Income Maintenance Manual

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3 PUBLIC ASSISTANCE FRAUD PROGRAM

3.1 FRAUD PROGRAM

3.1 Public Assistance Fraud Program

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3.1.1 Introduction

The Public Assistance Fraud Program is based on Chapter 49 of the Wisconsin Statutes. The Chapter 49 Fraud Program has been administered in all geographic areas of the state since January 1, 1998. The program consists of fraud prevention, fraud investigation, and fraud overpayment collection activities.

As part of the responsibilities for ensuring the integrity of the benefit programs they administer, both Wisconsin Works (W-2) and Income Maintenance (IM) agencies must operate fraud prevention programs to identify and prevent fraud or error from occurring in their programs. The agency determining eligibility for a particular benefit program is responsible for fraud prevention activities in that program.

Agencies must differentiate between the:

1. Routine verification for eligibility determination conducted on all applications and re-determinations detailed in the Medicaid Eligibility Handbook, FoodShare Handbook, W-2 Manual and the Child Care Manual.

2. The selection of items for referral to fraud prevention activities. (Chapter 3.2) (Prevention), and

3. The selection of cases for referral to fraud investigation. (Chapter 3.3)

These are three different types of activities. Policies, guidelines and procedures must be established for each activity. See Chapters 3.2 and 3.3. Separation of

these activities is also necessary for proper funding. See the 2005 CARS Consolidated/County HS/IM Programs Manual for additional information on proper reporting of these activities.

3.1.1.1 Structure

The W-2, IM, and tribal agencies administering public assistance programs are responsible for operating early fraud detection and prevention programs and for initiating claims and collections of fraudulent overpayments. These agencies are also responsible for determining which cases shall be referred to the agency's fraud investigation unit, the Department of Administration's Division of Hearings and Appeals for administrative disqualification hearings, and the local District Attorney's Office for prosecution.

Note: In Milwaukee County, the administration of W-2 is subdivided into multiple geographic service areas. Also, some multiple counties may be served by a W-2 agency consortium which acts as a single W-2 agency. All investigative service providers must interact with the appropriate W-2 agency and IM agency for a fraud investigation.

3.1.1.2 Fraud Plan

Each agency participating in the Chapter 49 Public Assistance Fraud Program, must complete and submit to the Department of Health and Family Services, (DHFS) Public Assistance Fraud Unit, a "fraud plan" based on a model fraud plan issued by DHFS. County and tribal IM agencies must submit their fraud plan within 30 days of the effective date of contract award. W-2 agencies must submit their fraud plan to the DWS W-2 Contract Administrator within 30 days from signing their W-2 contract. The DWS W-2 Contract Administrator will promptly forward the plan to the DHFS Public Assistance Fraud Unit for review. The fraud plan must include a listing of its administrative responsibilities, program responsibilities, a budget, a description of the fraud program's structure, an organization chart, and position descriptions for the staff positions identified on the organizational chart.

3.1.1.2.1 Plan Requirements

The requirements of the fraud plan are to:

1. Develop written policy and procedures for the operation of fraud prevention and fraud investigation components of the Fraud Program, including the selection process for identifying which cases are eligible for referral for Front End Verification (FEV) and fraud investigation.

2. Periodically validate the selection process to ensure that the cases selected are error-prone.

3. Meet the fraud standard target of a 30% success rate for cases referred to FEV and 50% success rate for cases referred for fraud investigations.

4. Ensure that any private individual and/or company that contracts with the agency to provide investigative services meets the Wisconsin Department of Regulation and Licensing requirements for private detectives.

5. Ensure that any service provider acting as the investigative service provider complies with the federal requirement to identify itself as representing the W-2/IM agency.

6. Maintain adequate audit documentation to support administrative cost claims.

7. Comply with all applicable state and federal program standards and fraud related corrective action plans incorporated into the W-2/IM contracts, *Income* Maintenance Manual (IMM), W-2 Manual, DHFS/DWD Operation and Administrator's memos, and supporting program handbooks.

8. Comply with all affirmative action, equal employment opportunity, and civil rights requirements referred to in the W-2/IM contracts. Tribal agencies are exempt from this requirement.

3.1.1.2.2 Model Program

DHFS/DWD recommends local agencies use the model fraud plan prepared by DHFS as a model for their local fraud prevention programs. (Attachments A,B,C,D of DHFS Administrator's Memo 05-04) Local agencies have discretion to design their own prevention programs to meet local circumstances. All fraud prevention programs must meet the fraud plan requirements of 3.1.1.2.1.

3.1.1.3. Legal Basis

State Statute 49.197 (1m) enables the Department of the Health and Family Services to establish a program to investigate suspected fraudulent activity on the part of recipients of Aid to Families with Dependent Children, Medicaid, FoodShare, W-2 and CC programs.

§49.795, §49.141 (W-2), §49.49 and §49.95 provide penalties for willfully making false representations related to acceptance of benefits and other acts interfering with proper program administration.

The fraud provisions in §49.95 apply to any action by a person to help an applicant or recipient obtain public assistance wrongfully. Wisconsin Statute §49.95(6) requires applicants and recipients to report to the applicable IM agency or W-2 agency, within 10 days, any and all changes in their income and/or assets. FoodShare recipients who qualify for reduced reporting requirements are subject to less restrictive reporting criteria for most changes. (FS 5.1.1).

The Food Stamp (FS) Act and the US Department of Agriculture's (USDA) federal regulations provide additional basis for penalties in the FoodShare program.

"The department shall establish a program to investigate suspected fraudulent activity on the part of recipients of Aid to Families with Dependent Children under s.49.19, on the part of participants in the Wisconsin Works Program under ss. 49.141 to 49.161, and, if the Department of Health and Family Services contracts with the department under sub. (5), on the part of recipients of Medicaid under subch. IV and food stamp benefits under the Food Stamp Program under 7 USC 2011 to 2036. ".

3.1.1.4 Notifying Client

Notify applicants and recipients of the fraud provisions by explaining the purpose and nature of public assistance and the intent and purpose of fraud provisions and penalties. In addition, point out the fraud related sections of:

1. W-2 and CC application (DES- 2471).
2. Medicaid Family and EBD Applications DWSW 2378-1.
3. FoodShare Program Application HCF 16019A (EBT Card and PIN Responsibility Statement).
4. The FoodShare Eligibility and Benefits brochure.
5. The Medicaid Eligibility and Benefits Booklet.

3.1.1.5 Definitions

Benefits-

> "Benefits" include AFDC benefits, W-2 payments, FS allotments, MA benefits, CC benefits and other services or assistance provided to a person or group because the person or group was found eligible for the benefit.

Bureau of Eligibility Management

The agency within the Department of Health and Family Services (DHFS), Division of Health Care Financing (DHCF), which is responsible for administering the statewide FoodShare and Medicaid programs. This agency also is responsible for administering the statewide fraud prevention and fraud investigation program for the FoodShare, Medicaid, W-2 and Child Care programs.

CARES-

CARES: The acronym used to identify the "Client Assistance for Re-employment and Economic Support" system, which is Wisconsin's automated eligibility determination, benefit calculation and management system for the AFDC, W-2, FoodShare, and Medicaid programs.

Chapter 49

That portion of Wisconsin Statutes, which pertains to the public assistance programs.

County Agency:

The county under contract with the DHFS to administer IM programs including Medicaid, FoodShare, Caretaker Supplement (CTS).

Coupon:

Any coupon, stamp, access device authorization card, cash or check, including an electronic benefit transfer card or personal identification card or type of certification provided under 7 CFR 271, subchapter C, for the purchase of eligible food.

