: 1971 c. 125, 145, 215, 307; 1973 c. 90, 147; 1975 c. 307; 1977 c. 196, 271, 418; 1979 c. 221; 1981 c. 20, 93; 1983 a. 27; 1985 a. 29, 176, 285; 1985 a. 332 ss. 251 (1), 253; 1987 a. 27, 328, 399, 403, 413; 1989 a. 31, 173, 336, 359; 1991 a. 6, 39, 275, 313, 315, 316; 1993 a. 16, 399, 491.

Pursuant to 49.50 (2), Stats 1969, the department has authority to prescribe state-wide compensation standards applicable to county welfare department employees. Under 46.22 (3) and 59.15 (2) (c), any fixing of salaries of such employees by county boards of supervisors must be within the limits of the state-wide prescribed standards. 59 Atty Gen 126.

Sub (5) grants authority to county boards to establish the salary levels of county welfare personnel where authority to do so is properly delegated pursuant to rules established by the department of health and social services. The requirement that federal standards must be complied with imposes a limitation on this power. 61 Atty Gen 434.

Under (2), power to classify positions in a county department of social services resides solely in the state department of health and social services. 65 Atty Gen 123.

49.51 Providing work experience and job training services. (1) In this section, "provider" means the department if it provides services for the program under s. 49.193 directly or an agency which contracts with the department under s. 49.193 (1) (b) to provide services for the program under s. 49.193.

(2) The provider in a county may contract with the county to provide job opportunity and basic skills services under s. 49.193 to recipients of general relief under s. 49.02. The number of general relief recipients receiving services under this subsection in a county may not exceed 20% of the number of aid to families with dependent children recipients receiving services under s. 49.193 in the county. The county shall reimburse the provider for the actual cost of services provided under this subsection.

History: 1987 a 27; 1991 a 39; 1993 a 16.

49.52 Reimbursement to counties. (1) (ad) 1. The department shall reimburse each county for reasonable costs of income maintenance administration according to a formula based on workload within the limits of available state and federal funds under s. 20.435 (4) (de) and (nL) by contract under s. 46.032. The amount of reimbursement calculated under this paragraph is in addition to any reimbursement provided to a county for fraud and error reduction under s. 49.197 (1m) and (4).

2. The department may adjust the amounts determined under subd. 1. for workload changes, administration of relief of needy Indian persons under s. 49.046 and computer network activities performed by counties.

(am) The department shall reimburse each county from the appropriations under s. 20.435 (4) (d) and (p) and (7) (b) and (o) for 100% of the cost of aid to families with dependent children granted under s. 49.19, for social services as approved by the department under ss. 46.215 (1), (2) (c) and (3) and 46.22 (1) (b) 8. and (e) 3., and for funeral expenses paid for recipients of aid under s. 49.30, except that no reimbursement may be made for the administration of or aid granted under s. 49.02.

(b) The department shall distribute support collections from the appropriation under s. 20.435 (4) (g).

(d) From the appropriations under s. 20.435 (7) (b) and (o), the department shall distribute the funding for social services, including funding for foster care or treatment foster care of a child receiving aid under s. 49.19, to county departments under ss. 46.215, 46.22 and 46.23 as provided under s. 46.40. County matching funds are required for the distributions under s. 46.40 (2), (3), (3m), (4), (8), (9) and (12). Each county's required match for a year equals 9.89% of the total of the county's distributions for that year for which matching funds are required plus the amount the county was required by s. 46.26 (2) (c), 1985 stats, to spend for juvenile delinquency-related services from its distribution for 1987. Matching funds may be from county tax levies, federal and state revenue sharing funds or private donations to the county that meet the requirements specified in s. 51.423 (5). Private donations may not exceed 25% of the total county match. If the county match is less than the amount required to generate the full amount of state and federal funds distributed for this period, the decrease in the amount of state and federal funds equals the difference between the required and the actual amount of county matching funds.

(dc) The department shall prorate the amount allocated to any county department under s. 46.215 or 46.22 under par. (d) to reflect actual federal funds available.

(f) 1. If any state matching funds allocated under par. (d) to match county funds are not claimed, the funds shall be redistributed for the purposes the department designates.

2. The county allocation to match aid increases shall be included in the contract under s. 46.031 (2g) and approved by January 1 of the year for which funds are allocated, in order to generate state aid matching funds. All funds allocated under par. (d) shall be included in the contract under s. 46.031 (2g) and approved.