Department:

For the purposes of this document, the "department" indicates the Department of Health and Family Services (DHFS). The Department of Workforce Development (DWD) contracts with DHFS for it to administer and supervise fraud program activities for the W-2 and child care programs.

EBT:

The acronym for Electronic Benefit Transfer, which is an electronic system that allows a recipient online access to his/her FoodShare benefits through the use of a POS or point of sale device at an FNS authorized retailer, authorizing the electronic payment of federal funds to the retailer for the approved purchase of eligible food items. (In Wisconsin EBT food stamp benefits are administered through the QUEST card.)

Error-Prone Profile:

Characteristics identified by a local agency as common to cases that indicate a need for front end verification (FEV).

Financial and Employment Planner (FEP):

The FEP is a case manager employed by or contracting with a W-2 agency and who provides: (1) W-2 eligibility determinations, job readiness screening, employability planning; (2) financial and employment case management services; and (3) makes referral to other public or private assistance programs or resources.

FoodShare Program

The Wisconsin Food Stamp Program was renamed Wisconsin FoodShare on October 16, 2004.

Fraud:

Making false statements, suppressing facts, or giving information which misrepresents true circumstances in order to become eligible or remain eligible for benefits under Chapter 49, Wis. Stats.

Fraud/FEV Gatekeeper

An employee, supervisor, or contracted person designated by a local W-2 or IM agency to review, track, monitor, and approve all FEV and Fraud referrals for the agency.

Fraud Investigation Tracking Screens (FITS):

The screens in the CARES Benefit Recovery Subsystem on which local agencies are required to enter data on FEV and fraud investigation activities, costs and investigation results (See CARES Guide, Section 1, Chapter 10.7 for screen illustrations and data field descriptions).

CARES screen BVIR must be used to initiate a Front-end verification (FEV referral) or a fraud investigation referral. CARES screen BVIT must be used by local agencies to approve or deny FEV or Fraud investigation refferals for investigation activities that may be funded by the fraud program. CARES screens BVIR, BVIT and BVPI are the primary FITS screens.

Fraud Investigation Referral:

A formal request issued through fraud referral documents from CARES (screens BVIR and BVIT) with supporting documentation in accordance with DWD and DHFS requirements. A fraud referral is issued by a W-2, county, or tribal agency or the Department of Health and Family Services to a fraud investigator. A fraud referral directs the fraud investigator to conduct an investigation where there is adequate documented information to suspect a program violation occurred. A clear statement of the possible/potential violation must be included in the request to allow the investigator to conduct a fact finding to verify the allegation or determine willful intent to defraud.

Fraud Period:

The time span during which suspected intentional program violations occurred.

Front-End Verification (FEV):

Front-End Verification (FEV) is a process of intense scrutiny of cases that exhibit characteristics of potential program violation. This process verifies the accuracy of specific information about a client at case application, review or reported change.

Front-end Verification (FEV) Referral:

A formal request issued through an FEV referral document from CARES BVIR and BVIT with supporting documentation in accordance with DWD and DHFS requirements. An FEV referral is authorized on CARES BVIT by an agency's Fraud/FEV Gatekeeper for the FEV investigator to conduct an in-depth verification of specific error-prone characteristics related to a case, generally, at application, review or a change report.

Income Maintenance Program:

A term in used in reference to the public assistance programs which include Medicaid, FoodShare, and CTS.

Income Maintenance (IM) Worker

A person employed by a county, or a governing body of a federally recognized American Indian tribe whose duties include determinations or re-determinations of income maintenance program eligibility.

Intentional Program Violation (IPV):

a. Intentional Program Violation (IPV)

An IPV is a finding by Administrative hearing, Court hearing, or signed agreement that a member of a W-2 assistance group intentionally made false or misleading statements, misrepresented, concealed, or withheld facts that resulted in a W-2, Job Access Loan, and/or Child Care benefit overpayment. (Wisconsin Statue 49. Three separate IPV findings results in permanent W-2 program ineligibility.

b. Intentional Program Violation [7 CFR 273.16 (c) FoodShare Program

(1) Making a false or misleading statement, misrepresenting, concealing or withholding facts, for the purpose of obtaining benefits for which one is not entitled.

(2) Improper use, presentation, transfer, acquisition, receipt, or possession of FoodShare benefits.

QUEST CARD:

QUEST is Wisconsin's name for its EBT card. (See EBT).

SSA:

Social Security Administration.

SSI: Supplemental Security Income.

This is a needs-tested program administered by SSA providing cash and/or medical benefits to persons who are blind, disabled, or elderly (65 or more years old).

Tribal Agency:

A Tribal Agency is a tribal governing body under contract with DHFS to administer the IM programs.

Trafficking:

Buying or selling FoodShare benefits in exchange for items other than eligible food. [7 CFR 271.2]

Wisconsin Works (W-2):

Wisconsin's Temporary Assistance to Needy Families (TANF) block grant program providing assistance to low income families to gain or maintain employment. W-2 is the program replacing Wisconsin's Aid to Families with Dependent Children (AFDC). See §49.141 to §49.161, Wis. Stats.

W-2 Agency:

County agency, tribal governing body, private agency or a public or a private consortium contracted by DWD to administer the Wisconsin Works (W-2) program.

Wisconsin SHARES:

Wisconsin SHARES is Wisconsin's child care subsidy program that provides assistance to low-income families in need of child care services to enable the recipient to work and/or participate in work activities as assigned by the W-2 agency. See **Wisconsin Statutes S.49.155**.

3.1.1.6 Public Assistance Fraud Unit/Prevention Contacts

The Public Assistance Fraud Unit has been integrated into the Bureau of Eligibility Management/Division of Health Care Financing in the Department of Health and Family Services (DHFS).

Contact Public Assistance Fraud Unit Staff at:

1. **Physical Address**
   Room 365
   1 West Wilson, Madison, WI

2. **Mail Address**
   Division of Health Care Financing
   Bureau of Eligibility Management

Public Assistance Fraud Unit
P.O. Box 309
Madison, WI 53701- 309

3. **FAX:**
   608-261-6861

FoodShare Staff are available to assist you with fraud prevention and related efforts. For information regarding general fraud program policy and procedures, including reporting potential trafficking of FoodShare benefits/cards, contact the following DHFS individuals:

Mike McKenzie
Public Assistance Fraud Unit Manager
Department of Health and Family Services
Phone: 608-266-0930
Email: mckenmi@dhfs.state.wi.us

Charles Billings
Fraud Program Contracts Specialist
Department of Health and Family Services
Phone: 608-266-9246
Email: billict@dhfs.state.wi.us

Barry Chase
Fraud Program Analyst
Department of Health and Family Services
Phone: 608-266-1849
Email: chasebb@dhfs.state.wi.us

For reporting specific suspected recipient misuse of his/her MA card, send the recipient's name, card number, address, a summary of your suspicions, and any supportive documentation to:

Lockin Program
Bureau of Eligibility Management
Division of Health Care Financing
PO Box 309
Madison, WI 53701

or call: MA Complaint Hot Line: (608) 267-2521

The Division of Health Care Financing will, if appropriate, issue a restricted card.