(g) In addition to funds allocated under par. (d) to (f), each county department under ss. 46.215 and 46.22 shall receive in its allocation funds appropriated by new legislation for new and expanded programs according to the purpose stated in such legislation.

(2) (a) The county treasurer and each director of a county department under s. 46.215, 46.22 or 46.23 shall monthly certify under oath to the department in such manner as the department prescribes the claim of the county for state reimbursement under this section and if the department approves such claim it shall certify to the department of administration for reimbursement to the county for amounts due under this subsection and payment claimed to be made to the counties monthly. The department may make advance payments prior to the beginning of each month equal to one-twelfth of the contracted amount.

(b) To facilitate prompt reimbursement the certificate of the department may be based on the certified statements of the county officers filed under par. (a). Funds recovered from audit adjustments from a prior fiscal year may be included in subsequent certifications only to pay counties owed funds as a result of any audit adjustment. By September 30 of each year the department shall submit a report to the appropriate standing committees under s. 13.172 (3) on funds recovered and paid out during the previous calendar year as a result of audit adjustments.

(4) (a) A county or federally recognized American Indian tribe is liable for all food stamp coupons lost, misappropriated or destroyed while under the county's or tribe's direct control, except as provided in par. (b).

(b) A county or federally recognized American Indian tribe is not liable for food stamp coupons lost in natural disasters if it provides evidence acceptable to the department that the coupons were destroyed and not redeemed.

(c) A county or federally recognized American Indian tribe is liable for food stamp coupons mailed to residents of the county or members of the tribe and lost in the mail due to incorrect information submitted to the department by the county or tribe.

(5) The department shall withhold the value of food stamp losses for which a county or federally recognized American Indian tribe is liable under sub. (4) from the payment to the county or tribe under s. 20.435 (4) (de) and (nL) and reimburse the federal government from the funds withheld.

History: 1971 c. 125; 1971 c. 164 s. 92; 1971 c. 215; 1973 c. 90, 147, 333; 1975 c. 39, 82, 200; 1975 c. 224 s. 146; 1977 c. 29; 1977 c. 354 s. 101; 1977 c. 418; 1979 c. 34 ss. 840 to 842, 2102 (20) (a); 1979 c. 177; 1979 c. 221 ss. 392p to 399, 2202 (20); 1981 c. 20; 1981 c. 93 ss. 94 to 103m, 186; 1981 c. 314 s. 146; 1981 c. 331; 1983 a 27 ss. 1082 to 1087, 2202 (20); 1983 a 192; 1985 a 29, 120, 176; 1987 a 27, 186, 399; 1987 a 403 s 256; 1987 a 413; 1989 a 31, 56, 107, 122; 1991 a 6, 32, 39, 189, 269, 315; 1993 a 16, 446, 491.

49.53 Limitation on giving information. (1m) Except as provided under sub. (2), (3) or (4), no person may use or disclose information concerning applicants and recipients of general relief under s. 49.02, aid to families with dependent children, social services, child and spousal support and establishment of paternity services under s. 46.25, or supplemental payments under s. 49.177, for any purpose not connected with the administration of the programs. Any person violating this subsection may be fined not less than \$25 nor more than \$500 or imprisoned in the county jail not less than 10 days nor more than one year or both.

(2) (a) Each county department under s. 46.215 or 46.22 administering aid to families with dependent children and each official or agency administering general relief shall maintain a

monthly report at its office showing the names and addresses of all persons receiving such aids together with the amount paid during the preceding month. Nothing in this paragraph shall be construed to authorize or require the disclosure in the report of any information (names, addresses, amounts of aid or otherwise) pertaining to adoptions, or aid furnished for the care of children in foster homes or treatment foster homes under s. 49.19 (10).

(b) Such report shall be open to public inspection at all times during regular office hours and may be destroyed after the next succeeding report becomes available. Any person except any public officer, seeking permission to inspect such book shall be required to prove his or her identity and to sign a statement setting forth his or her address and the reasons for making the request and indicating that he or she understands the provisions of par. (c) with respect to the use of the information obtained. The use of a fictitious name is a violation of this section. Within 72 hours after any such record has been inspected, the agency shall mail to each person whose record was inspected a notification of that fact and the name and address of the person making such inspection. The agency shall keep a record of such requests.

(c) It is unlawful to use any information obtained through access to such report for political or commercial purposes. The violation of this provision is punishable upon conviction as provided in sub. (1m).

(3) Each county department under s. 46.215 or 46.22 may release the current address of a recipient of aid under s. 49.19 to a law enforcement officer if the officer meets all of the following conditions:

(a) The officer provides, in writing, the name and social security number of the recipient.

(b) The officer satisfactorily demonstrates, in writing, all of the following:

1. That the recipient is a fugitive felon under 42 USC 602 (a) (9).

2. That the location or apprehension of the felon under subd. 1. is within the official duties of the officer.

3. That the officer is making the request in the proper exercise of his or her duties under subd. 2.

(4) A general relief agency shall, upon request, provide all of the following information concerning each person receiving general relief during that month to a law enforcement officer for use under s. 49.02 (12):

(a) Name, including middle initial, address, date of birth and sex.

(b) General relief case number.

History: 1973 c. 147; 1975 c. 82; 1977 c. 261; 1981 c. 93; 1983 a. 27; 1985 a. 29, 176; 1987 a. 403 s. 256; 1989 a. 359; 1991 a. 316, 322; 1993 a. 446.

This section does not deny access to records as to general relief granted. *McCrosen v. Nekoosa-Edwards Paper Co.* 59 W (2d) 245, 208 NW (2d) 148.

Sub. (1), 1987 stats. [now (1m)] did not preclude defendant in paternity case from inspecting record which may contain relevant evidence to impeach complainant. Procedure for disclosure adopted. *State ex rel. Dombrowski v. Moser*, 113 W (2d) 296, 334 NW (2d) 878 (1983).

Discussion of standards for disclosure of AFDC payments under sub. (1m) *State v. Hollingsworth*, 160 W (2d) 883, 467 NW (2d) 555 (Ct. App. 1991).

Function of county agency in furnishing information to public regarding social security aid recipients is nondiscretionary and limited under 49.53 (2), Stats. 1969. County welfare boards are an integral part of county administration and entitled to full access to case records. Advisory committees are not. Access to information concerning individual social security aid recipients by county board of supervisors is limited by its limited role in administration of the aid programs. 59 Atty. Gen. 240.

Only amounts of monthly payments to AFDC recipients, together with their names and addresses, may be released to department of revenue by department of health and social services. AFDC recipients must be notified when such information is released 69 Atty. Gen. 95.

Information contained in a county paternity case file may be released for purposes of fraud investigation of the public assistance programs specified in 49.53. 80 Atty. Gen. 226.

49.54 Income determination. In determining the amount of aid to be granted a person applying for supplemental payments under s. 49.177, income shall be disregarded to the extent allowed by federal regulations.

History: 1971 c. 87; 1973 c. 147.

49.65 Third party liability. (1) DEFINITION. In this section, "insurer" includes a sponsor, other than an insurer, that contracts to provide health care services to members of a group.

(2) SUBROGATION. The department, county or elected tribal governing body providing any public assistance under this chapter as a result of the occurrence of an injury, sickness or death which creates a claim or cause of action, whether in tort or contract, on the part of a public assistance recipient or beneficiary or the estate of a recipient or beneficiary against a 3rd party, including an insurer, is subrogated to the rights of the recipient, beneficiary or estate and may make a claim or maintain an action or intervene in a claim or action by the recipient, beneficiary or estate against the 3rd party.

(3) ASSIGNMENT OF ACTIONS. The department, county or elected tribal governing body providing any public assistance authorized under this chapter, including medical assistance, as a result of the occurrence of injury, sickness or death which results in a possible recovery of indemnity from a 3rd party, including an insurer, may require an assignment from the applicant, recipient or beneficiary of such public assistance or legally appointed representative of the incompetent or deceased applicant, recipient or beneficiary giving it the right to make a claim against the 3rd party.

(4) CONTROL OF ACTION. The applicant or recipient or any party having a right under this section may make a claim against the 3rd party or may commence an action and shall join the other party as provided under s. 803.03 (2). Each shall have an equal voice in the prosecution of such claim or action.

(5) RECOVERY; HOW COMPUTED. Reasonable costs of collection including attorney fees shall be deducted first. The amount of assistance granted as a result of the occurrence of the injury, sickness or death shall be deducted next and the remainder shall be paid to the public assistance recipient or other party entitled to payment.

(6) DEPARTMENT'S DUTIES AND POWERS. The department shall enforce its rights under this section and may contract for the recovery of any claim or right of indemnity arising under this section.

(7) PAYMENTS TO LOCAL UNITS OF GOVERNMENT. (a) Any county or elected tribal governing body that has made a recovery under this section shall receive an incentive payment from the sum recovered as provided under this subsection.