For inquiries about potential fraud issues relating to specific public assistance programs, contact the individuals listed below for the specific program:

FoodShare Program:
Barry Chase
Fraud Program Analyst
Department of Health and Family Services
Phone: 608-266-1849
Email: chasebb@dhfs.state.wi.us

Medical Assistance Programs:
Al Keup
Planning and Policy Analyst
Department of Health and Family services
Phone: 608-261-7786
Email: keupao@dhfs.state.wi.us

Wisconsin Works (W-2) Programs:
Robert Plakus
Program and Planning Analyst
Department of Workforce Development
Phone: 608-267-3708/
Email: robert.plakus@dwd.state.wi.us

Wisconsin Works (W-2) Programs:
Janice Peters
W-2 Section Chief
Department of Workforce Development
Phone: 608-266-7456
Email: janice.peters@dwd.state.wi.us

Child Care Program:
Jim Bates
Policy and Planning Analyst
Department of Workforce Development
Phone: 608-266-6946
Email: Jim.Bates@dwd.state.wi.us

Public Assistance Collections Unit (PACU)
Fay Simonini
Collections Supervisor
Department of Workforce Development

Phone: 608-267-2187

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3.2 FRAUD PREVENTION/ FRONT END VERIFICATION

3.2.1 Fraud Prevention

3.2.1.1 Fraud Prevention Plan
3.2.1.2 Model Program Fraud Plan
3.2.1.3 Program Resource

The fraud prevention program involves a process of intense scrutiny of specific elements or circumstances of individual cases that exhibit evidence or characteristics of potential program violation. Prevention actions are intended to prevent issuance of incorrect benefits and involves more in-depth verification than the routine verification used for program eligibility determination.

The primary goal of the prevention program activities is to insure accurate benefit issuance, not to accomplish criminal prosecution. The results of the prevention activities are used in determining benefit eligibility and to help in determining the need for further fraud control actions.

3.2.1.1 Fraud Prevention Plan

The fraud prevention program is a component of the general fraud program operating in every county and tribal geographic area of the state. DHFS requires each county and tribal IM agency to submit an annual fraud plan that includes their prevention program. DWD W-2 contracts require W-2 agencies to submit a fraud plan within 30 days of the signing of the W-2 contract.

3.2.1.2 Model Program Fraud Plan

DHFS annually provides a model Public Assistance fraud plan to all IM/W-2 agencies. DHFS recommends that all local agencies use the model fraud plan as a guide for their local fraud prevention programs. W-2 contracts indicate major components of what W-2 agency fraud prevention plans should address. W-2 contracts refer to DHFS IMM fraud materials and requires W-2 agencies to submit their fraud prevention and detection plan to the DWS W-2 Contract Administrator for review within 30 days the signing of the W-2 contract. The DWS W-2 Contract Administrator will promptly forward each plan to the DHFS fraud unit.

3.2.1.3 Program Resource

DHFS and DWD support fraud and fraud prevention. Program responsibility for fraud and fraud prevention rests with the Bureau of Eligibility Management/Division of Health Care Financing in the Department of Health and Family Services. See Section 3.1.1.6 for public assistance fraud contacts.

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3.2.2 FRONT END VERIFICATION (FEV)

Front end-verification (FEV) is one method of preventing fraud. FEV is a process of intense scrutiny of cases that exhibit characteristics of potential program violations or errors. When a case is referred by a case worker to a local agency or local agency contracted FEV Specialist or Investigator, s/he performs a more in-depth verification than the routine verification for eligibility determination.

FEV focuses on particular elements or circumstances of a specific case. The FEV Specialist or Investigator confirms or verifies the accuracy of information provided by the client at application, review, or change. S/he provides the results of the FEV to the IM and/or W-2 staff for use in verifying eligibility for program services or for fraud investigation referral when applicable.

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3.2.3 FEV CASE APPLICATION

FEV should not be routinely required on all new case applications, reviews, or changes. Cases referred for FEV must exhibit characteristics of a potential program error prone profile (3.2.4).

Local IM and W-2 agencies must establish an error-prone profile for all intake staff and program eligibility workers to use to determine if a case meets criteria for an FEV referral. Measure all cases against the error-prone profile in a consistent manner to avoid biased selection for FEV. Intake staff and program eligibility workers should refer a case for FEV when it meets the error-prone profile.

3.2.3.1 Benefit Delay Prohibited

Do not delay issuance of program benefits if a case is referred for FEV. Program benefit processing deadlines must be observed even if the FEV results have not been received. Benefit recoupment can be completed at a later date, if an overpayment is established.

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3.2.4 FEV ERROR-PRONE PROFILE

3.2.4.1 Characteristics for an Error-Prone Profile
3.2.4.1.1 Residence
3.2.4.1.2 Household Composition
3.2.4.1.3 Assets
3.2.4.1.4 Earned Income
3.2.4.1.5 Unearned Income
3.2.4.1.6 General Criteria

An error-prone case profile is a list of characteristics recognized by the local agency as common to error cases. Cases showing these characteristics or meeting the error-prone profile are referred for FEV.

Profiles allow a local agency to allocate administrative and investigative resources to those cases according to their potential for error.

The agency's Error Prone Profile characteristics should be evaluated regularly to determine if they are actually identifying errors. The recommended target is that 30% of those cases referred to FEV would result in a referal to the Fraud Investigator. If an agency, does not meet the 30% target, the agency should remove characteristics that are not error prone and consider adding other characteristics that the agency believes may be error-prone, as appropriate.

The criteria must accommodate situations applicable to the specific agency. One method of creating the profile is to use QC reports on cases in which either client error or potential fraud was identified by workers. Another would be a review of cases referred for fraud investigation where fraud or error was found by formal investigation. By examining actual fraud cases, it’s possible to determine types of situations that resulted in error. It’s also possible to discover from these cases a pattern of clues or signs of potential fraud. Second party review findings provide another source of information.

Some simple possible “case flagging” examples,

- Are there questions left blank on the application form?
- Is there unusual movement of people into and out of the household?
- Do household expenses exceed total household income?

Because error-prone profile criteria are likely to change over time, review the criteria annually as part of your fraud plan. Economic condition changes in your area may influence the criteria. FEV activities may prove that some

characteristics originally thought to show potential errors are irrelevant and not cost effective to pursue.

The following are characteristics that may not be used when developing an error prone profile.

Race, color, national origin, ethnic background, sexual orientation, religion, age, political belief, disability, association with a person with a disability or marital status. Federal regulations specifically prohibit error-prone profiles from targeting migrant farm workers or Native Americans.

3.2.4.1 Characteristics for an Error-Prone Profile

Following are some examples of “high risk” or relevant characteristics that may be helpful in developing an error-prone profile. Some items are not applicable for all programs.

3.2.4.1.1 Residence

Error prone residence indicators include:

1. Conflicting documentation or verification differing from that reported by the applicant or recipient.

2. Recent arrival (within the prior three months) in your county/tribal area. (You must exclude migrant farm workers, the homeless and residents of shelters from those targeted for FEV.)

3. Highly mobile families who rarely stay in one location for more than two or three months. (except for migrant farm workers).

3.2.4.1.2 Household Composition

Error prone indicators for household composition include:

1. Employable household members listed on the application, and then later reported to have moved.

2. Collateral contact statement is inconsistent with the client’s statement of household size.

3. Landlord's address is same as clients, but landlord is not included as a household member.

4. Landlord is the absent parent, male/female friend, or ex-spouse.

5. An unmarried client gives birth to a baby who is given the same last name as a male friend, but client claims male friend does not live with her.

6. Client reports someone else pays the rent for several months, but that person is not listed in the home.

7. Household reports large increases or decreases in household size or a frequently fluctuating household size.

3.2.4.1.3 Assets

Error prone indicators for assets include:

1. Client reports no assets or resources on the application, but has no unpaid bills.
2. Client reports no vehicle but has no reasonable explanation of his/her transportation method (if s/he lives remote from public transportation.)
3. Applicant claims no income for an extended period of time but offers no satisfactory explanation of how s/he met needs before applying.
4. Information provided by the client shows a substantial reduction in assets just prior to application for assistance.
5. Reported assets are very near or equal to the asset limits.