(b) The incentive payment shall be an amount equal to 15% of the amount recovered because of benefits paid under s. 49.46, 49.465, 49.468 or 49.47. The incentive payment shall be taken from the federal share of the sum recovered as provided under 42 CFR 433.153 and 433.154.

(c) The incentive payment shall be an amount equal to 15% of the amount recovered because of benefits paid under s. 49.046, 49.19, 49.20 or 49.30 or as state supplemental payments under s. 49.177. The incentive payment shall be taken from the state share of the sum recovered, except that the incentive payment for an amount recovered because of benefits paid under s. 49.19 shall be considered an administrative cost under s. 49.19 for the purpose of claiming federal funding.

(d) Any county or elected tribal governing body that has made a recovery under this section for which it is eligible to receive an incentive payment under par. (b) or (c) shall report such recovery to the department within 30 days after the end of the month in which the recovery is made in a manner specified by the department.

(e) The amount of the recovery remaining after payments are made under pars. (b) and (c) shall be deposited in the state treasury and credited to the appropriation from which the assistance was originally paid.

(8) WELFARE CLAIMS NOT PREJUDICED BY RECIPIENT'S RELEASE.

(a) No person who has or may have a claim or cause of action in tort or contract and who has received assistance under this chapter as a result of the occurrence that creates the claim or cause of action may release the liable party or the liable party's insurer from liability to the units of government specified in sub. (2). Any

payment to a beneficiary or recipient of assistance under this chapter in consideration of a release from liability is evidence of the payer's liability to the unit of government that granted the assistance.

(b) Liability under par. (a) is to the extent of assistance payments under this chapter resulting from the occurrence creating the claim or cause of action, but not in excess of any insurance policy limits, counting payments made to the injured person. The unit of government administering assistance shall include in its claim any assistance paid to or on behalf of dependents of the injured person, to the extent that eligibility for assistance resulted from the occurrence creating the claim or cause of action.

(9) **POWERS OF HEALTH MAINTENANCE ORGANIZATIONS.** A health maintenance organization or other prepaid health care plan has the powers of the department under subs. (2) to (5) to recover the costs which the organization or plan incurs in treating an individual if all of the following circumstances are present:

(a) The costs result from an occurrence of an injury or sickness of an individual who is a recipient of medical assistance.

(b) The occurrence of the injury or sickness creates a claim or cause of action on the part of the recipient or the estate of the recipient.

(c) The medical costs are incurred during a period for which the department pays a capitation or enrollment fee for the recipient.

History: 1977 c. 29; 1979 c. 221; 1981 c. 20; 1983 a. 27, 465; 1985 a. 29 ss 1051, 1052, 3200 (23); 1987 a. 27 s. 3202 (24); 1989 a. 31.

Counties were entitled to be reimbursed for medical assistance from insurance settlements obtained by accident victims, despite fact that neither victim had been fully compensated. *Waukesha County v. Johnson*, 107 W (2d) 155, 320 NW (2d) 1 (Ct. App. 1982).

County recouped medical assistance payments from recipient of assistance who was minor. *Perkins v. Utneher*, 122 W (2d) 497, 361 NW (2d) 739 (Ct. App. 1984).

Attorney's fees are not chargeable against public assistance recovered in an action under this section. 70 Atty. Gen. 61.

49.70 Menominee Enterprises, Inc., bonds, acquisition. (1) The department is authorized to exercise options to purchase securities assigned to the state of Wisconsin under s. 710.05, 1973 stats., at par value, or to accept an assignment of such securities, for the purpose of providing relief, public assistance or welfare aid under this section.

(2) The department shall exercise the options to purchase such securities or accept an assignment of such securities when it finds that the owner of the securities is a resident of this state and is in need of general relief, public assistance or welfare aid, or who but for the ownership of such securities would qualify for general relief, public assistance or other welfare aid. If the department exercises an option to purchase such security, the purchase price shall be paid out, at par value, as general relief. Where the department accepts an assignment of such security as provided in this section it shall pay out as general relief an amount equal to the par value of the security assigned. The general relief furnished, whether by money or otherwise, shall be at such times and in such amounts as will in the discretion of the department meet the needs of the recipient and protect the public. The department is authorized to exercise the options to purchase assigned to it in whole or in part, or to accept an assignment of such securities in whole or in part. The department is granted such authority as may be necessary and convenient to enable it to exercise the functions and perform the duties required of it by this section, including without limitation because of enumeration the authority to promulgate rules governing eligibility and the furnishing and paying of general relief under this section, the authority to enter into suitable agreements with the owner of the security or other appropriate persons for the purpose of carrying out this section, and the authority to sell or transfer the securities or defend and prosecute all actions concerning it and pay all just claims against it and do all other things necessary for the protection, preservation and management of the securities.

(3) If the relief, public assistance, or other welfare aid provided pursuant to this section is discontinued during the life of the

person receiving such aid and the value of the securities transferred to the department exceed the total amount of assistance paid under this section, the excess of such property shall be returned to such person; and in the event of the person's death the excess shall be considered the property of such person for administration proceedings.

(4) The department may make loans to the owner of such securities for relief and welfare purposes which loans shall be secured by pledges of the securities to the state. The department may by rule establish the purposes for which loans may be made, permissible interest rates and fees, time and manner in which the loan is paid out, time and manner of repayment, general procedures to be followed in making loans, the action which shall be taken if a borrower defaults on a loan, maximum amount which may be loaned to any one borrower, and any other rules necessary to carry out the purposes of this section.

(5) Nothing in this section as created by chapter 2, laws of Special Session of 1963, is in derogation of other rights and remedies provided by law.

(6) On and after May 20, 1972, where the owner of such security is otherwise eligible for welfare assistance, such security shall be an exempt asset under the welfare law and shall not disqualify such person from receiving welfare assistance.

History: 1971 c. 302; 1975 c. 422 s. 163; 1981 c. 390 s. 252; 1983 a. 189 s. 329 (19); 1985 a. 29; 120; 1989 a. 359; 1991 a. 316.

NOTE: Ch. 303, 1971 laws, provided for returning to its original owners *Menominee Enterprises, Inc.* bonds assigned to the state as a condition for receiving public assistance.

49.80 Low-income energy assistance. (1) **DEFINITIONS.** In this section:

(a) "County department" means a county department under s. 46.215 or 46.22.

(am) "Crisis assistance" means a benefit that is given to a household experiencing or at risk of experiencing a heating-related emergency.

(b) "Dwelling" means the residence of a low-income warm room program volunteer.

(bm) "Heating assistance" means a benefit, other than crisis assistance, that is given to a household to assist in meeting the cost of home heating.

(c) "Household" means any individual or group of individuals who are living together as one economic unit for whom residential energy is customarily purchased in common or who make undesignated payments for energy in the form of rent.

(d) "Low-income warm room program materials" include a removable, insulated radiator blanket, a portable remote control thermostat and other cost-efficient materials or repairs necessary to achieve maximum heating efficiency in a dwelling.

(e) "Low-income warm room program volunteer" means a person who is eligible for assistance under 42 USC 8621 to 8629, whose dwelling, in comparison to the dwellings of other persons eligible for assistance under 42 USC 8621 to 8629, has a high ratio of space to occupant, and who volunteers to take the training under sub. (2) (b) and to cooperate with the department in the installation and operation of low-income warm room program materials in his or her dwelling.

(em) "Utility allowance" means the amount of utility costs paid by those individuals in subsidized housing who pay their own utility bills, as averaged from total utility costs for the housing unit by the housing authority.

(2) **ADMINISTRATION.** (a) The department shall administer low-income energy assistance as provided in this section to assist an eligible household to meet the costs of home energy with low-income home energy assistance benefits authorized under 42 USC 8621 to 8629.

(b) The department of health and social services shall administer a low-income warm room program to install low-income warm room program materials in the dwellings of low-income warm room program volunteers and to train the low-income

warm room program volunteers and the members of each low-income warm room program volunteer's household in the operation of the low-income warm room program materials to achieve maximum health and heating efficiency.

(3) **FUNDING** Subject to s. 16.54 (2), the department shall, within the limits of the availability of federal funds received under 42 USC 8621 to 8629:

(b) By October 1 of every year from the appropriation under s. 20.435 (4) (md), determine the total amount available for payment of heating assistance under sub. (6) and determine the benefit schedule.

(c) From the appropriation under s. 20.435 (4) (mc), allocate \$1,100,000 in each federal fiscal year for the department's expenses in administering the funds to provide low-income energy assistance.

(d) From the appropriation under s. 20.435 (4) (md), allocate \$2,900,000 in each federal fiscal year for the expenses of a county department, another local governmental agency or a private nonprofit organization in administering under sub. (4) the funds to provide low-income energy assistance.