3.2.4.1.4 Earned Income

Error prone indicators for earned income include:

1. Reported income is different than IRS records or state tax forms.
2. Client’s expenses are being met, although client’s reported income is not enough to satisfy the obligations.
3. Self-employment income reported to have stopped (potential business assets available).
4. Client reports zero income but states someone else paying the bills.
5. Household that has a wage earner who becomes unemployed, and reports no UI, or reports UI has stopped but employment has not resumed.
6. Household that has child(ren) age 16 or over who are not in school or employed.
7. A FoodShare applicant reports zero income, does not request further assistance such as W-2, and is unable to clarify how needs are being met (possible unreported source of income).

3.2.4.1.5 Unearned Income

Error prone indicators for unearned income include:

1. Household with all members 65 or older that does not report SSA, SSI, VA, or other pensions may have income-producing assets.

2. Household member claims disability but does not report SSI, SSA, or worker's compensation.

3.2.4.1.6 General Criteria

General error-prone criteria include:

1. The client has provided contradictory information or made statements inconsistent with information provided by her/him during a previous contact, in the application form, or in a recent Six Month Review Form (SMRF) or review.

2. Case was previously closed for loss of contact or failure to provide essential information.

3. Case in which fraud was previously alleged or committed.

4. Case in which information provided by applicant is incomplete or not clear.

5. The case previously was referred for FEV which resulted in either denial or reduction of benefits.

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3.2.5 FEV Referral Steps

IM and/or W-2 staff must initiate the FEV referral in CARES on the BVIR screen. Specific information about the referral should be documented on the BVCC comment screen after the BVIR referral screen is processed.

The steps IM or W-2 agency staff must take to initiate and process an FEV referral are as follows:

1. Conduct the interview and compare the case characteristics to the error-prone profile.
2. Specify the error-prone reason(s) of concern and refer the case using the BVIR investigation referral screen in CARES, to the agency's fraud or FEV gatekeeper, who may be an ES Supervisor or a designated FEV/fraud program specialist**.**
3. Provide specific information regarding the referral on screen BVCC.
4. Approve or deny the case after receiving the results of FEV prior to the final eligibility determination, the applicant will be contacted and given an opportunity to resolve discrepancies between the information s/he provided and the information obtained through FEV.
5. Determine and coordinate any benefit savings resulting from FEV and provide them to the person responsible for reporting on the BVIT and BVPI screens on CARES.

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3.2.6 FEV SPECIALIST FunctionS

3.2.6.1 Confidentiality
3.2.6.1.1 Personal Rights
3.2.6.2 Sources for FEV
3.2.6.2.1 Residence and Household Composition Information by Field Verification
3.2.6.2.2 Information by Collateral Contacts
3.2.6.2.3 Information by Surveillance
3.2.6.2.4 Vehicles & Assets Information
3.2.6.2.5 Income Information

FEV specialist functions can be performed by a part-time or full time agency employee or a contracted service provider. An agency should have a single FEV specialist and a back up, unless the workload warrants more than one position performing this function. The FEV specialist does not approve or deny a group's eligibility or issue benefits.

The FEV specialist typically will:

1. Verify that a case meets the criteria for FEV referral. If the referral does not appear to meet the agency's error-prone profile criteria, the FEV specialist should discuss the reason for the referral with the agency's Gatekeeper before proceeding
2. Determine which FEV activities are appropriate for the referred case.
3. Estimate the approximate time needed to perform FEV activities. When possible, complete FEV activities prior to issuance of benefits. (See Note below with processing timelines.)
4. Perform activities to verify the information that prompted the referral.
5. Report (in writing) the results of the FEV to the agency Gatekeeper, who will approve the report and forward its findings to the eligibility worker and/or the W-2 agency supervisor who performs the case management functions.
6. If the FEV results show a possible prior fraudulent overpayment, include that information in the written report. The Gatekeeper should record that information on the BVCC screen linked to the BVIR, BVIT and BVPI screens.

NOTE:

Case workers are required to follow processing requirements for cases that have been referred to FEV including:

- Expedited FS criteria and

- 30-day limit for processing applications

CARES allows 30 calendar days for a timely completion date to be recorded on the BVIT screen for an FEV investigation. If an FEV investigation is expected to exceed 30 days, the agency's Gatekeeper should record an Extension Due Date on the BVIT screen and provide an explanation on the BVCC screen.

3.2.6.1 Confidentiality

Do not divulge information about the client or investigations for any purpose not connected with the **direct administration** of the benefit programs. Penalties for unauthorized release of an applicant or recipient's information may include a fine of $25 to $500 or imprisonment of 10 days to more than one year or both. (§49.83, Wis. Stats)

3.2.6.1.1 Personal Rights

As detailed in Wis. Stat. §49.81, DHFS, DWD and all public assistance and relief granting agencies are required to respect the following rights of recipients of public assistance.

1. The right to be treated with respect.
2. The right to confidentiality of agency records and files.

   NOTE: Federal law allows for the use of records:

   a. To locate a person, or the assets of a person:

      - who failed to file tax returns, or
      - who underreported taxable income or
      - who is a delinquent taxpayer,

   b. For identifying fraudulent tax returns or

   c. Providing information for tax-related prosecutions, or

   d. Auditing or accounting purposes to the extent permitted under federal law.

3. The right to access to agency records and files relating to the applicant/recipient's case, except that the agency may withhold information obtained under a promise of confidentiality made to the

provider of the information.

4. The right to a speedy determination of eligibility for public assistance, to notice of any proposed change in such eligibility, and, in the case of assistance, to a speedy appeal.

The method used to verify information when determining eligibility must not violate the client's rights, privacy or personnel dignity. (Grandberry v. Schmidt).

3.2.6.2 Sources for FEV

Following are some suggested resources which should provide FEV related information. Agencies are not limited to using only these sources. Select the most appropriate resources and procedures.

3.2.6.2.1 Residence and Household Composition Information by Field Verification

Field verification is a visit to an assistance group's residence to verify factors affecting eligibility for program benefits. Field verification should only be attempted when other attempts at verification have failed and the assistance group has been provided advance notice of visit.

When documentary evidence is insufficient to determine eligibility or a case fits the error prone profile a visit to the assistance group’s residence may be appropriate.

Generally, field verification involves residency or household composition. Field Verification can only be conducted when:

1. Clients are given advance notice of the date of the visit; and,

2. Documentary evidence cannot be obtained or is insufficient to make a final determination of eligibility or benefit level.

If field verification must be conducted and the advance notice of the date is given, inform the client of the information in question. Document issuance of the notice in the IM and/or W-2 record or BVCC screen for the referral, or both.

Do not conduct field verifications earlier than 8 a.m. or later than 8 p.m. DHFS and DWD recommend field verification visits take place during normal business hours unless there are special circumstances. Document any special circumstances in the FEV Specialist's or Investigator’s report. Examples of special circumstances are:

1. It is necessary to accommodate the client's work schedule.

2. The FEV Specialist/Investigator has made 2 unsuccessful attempts to contact the client at their residence between the hours of 8 am to 8 pm.

Conducting the Field Verification

1. At the residence, identify yourself to the client and explain the reason for your visit.
2. Request identification (Social Security card, driver's license, state ID, etc.) from the client.
3. Treat the client(s) and all other persons in the household with respect. Do not coerce them.
4. Ask permission to enter the residence. Do not attempt to enter if the client refuses to give consent. You may inform the client that refusal may delay issuance of benefits but you may not tell the client that there will be automatic denial of the case.
5. Inform the person who gave consent for you to enter the residence that s/he may withdraw that consent at any time. Anything in plain view that is pertinent to determining proper benefits may be included in the written FEV report.
6. You may ask to see areas of the residence. Do not demand access, or inspect closets, cabinets, attics, basements, garages, etc. without the resident's consent.

3.2.6.2.2 Information by Collateral Contacts

A collateral contact is an oral or written confirmation of a household's circumstances by a person outside the household.

A collateral contact is an oral confirmation of a household's circumstances by a person outside the household.

Do NOT contact individuals not designated as collateral contacts by the household unless:

a. The household fails to designate a collateral contact or designates one which is unacceptable to the agency; and,

b. Documentary evidence cannot be obtained or is insufficient to make a firm determination of eligibility or benefit level.

Examples of acceptable collateral contacts may include employers, landlords, social service agencies, migrant service agencies, and neighbors of the household who can be expected to provide accurate third-party verification.

3.2.6.2.3 Information by Surveillance

You may use legal surveillance in completing an FEV investigation of residence or household composition.

3.2.6.2.4 Vehicles & Assets Information

Examples of sources to verify vehicles and assets include:

1. Department of Transportation.
2. Register of Deeds for mortgage or debt information.
3. Credit bureaus.
4. Banking and other financial institutions.
5. Auto appraisers for collector vehicles.

3.2.6.2.5 Income Information

Examples of sources to verify income include:

1. State wage matches.
2. Contact with employer.
3. State and federal tax information.
4. Child support records.
5. Social Security Administration.
6. Financial institutions.

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3.3 FRAUD AND INTENTIONAL PROGRAM VIOLATION

3.3.1 identifying suspected Fraud/Intentional Program Violation (IPV)

3.3.1.1 Elements of Fraud or Intentional Program Violation
3.3.1.2 Personal Rights
3.3.1.3 Recipient Fraud
3.3.1.4 Provider/Vendor
3.3.1.5 Identifying Potential Fraud
3.3.1.6 Reporting Potential Recipient FoodShare Trafficking

This section provides information on identifying potential fraud/IPV elements and defines different types of fraudulent activity.

3.3.1.1 Elements of Fraud or Intentional Program Violation (IPV)

The intent and mental competence of the client are important elements in identifying suspected fraud. For example, misrepresentation with intent to defraud is probably present when a client reports being unemployed during a given period when in fact s/he received earnings from employment in the period identified. A misstatement due to the client's misunderstanding of what constitutes income may not be fraud.

Examples of critical indicators of fraud/IPV are:

1. Reluctance or refusal to provide needed information about income, resources, or relevant eligibility factors.

2. Failure to report a change in circumstances that would affect eligibility.

3. Committing any act in violation of a benefit program, State statute or program regulation.

3.3.1.2 Personal Rights

When investigating potential fraudulent activities adhere to the Public Assistance Recipients' Bill of Rights detailed in 3.2.6.1.

3.3.1.3 Recipient Fraud

Examples of recipient fraud include:

1. Collusion with a provider of benefit services to receive undue benefits/ payments (for example, childcare, subsidized jobs, health care).

2. Concealing income or assets by failure to report ownership or acquisition such as:

    a. Unreported income from jobs or from Unemployment Compensation, Social Security Benefits, Workers Compensation.

    b. Unreported assets or resources such as vehicles, savings accounts, etc.

3. Disposing of substantial assets without informing the agency.

4. Concealing circumstances or a change in circumstances which, if made known to the IM or W-2 agency, would have resulted in a decrease or discontinuance of the payment or other benefits.

   For example, failure to report a change in family composition, such as the return of the absent parent to the home or the departure of an eligible member from the home.

5. Misrepresenting the number and relationship of members of the family unit.

6. Misuse of the lost, stolen or destroyed benefits process.

7. Trafficking or fraudulent use of FoodShare benefits.

8. Misrepresenting identity or residence for the purposes of receiving FS or W-2 benefits from one or more agencies simultaneously. See W-2 Manual 11.4.1 and FSHB Appendix 6.1.3 for a detailed description of the violation.

3.3.1.4 Provider/Vendor

Provider and vendor fraud can occur in collusion with a participant or independently. Agency staff should be familiar with program regulations and be alert to actions that could be an indication of possible provider fraud. When appropriate, refer these allegations for investigation per guidelines found in (See 3.3.4).

Examples of provider fraud include but are not limited to:

1. Claiming compensation for program services that were not provided. (Child Care, Health Care, trial jobs, training etc.)

2. Receiving kickbacks, bribes or rebates.

   Examples of kickbacks, rebates or bribes include but are not limted to:

   a. A child care provider paying a client a portion of the child care fees as an inducement to the client to place his/her children in the provider's care.

   b. A child care provider returning a portion of his/her fees to a W-2 worker for referring clients to the provider.

   c. A child care provider paying a portion of chid care fees claimed to a W-2 caseworker as a reward the worker for overlooking excessive hours claimed or unreported absences of children.

   d. A W-2 worker receiving a fee from a client to approve false job activities reports.

   e. A W-2 worker receiving payment from an employer for directing clients to the employer or for approving excessive hourly wage reports.

   f. A transportation provider paying a W-2 worker a portion of transportation expense payments to approve excessive transportation expense claims.

3. Assisting applicants to make false claims to obtain benefits for themselves.

3.3.1.5 Identifying Potential Fraud

Potential fraud may be identified by many sources, including:

1. Financial and Employment Planner (FEP), IM staff, and other agency personnel.
2. Complaints from general public.
3. Periodic audits of suspected providers.
4. Use of computer databases.

   a. CARES

b. DWD files, including wage and employer information for anyone with an employer in the state (e.g. New Hire).

c. Federal agencies.

- Social Security benefits.
- Wage information.
- IRS interest income from savings.
- Unemployment benefits from other states.
- Interstate Data Exchanges.
- Interstate Matches.

d. EBT transaction data

5. USDA Food & Nutrition Services (FNS) personnel.

3.3.1.6 Reporting Potential Recipient FoodShare Trafficking

When a local agency has information that a FoodShare program client is engaged in trafficking or fraudulent use of FoodShare benefits, the local agency should forward this information in writing to DHFS. (See section 3.1.1.6) DHFS will coordinate with FNS to ensure that no further action will take place that will jeopardize an investigation that might be in progress by FNS.

1. If no contact with a client by the local agency has yet occurred regarding the alleged fraudulent activity, no contact will be initiated.

2. If contact has occurred by the local agency regarding the alleged fraudulent activity, further activity will cease until authorization from FNS is received.

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3.3.2 REFERRALS FOR FRAUD INVESTIGATION

3.3.2.1 Selection Criteria for Fraud Investigation
3.3.2.2.1 Worker-Initiated
3.3.2.2.2 Gatekeeper Review
3.3.2.3 Referral Documentation for a Fraud Investigation
3.3.2.4 CARES Fraud Screen Required Tracking
3.3.2.5 Agency Disposition of Fraud Investigation

Agency staff must differentiate between the selection of cases and activities used for referral to fraud investigation (3.3), and the selection of cases and activities used in the fraud prevention/FEV program (3.2). A clear separation of these activities is necessary for establishing effective procedures for selecting cases for referral.

3.3.2.1 Selection Criteria for Fraud Investigation

The primary purpose of a fraud investigation is to determine the correctness of an allegation that a recipient of a public assistance benefit **intended** to misrepresent his or her eligibility criteria or committed any act that constitutes an intentional program violation (IPV). A careful examination of a case record by the agency administrating the program is essential in determining whether it should be referred to the fraud investigation unit.

A fraud investigation referral should not be used in every case with questionable circumstances that pertain to an eligibility determination or verification. Early detection and/or fraud prevention activities are the responsibility of the local agency administering the program.