(e) From the appropriation under s. 20.435 (4) (md):

1. Allocate and transfer to the appropriation under s. 20.505 (7) (km), 15% of the moneys received under 42 USC 8621 to 8629 in each federal fiscal year under the priority of maintaining funding for the geographical areas on July 20, 1985, and, if funding is reduced, prorating contracted levels of payment, for the weatherization assistance program administered by the department of administration under s. 16.39.

2. Allocate \$2,400,000 in each federal fiscal year for the payment of crisis assistance benefits to meet weather-related or fuel supply shortage emergencies under sub. (8).

3. Except as provided under subd. 6., allocate the balance of funds received under 42 USC 8621 to 8629 in a federal fiscal year, after making the allocations under pars. (c) and (d) and subds. 1. and 2., for the payment of heating assistance under sub. (6).

6. If federal funds received under 42 USC 8621 to 8629 in a federal fiscal year total less than 90% of the amount received in the previous federal fiscal year, submit a plan of expenditure under s. 16.54 (2) (b).

7. By October 1 of each year and after consulting with the department of administration, allocate funds budgeted but not spent and any funds remaining from previous fiscal years to heating assistance under sub. (6) or to the weatherization assistance program under s. 16.39.

(4) **APPLICATION PROCEDURE** (a) A household may apply after September 30 and before May 16 of any year for heating assistance from the county department under s. 46.215 (1) (n) or 46.22 (1) (b) 10. or from another local governmental agency or a private nonprofit organization with which the department contracts to administer the heating assistance program, and shall have the opportunity to do so on a form prescribed by the department for that purpose.

(b) If by February 1 of any year the number of households applying under par. (a) substantially exceeds the number anticipated, the department may reduce the amounts of payments made under sub. (6) made after that date. The department may suspend the processing of additional applications received until the department adjusts benefit amounts payable.

(5) **ELIGIBILITY** Subject to the requirements of subs. (4) (b) and (8), the following shall receive low-income energy assistance under this section:

(b) A household with income which is not more than 150% of the income poverty guidelines for the nonfarm population of the United States as prescribed by the federal office of management and budget under 42 USC 9902 (2).

(c) A household entirely composed of persons receiving aid to families with dependent children under s. 49.19, food stamps under 7 USC 2011 to 2029, or supplemental security income or

state supplemental payments under 42 USC 1381 to 1383c or s. 49.177.

(d) A household with income within the limits specified under par. (b) that resides in housing that is subsidized or administered by a municipality, a county, the state or the federal government in which a utility allowance is applied to determine the amount of rent or the amount of the subsidy.

(6) **BENEFITS** Within the limits of federal funds allocated under sub. (3) and subject to the requirements of sub. (4) (b) and s. 16.54 (2) (b), heating assistance shall be paid under this section according to a benefit schedule established by the department based on household income, family size and energy costs.

(7) **INDIVIDUALS IN STATE PRISONS** No payment under sub. (6) may be made to a prisoner who is imprisoned in a state prison under s. 302.01 or to a person placed at a secured correctional facility, as defined in s. 48.02 (15m).

(8) **CRISIS ASSISTANCE PROGRAM** A household eligible for heating assistance under sub. (6) may also be eligible for a crisis assistance payment to meet a weather-related or fuel supply shortage crisis. The department shall define the circumstances constituting a crisis for which a payment may be made and shall establish the amount of payment to an eligible household or individual. The department may delegate a portion of its responsibility under this subsection to a county department under s. 46.215 or 46.22 or to another local governmental agency or a private nonprofit organization.

History: 1985 a. 29 ss. 1055g, 2488h to 2488n; 1985 a. 176, 332; 1987 a. 27; 1989 a. 31, 359; 1991 a. 39; 1993 a. 16

49.90 Liability of relatives; enforcement. (1) (a) 1. The parent and spouse of any dependent person who is unable to maintain himself or herself shall maintain such dependent person, so far as able, in a manner approved by the authorities having charge of the dependent, or by the board in charge of the institution where such dependent person is; but no parent shall be required to support a child 18 years of age or older.

2. Except as provided under subs. (11) and (13) (a), the parent of a dependent person under the age of 18 shall maintain a child of the dependent person so far as the parent is able and to the extent that the dependent person is unable to do so. The requirement under this subdivision does not supplant any requirement under subd. 1. and applies regardless of whether a court has ordered maintenance by the parent of the dependent person or established a level of maintenance by the parent of the dependent person.

(b) For purposes of this section those persons receiving benefits under federal Title XVI or under s. 49.177 shall not be deemed dependent persons.

(c) For the purpose of determining the ability of a parent or spouse to maintain a dependent person or the ability of a parent to support the child of his or her dependent child under the age of 18, credit granted under subch. VIII of ch. 71 shall not be considered.

(1m) Each spouse has an equal obligation to support the other spouse as provided in this chapter. Each parent has an equal obligation to support his or her minor children as provided in this chapter and ch. 48. Each parent of a dependent person under the age of 18 has an equal obligation to support the child of the dependent person as provided under sub. (1) (a) 2.

(2) Upon failure of these relatives to provide maintenance the authorities or board shall submit to the corporation counsel a report of its findings. Upon receipt of the report the corporation counsel shall, within 60 days, apply to the circuit court for the county in which the dependent person under sub. (1) (a) 1. or the child of a dependent person under sub. (1) (a) 2. resides for an order to compel the maintenance. Upon such an application the corporation counsel shall make a written report to the county department under s. 46.215, 46.22 or 46.23, with a copy to the chairperson of the county board of supervisors in a county with a single-county department or the county boards of supervisors in counties with a multicounty department, and to the department of health and social services.

(2g) In addition to the remedy specified in sub. (2), upon failure of a grandparent to provide maintenance under sub. (1) (a) 2., another grandparent who is or may be required to provide maintenance under sub. (1) (a) 2., a child of a dependent minor or the child's parent may apply to the circuit court for the county in which the child resides for an order to compel the provision of maintenance. A county department under s. 46.215, 46.22 or 46.23, a county child support agency or the department may initiate an action to obtain maintenance of the child by the child's grandparent under sub. (1) (a) 2., regardless of whether the child receives public assistance.

(2r) An action under sub. (2) or (2g) for maintenance of a grandchild by a grandparent may be joined with an action to determine paternity under s. 767.45 (1) or an action for child support under s. 767.02 (1) (f) or (j) or 767.08, or both.

(3) At least 10 days prior to the hearing on the application under sub. (2) or (2g), notice of the hearing shall be served upon the grandparent or other relative who is alleged not to have provided maintenance, in the manner provided for the service of summons in courts of record.

(4) The circuit court shall in a summary way hear the allegations and proofs of the parties and by order require maintenance from these relatives, if they have sufficient ability, considering their own future maintenance and making reasonable allowance for the protection of the property and investments from which they derive their living and their care and protection in old age, in the following order: First the husband or wife; then the father and the mother; and then the grandparents in the instances in which sub. (1) (a) 2. applies. The order shall specify a sum which will be sufficient for the support of the dependent person under sub. (1) (a) 1. or the maintenance of a child of a dependent person under sub. (1) (a) 2., to be paid weekly or monthly, during a period fixed by the order or until the further order of the court. If the court is satisfied that any such relative is unable wholly to maintain the dependent person or the child, but is able to contribute to the person's support or the child's maintenance, the court may direct 2 or more of the relatives to maintain the person or the child and prescribe the proportion each shall contribute. If the court is satisfied that these relatives are unable together wholly to maintain the dependent person or the child, but are able to contribute to the person's support or the child's maintenance, the court shall direct a sum to be paid weekly or monthly by each relative in proportion to ability. Contributions directed by court order, if for less than full support, shall be paid to the department and distributed as required by state and federal law. An order under this subsection that relates to maintenance required under sub. (1) (a) 2. shall specifically assign responsibility for and direct the manner of payment of the child's health care expenses, subject to the limitations under subs. (1) (a) 2. and (11). Upon application of any party affected by the order and upon like notice and procedure, the court may modify such an order. Obedience to such an order may be enforced by proceedings for contempt.

(5) Any party aggrieved by such order may appeal therefrom but when the appeal is taken by the authorities having charge of the dependent person an undertaking need not be filed.

(6) If any relative who has been ordered to maintain an institutionalized dependent person or an institutionalized child of a dependent person under 18 years of age neglects to do as ordered, the authorities in charge of the dependent or child or in charge of the institution may recover in an action on behalf of the general relief agency or institution for general relief or support accorded the dependent person or child against such relative the sum prescribed for each week the order was disobeyed up to the time of judgment, with costs.

(7) When the income of a responsible relative is such that the relative would be expected to make a contribution to the support of the recipient and such recipient lives in the relative's home and requires care, a reasonable amount may be deducted from the expected contribution in exchange for the care provided.

(9) In any action under this section the court may impose any sum ordered paid by a party as a charge upon any specific real estate of the party liable or may require sufficient security to be given for payment according to the judgment or order.