In most suspected fraud cases referred to an investigator by an IM or W-2 agency:

1. A benefit overpayment is suspected and the agency has reason to believe the overpayment is the result of misrepresentation of program eligibility requirements. The misrepresentation of program eligibility or fraudulent activity may be the result of;

    a. False or misleading statements of circumstances.
    b. Failure to report a change in circumstances.
    c. Concealed or withheld facts.
    d. Violation of a program regulation or State statute relating to program benefits.

2. The benefit(s) would not have been provided but for the false representation.
3. The conduct of the benefit recipient indicates the misrepresentation or fraudulent use of the benefit was done with knowledge and intent.

3.3.2.2 Timely Fraud Referral and CARES Entry

Agencies are responsible for timely referral of participants receiving payment or services for investigation when fraud is suspected.

Agencies are responsible for properly reporting all investigation referrals in a timely manner on the Fraud Investigation Tracking Screens (FITS) on CARES. The initial referral must be entered on the BVIR screen on CARES.

3.3.2.2.1 Worker-Initiated

A case worker initiates a fraud referral on CARES screen BVIR. The agency's Gatekeeper approves or denies the investigation referral on CARES screen BVIT

3.3.2.2.2 Gatekeeper Review

1. The gatekeeper makes an assessment as to whether the case meets the agency's fraud program referral criteria. A general guideline would be to not refer cases where the overpayment amount is expected to be less than the cost of investigation. Aggravating circumstances, such as multiple violations or multiple violators, are acceptable exceptions.

2. The fraud Gatekeeper approves or denies the investigation referral on the BVIT screen in CARES.

3.3.2.3 Referral Documentation for a Fraud Investigation

The fraud referral should contain all relevant data the agency has on the case to help the fraud investigator.

Including but not limited to:

1. A statement of the fraud allegation.
2. The original application for assistance of the suspect including:

    a. The source and amount of any *income*.
    b. An evaluation of the recipient's resources or assets.

3. Any Notice of Responsibility or program violation warnings given to and/or signed by the recipient at any time prior to or during the fraud period.

4. Identification of all related public benefit programs the recipient is receiving.

5. All eligibility review information within the fraud period.

6. A statement of the estimated overpayment amount and suspected fraud period.

7. CARES-generated information identifying the recipient and benefit issuance history paid to the recipient during the alleged fraud period.

8. A list of all workers involved with the recipient in the case.

9. A statement from the referring agency indicating the case file has been reviewed by the agency and reveals the recipient had failed to report required changes.

3.3.2.4 CARES Fraud Screen Required Tracking

All fraud investigation cases are tracked on the CARES Benefit Recovery subsystem on screens BVIR, BVIT, and BVPI. Specific information documenting circumstances surrounding the referral should be entered on the BVCC screens that attach to BVIR, BVIT and BVPI screens. These screens are collectively called the Fraud Investigation Tracking Screens (FITS): (See CARES Guide, Section 1, Chapter 10.7)

All investigation information is entered into CARES by the referral agency including; (information generated on screens BVIR and BVIT)

1. Name of primary person.
2. SSN of Primary Person.
3. Benefit programs involved and period of overpayment.
4. Identity of referring agency, worker, and investigation agency.
5. Investigation decision date.
6. Investigation completion date.

When the fraud investigation report is returned to the referral agency, the local agency is responsible for accepting the investigation report and closing the investigation referral.

The agency fraud Gatekeeper or other designated worker must enter the investigation costs and investigation completion date on the BVIT screen.

The investigation referral continues to be tracked in the FITS/BVPI screens until final case disposition is determined by the Gatekeeper or other designated staff. The referral agency Gatekeeper or designated staff should document the investigation disposition for each program in the BVPI screen for the respective programs. Explanatory information should be recorded on the BVCC screens.

3.3.2.5 Agency Disposition of Fraud Investigation

Based on the fraud investigation findings, the referral agency is responsible for initiating the processes for prosecution of fraud cases and calculating and collecting fraudulent overpayments verified by the investigation.

When the investigation finds that a person committed an alleged intentional program violation (IPV), the agency must decide whether to refer the case to:

1. District Attorney (DA) for prosecution (3.3.5);
   or
2. Administrative Disqualification Hearing (ADH) (3.3.10),
   or
3. Make no referral for IPV/fraud determination.

The reason for not referring the case for IPV determination must be recorded on CARES screen BVPI with an appropriate code such as "insufficient overpayment", "can not find individual", etc.

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3.3.3 Conducting Recipient Fraud investigation

3.3.3.1 Confidentiality
3.3.3.2 Basic Fraud Investigative Plan
3.3.3.3 Investigator's Report Case Documentation
3.3.3.4 Timeliness of Investigator's Report
3.3.3.5 Satisfactory Completed Investigation
3.3.3.6 Corrective Action Plan for Investigation Deficiencies

Each agency should request the local DA establish specific criteria for referring public assistance cases for prosecution. The fraud investigator should then develop a work plan for case investigations to produce documentation according to those guidelines.

3.3.3.1 Confidentiality

Respect client's rights as detailed in 3.2.6.1.

3.3.3.2 Basic Fraud Investigative Plan

Using a checklist format, the fraud investigator must document the alleged facts from the complaint to be investigated.

1. Review the allegations contained in the complaint/investigation referral.
2. Formulate the plan objective. (Investigate to find evidence to substantiate the allegations of intentional program violation. Is there a provable violation of Chapter 49 of Wis. Statutes?).
3. Review the recipient's case record and supporting referral documentation as provided. Determine what was the original basis of eligibility and if the record contains any notice to the program agency that the original circumstances changed.
4. Conduct case driven resource search. (Depending on the program and eligibility requirements, information resources can vary. For example, check with the school for a child living in a household, or check with an employer for unreported work *income*, or check service provider records for appropriate payment documentation).
5. Conduct a personal search for witnesses such as neighbors or others and conduct interviews to obtain relevant information.
6. Review the results of the investigation and confirm or redetermine the tentative fraud period specified on the BVIR referral screen.
7. Interview the recipient’s caseworker(s) assigned during the fraud period. Determine if the recipient told them of a change in eligibility circumstances or what routine procedures would have been followed by

the worker including documents generated for the case record. Establish if the worker(s) can identify the recipient.

8. Attempt to interview the suspect/recipient regarding the allegations of complaint. Inform the suspect/recipients of their rights to say nothing and to refuse contact with the investigator. However, the agency must give the individual opportunity to respond to the fraud allegation. Ask the current caseworker to be present.
9. If complaint is substantiated, obtain certified/ notarized copies of appropriate documents to be used as evidence.
10. Return the satisfactory completed investigation report to the referring agency.

3.3.3.3 Investigator's Report Case Documentation

The investigator must give the referral agency a written investigation report for each completed investigation. The report must document information in a logical sequence that incorporates who, what, when, where, why, and how in the body and substance of the investigative findings; it must address the specific allegation findings requested in the referral from the requesting agency.

The investigation report must contain the:

1. Identification of the client/contact person and verification of identity provided (for example, photo ID, driver's license).
2. Relationship of the contact person to the client.
3. Written interview(s) with the contact person documenting all relevant information.
4. Summary of the Investigator's findings.

Completed investigations must contain a summary conclusion with a recommendation to the referral agency to do one of the following:

1. Proceed with a case for administrative disposition.
2. Proceed with a case that meets the criteria for prosecution established by the local District Attorney's office and recommend adjudication of the case. Apart from the adjudication process, note that the case may be subject to administrative sanction, recoupment and/or repayment.
3. Take no action to establish an IPV because the fraud allegation was not substantiated.

   The referring agency should require the investigation report to address the minimum criteria specified by the District Attorney's guidelines for prosecution of public assistance fraud, if the DA has provided such guidelines.