(10) If an action under this section relates to support or maintenance of a child, to the extent appropriate the court shall determine maintenance or support in the manner in which support is determined under s. 767.25.

(11) Except as provided in sub. (13) (b), the parent of a dependent person who is under the age of 18 and is alleged to be the father of a child is responsible for maintenance of that child only if the paternity of the child has been determined to be that of the dependent person as provided in subch. VIII of ch. 48 or under ss. 767.45 to 767.60. Subject to the limitations under sub. (1) (a), if a parent of a dependent person is liable for the health care expenses of the dependent person's child under sub. (4), this liability extends to all expenses of the child's medical care and treatment, including those associated with the childbirth, regardless of whether they were incurred prior to the determination of paternity and regardless of whether the determination of paternity is made after the child's father attains 18 years of age, except that the period for which maintenance payment is ordered for the parent of a dependent person may not extend beyond the date on which the dependent person attains 18 years of age. The court may limit the liability of the dependent person's parent for the child's medical expenses if the expenses exceed 5% of the parent's federal adjusted gross income for the previous taxable year, if the parent files separately, or 5% of the sum of the parents' federal adjusted gross income for the previous taxable year, if the parents file jointly.

(12) The parent of a dependent person who maintains a child of the dependent person under sub. (1) (a) 2. may, after the dependent person attains the age of 18, apply to the circuit court for the county in which the child resides for an order to compel restitution by the dependent person of the amount of maintenance provided to the dependent person's child by that parent. The circuit court shall in a summary way hear the allegations and proof of the parties and, after considering the financial resources and the future ability of the dependent person to pay, may by order specify a sum in payment of the restitution, to be paid weekly or monthly, during a period fixed by the order or until further order of the court. Upon application of any party affected by the order and following notice and an opportunity for presentation of allegations and proof by the parties, the court may modify the order. The parent of the dependent person may file a restitution order with the clerk of circuit court. Upon payment of the fee under s. 814.61 (5) (a), the clerk shall enter the order on the judgment docket under s. 806.10 in the same manner as for a judgment in a civil action. Thereafter, the parent of the dependent person may enforce the order against the dependent person in the same manner as for a judgment in a civil action.

(13) (a) The parent of a dependent person who is the victim of a sexual assault under s. 940.225 (1) (a) for which a conviction is obtained and which results in the birth of a child before the dependent person attains the age of 18 is not responsible under sub. (1) (a) 2. for the maintenance of that child of the dependent person.

(b) If a dependent person is convicted at any time of causing a pregnancy under s. 940.225 (1) (a) which results in the birth of a child before the dependent person attains the age of 18, the parent of that dependent person is solely liable under the requirements of sub. (1) (a) 2. for the maintenance of the dependent person's child.

(c) If the parent of the dependent person specified in par. (a) provides maintenance to the dependent person's child and if par. (b) applies, the parent may apply to the circuit court for the county in which the child resides for an order to compel restitution by the parent specified in par. (b) of the amount of maintenance provided. The circuit court shall in a summary way hear the allega-

tions and proof of the parties and, after considering the financial resources and future ability of the parent of the dependent person specified in par. (b) to pay, may by order specify a sum in payment of the restitution, to be paid weekly or monthly, during a period fixed by the order or until further order of the court. Upon application of any party affected by the order and following notice and an opportunity for presentation of allegations and proof by the parties, the court may modify the order. The parent specified in par. (a) may file a restitution order with the clerk of circuit court. Upon payment of a fee under s. 814.61 (5) (a), the clerk shall enter the

order on the judgment docket under s. 806.10 in the same manner as for a judgment in a civil action. Thereafter, the parent specified in par. (a) may enforce the order against the parent specified in par. (b) in the same manner as for a judgment in a civil action.

History: 1973 c. 90 ss. 296e, 560 (2); 1973 c. 147, 336; Sup. Ct. Order, 67 W (2d) 585, 773 (1975); 1975 c. 82, 199; 1977 c. 271, 449; 1979 c. 221, 352; 1981 c. 317; 1983 a. 186; 1985 a. 29 ss. 1055m, 1108 to 1114, 3200 (23); 1985 a. 56, 176, 311, 332; Stats. 1985 s. 49.90; 1987 a. 312 s. 17; 1987 a. 399; 1989 a. 31; 1991 a. 316.

Sub. (1) (a) 2 is substantive provision and legislative intent indicates it is to have prospective effect only. In re Paternity of C.J.H., 149 W (2d) 624, 439 NW (2d) 615 (Ct. App. 1989).