3.3.3.4 Timeliness of Investigator's Report

The fraud investigator's final report should be delivered to the referral agency within 90 days of the fraud referral date listed on the BVIT screen.

Investigations that exceed this 90-calendar day time frame will be out of compliance unless additional time is requested and approved. For such cases the investigator should request in writing an extension from the referral agency. The extension request should state the reason for the delay. The extension request must be reviewed and returned to the investigating service provider indicating approval or denial. Requests must be submitted in writing for approval by the 80th calendar day following the date of the investigation referral by the referring agency. The referral agency must enter the end date for the extension period in the appropriate field on the BVIT screen on CARES.

3.3.3.5 Satisfactory Completed Investigation

A satisfactorily completed investigation is determined by, but not limited to, these factors:

1. Investigation report and findings address all issues of the fraud referral allegations.
2. Documentation of all essential investigation elements is adequate.
3. Factual and accurately reported data is provided.
4. Timeliness criteria are met (completion in 90 calendar days or within the agreed extended time frame).

If the referral agency determines that any of these factors are lacking, the report may be found unsatisfactory and referred back to the investigation service provider for corrective action.

The investigation service provider may exercise the option to bring any unresolved matter concerning reports or any issue related to performance to the attention of the DHFS for resolution.

3.3.3.6 Corrective Action Plan for Investigation Deficiencies

When the referring agency or DHFS notifies the investigation service provider in writing that its investigation report failed to meet requirements detailed in (3.3.3.2, 3.3.3.3, 3.3.3.4, 3.3.3.5), the investigation service provider must present the referring agency or DHFS with a corrective action plan within 5 business days that will include:

1. Specific description and identification of the deficiency.

2. For each deficiency:

a. An outline of corrective actions to be taken.
b. Description of expected outcomes of each action.
c. A target date for implementing the action plan.
d. A date by which deficiency will be corrected.

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3.3.4 VENDOR/PROVIDER FRAUD INVESTIGATIONS

3.3.4.1 W-2 Provider/Vendor Fraud
3.3.4.1.1. W-2 Vendor/Provider Fraud Investigation Procedures
3.3.4.2 MA Provider Fraud
3.3.4.3 FoodShare Retailer Fraud/Trafficking
3.3.4.4 State Law Enforcement Board Investigations

Possible provider/vendor fraud may be identified by many sources, including:

1. Financial and Employment Planner (FEP), IM staff, and other agency personnel.
2. Complaints from general public.
3. Periodic audits of suspected providers.
4. Use of computer databases.

    a. *CARES*

    b. DWD files, including wage and employer information for anyone with an employer in the state.

    c. Federal agencies.

        - Social Security benefits.
        - Wage information.
        - IRS interest income from savings.
        - Unemployment benefits from other states.
        - Interstate Data Exchanges.
        - Match Wisconsin benefit recipients caseload against other states.

    d. EBT transaction data

Documents are the essential source of evidence in vendor/provider fraud cases. Audits of the vendor/provider records, as provided by state statute and contract, are a common basis of a fraud investigation referral. However, vendor/provider fraud can also be reported as noted below.

3.3.4.1 W-2 Provider/Vendor Fraud

The W-2 agency and the State have the ability to pursue a civil or criminal action against any entity that receives funds to which it was not entitled. The W-2 agency contracts are specific regarding the responsibility of each W-2 agency to

monitor its subcontractors and recover any overpaid amounts that resulted for any reason.

The following conduct by vendors/providers of the W-2 program are prohibited/fraudulent (§49.141, Wis. Stats.)

1. Knowingly and willfully making or causing to be made any false statement or representation of a material fact in any application for any benefit or payment.

2. Having knowledge of the occurrence of any event affecting the initial or continued eligibility for a benefit or payment under the W-2 program and concealing or failing to disclose that event with fraudulent intent to secure a benefit or payment under Wisconsin Works either in a greater amount or quantity than is due or when no such benefit or payment is authorized.

3. Soliciting or receiving kickbacks, cash or other forms of compensation, for referring an individual or individuals arranging or furnishing an item or service for which payment is received under the W-2 program

   This provision does not include an amount paid by an employer to an employee who has a bona fide employment relationship with the employer for employment in the provision of covered items or services.

4. W-2 providers/vendors may not knowingly charge a W-2 recipient for services provided under W-2 nor can they charge a W-2 recipient for non-W-2 services without first notifying the recipient of potential charges.

3.3.4.1.1. W-2 Vendor/Provider Fraud Investigation Reporting

Report W-2 program vendor/provider fraud to the W-2 program contacts noted in 3.1.1.6. and/or to the local W-2 agency management, if appropriate.

3.3.4.2 MA Provider Fraud

The following activities conducted by providers or vendors of the Medicaid program are considered fraudulent per Wis. Stat. §49.49(1) (a):

1. Intentionally making or causing to be made a false statement or representation of fact in an application for a benefit or payment.

2. Intentionally making or causing to be made a false statement or representation of a fact for use in determining rights to benefits or payments.

3. Having knowledge of an event affecting initial or continued right to a benefit or payment and intentionally failing to disclose such event.

4. Soliciting or receiving kickbacks, cash or other forms of compensation, for referring an individual or individuals or arranging or furnishing an item or service for which payment is received under the MA program.

5. MA providers/vendors may not knowingly impose upon a recipient charges in addition to payments received for services under Medicaid or knowingly impose direct charges upon a recipient in lieu of obtaining payment under Medicaid unless benefits or services are not provided under W2 and the recipient is advised of this fact prior to receiving the service.

3.3.4.2.1 MA Provider Fraud Reporting

If circumstances reveal a potentially fraudulent MA case involving a recipient and/or provider, compile the necessary data about MA claims paid to the recipient and provider and refer the case to the Department of Health and Family Services (DHFS) at:

Division of Health Care Financing
Bureau of Health Care Program Integrity (BHCPI)
PO Box 309
Madison, WI 53701
Telephone: (608) 266-5540
Fax: (608) 266-1096

The Wisconsin Department of Justice prosecutes vendor/provider criminal violations of MA laws (State Stat. §49.495). The designated unit within the Department of Justice is:

Medicaid Fraud Control
Wisconsin Department of Justice
P.O. Box 7857
Madison, WI 53707-7857

Phone # 608-266-1221

3.3.4.3 FoodShare Retailer Fraud/Trafficking and Reporting

A FoodShare retailer is a store authorized by FNS to sell food products in exchange for FoodShare benefits using the Wisconsin Quest Card.

Examples of FoodShare retailer fraud include but are not limited to:

1. Redeeming more FoodShare benefits than the value of food sales.
2. Selling ineligible items;

3. Accepting FoodShare benefits in payment for food sold to a FoodShare household on credit;
4. Buying or selling FoodShare benefits,

Use the toll-free hotline [(800) 424-9121] to report fraud, waste, or abuse committed by a FoodShare retailer to receive and redeem FoodShare benefits.

3.3.4.4 State Law Enforcement Bureau Program

When there is an identified problem of FoodShare trafficking, the State Law Enforcement Bureau (SLEB) program provides funding for 50% of administrative costs, as well as QUEST CARDS to local law enforcement agencies to conduct FoodShare trafficking investigations. Contact the State SLEB Manager [(608) 266-9246] to determine if there is a SLEB investigation agency in your county or for information concerning the SLEB program.

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3.3.5 REFERRAL TO Prosecution

3.3.5.1 Referral Criteria
3.3.5.2 Referral Letter to DA
3.3.5.3 Prosecution Timeliness
3.3.5.4 Pre-Charge Diversion
3.3.5.5 Pre-Trial Agreement
3.3.5.6 Deferred Prosecution Agreement
3.3.5.7 Disqualification Consent Agreement
3.3.5.8 Court Decision/ Court Order
3.3.5.9 Court Order Disqualification/IPV Reporting in CARES

When the agency director (or designee) decides the case meets the criteria for prosecution, refer the case to the District Attorney.

3.3.5.1 Referral Criteria

The referral agency is responsible for initiating the process for prosecution of fraud and the collection of fraudulent overpayments. The agency will determine if a case should be referred for prosecution based on whether or not the:

1. Completed investigation report supports the allegation of fraud.
2. Investigation was completed in a timely manner.
3. Case meets the local agency's policy and cost effective criteria.
4. Case meets the local DA's prosecution criteria.
5. Investigation Service Provider recommends prosecution or not.

The agency administrating the benefit is responsible for addressing the guidelines specified by the District Attorney.

Additional investigation documentation may be necessary for the final case disposition depending on the disposition type (trial vs. pre-trial diversion) and special case circumstances.

3.3.5.1.1 Local Agreements

Agencies responsible for administering public assistance programs are strongly encouraged to develop memoranda of understanding (MOU) or other written agreements with their local District Attorney's Office to establish the conditions under which a referral for prosecution will be made.

The MOU or other written agreement with the District Attorney's Office should contain selection criteria including documentation and any other requirements (e.g. the format) for making a satisfactory referral to prosecution.

3.3.5.1.2 Referral Content Recommendations for Agencies Without Local Agreements

The following materials are recommended by the Wisconsin District Attorney's Association, et.al, for making a satisfactory referral to prosecution.

1. Documentation that the recipient signed the application/review form.
2. Documentation of sources and amounts of *income* and assets.
3. Documentation of relevant changes in the case circumstances.
4. Documentation that the recipient received more program benefits than s/he was entitled to.
5. Calculation of the amount of all overpayments subject to prosecution.
6. A written summary of an interview or an attempted interview with the recipient or the recipient's signed statement regarding the allegations.
7. The IM/W-2 agency's recommendation regarding restitution, including possible repayment by recoupment from on-going financial assistance benefits in accordance with IM/W-2 policy.
8. A copy of the investigation report with a prosecution recommendation from the investigative service.

3.3.5.2 Referral Letter to DA

After the agency director (or designee) reviews the investigation report and determines the case qualifies for prosecution, refer the case with a letter of referral to the District Attorney. (File an agency copy in the case record.) Include in your letter to the DA:

1. A synopsis of the fraudulent activity.
2. The investigation's summary supporting the allegation.
3. A list of supporting documentation.
4. All information obtained in the investigation.
5. Full overpayment amount and appropriate program penalties.

Note: If the fraudulent activity involved the FoodShare program, include with your referral to the DA a request that the DA's office recommend to the court that a disqualification penalty, as provided in §49.795 (8)(d), (e), (f), Wis. Stats., be imposed in addition to any other civil or criminal fraud penalties.

3.3.5.3 Prosecution Timeliness

Time limitations on initial determinations by the DA's Office are desired to ensure that referrals are dealt with timely and appropriately by the criminal justice system and/or the program administrative process. It is recommended that

memoranda of understanding include prosecution time lines. Here is an example suggested for the MOU:

1. Within 60 days after a fraud referral by the IM/W-2 agency or its designee is sent or made to the District Attorney's Office for prosecution the DA's Office shall review the referral and do one of the following:

    a. Determine that the referral meets the criteria for prosecution, established by the DA's Office and initiate the prosecutorial process established by that office.

-or-

    b. Notify the W-2 agency that insufficient information is provided for the DA's Office to determine whether its criteria for prosecution are met and request the specific information needed to make that determination.

-or-

    c. Return the referral to the W-2 agency for administrative disposition with the determination that it does not meet the criteria established by the DA's Office for pursuing criminal prosecution.

-or-

    d. Return the referral to the IM/W-2 agency with notation of the DA Office's discretionary decision not to pursue prosecution and why.

2. The District Attorney's Office will send a written disposition of each prosecution referral to the IM/W-2 agency within 10 working days after completion of the case. The written disposition will include the following information:

    a. The conviction and sentence ordered or approved by the court.
    b. The disqualification action ordered by the court.
    c. The amount of overpayment charged by the District Attorney .
    d. The amount of overpayment read into the court decision, in addition to the amount charged.

3.3.5.4 Pre-Charge Diversion Agreement

The Pre-Charge diversion agreement is an alternative for anyone referred to the DA for an alleged IPV. It permits recovery of over issued benefits from the group member without the stigma of actual court prosecution. The referral agency should have an agreement with its local DA that provides for at least a 10 day advance written notification to the individual of the consequences of signing the consent agreement.

The pre-charge diversion agreement can be used at the point in the legal process prior to the DA filing criminal charges with the court of jurisdiction. The Pre-Charge Diversion Agreement is a contract between the person who admits to committing an IPV and the DA. The Agreement includes:

1. A statement by the person that s/he did commit an IPV;

2. An agreement that s/he will make full restitution of all benefit over issuance resulting from the IPV;

3. An agreement to waive his/her right to an administrative disqualification hearing and agree to the appropriate program disqualification penalties;

4. An optional agreement that s/he will pay associated costs, assessed costs and any additional penalties.

The offender makes restitution payments directly the IM/W-2 agency, unless other arrangements are incorporated into the Agreement.

3.3.5.5 Pre-Trial Agreement

The Pre-Trial diversion agreement is similar to the Pre-Charge agreement in that it is a contract between the person who admits to committing an IPV and the DA and it includes the same stipulations listed in 3.3.5.4, “Pre-Charge Diversion Agreement”. It is usually initiated after criminal charges have been filed with the court of jurisdiction. The agreement or contract requires the judge's signature.

The Pre-Trial diversion agreement can be used at any point in the legal process that the DA or court wishes, including after the entry of a guilty or no contest plea by the defendant.

3.3.5.6 Deferred Prosecution Agreement

A Deferred Prosecution Agreement does not affect DWD or DHFS rights as a creditor to collect overpayments. It merely provides that no further prosecution of the client will occur if the client performs certain community service activities. The local agency should recover the overpayment as it has calculated it and is not limited by the deferred prosecution agreement regarding collections. The 10 day notification guidance in Section 3.3.5.4 also applies to a deferred prosecution agreement.

3.3.5.7 Disqualification Consent Agreement

If a client's case has been referred to the District Attorney for prosecution for civil or criminal misrepresentation or Fraud in W-2, CC and/or FoodShare, the client may defer prosecution by signing a Disqualification Consent Agreement (HCF 16025). By signing

this agreement the client agrees to the penalties listed on the Form HCF 16025, even though the client has not been found guilty through court proceedings.

If the client signing the Disqualification consent agreement is not the head of the household, the head of the household must also sign this form in the line provided.

3.3.5.8 Court Decision/ Court Order

When a court decides a recipient has committed fraud:

1. Continue the direct, provider or vendor payment if program eligibility continues.

2. Recover the overpayment in accordance with the amount and method detailed in 10.3.2 of the W-2 manual, 6.2.2 of MEH, and 7.3.2 of FSH, and Chapter 5 of the Benefit Recovery Manual for CC.

3. Immediately enter the FS IPV on the AIIP screen on CARES. This initiates the appropriate sanction period on CARES.

4. If a court's determination that someone was guilty of an IPV is later overturned or reversed by a superior court, immediately end the disqualification period. Restore any benefits denied in the original IPV disqualification.

5. If a court does not impose a disqualification period for someone it finds has committed intentional program violation, initiate a disqualification period according to 3.3.5.8, unless contrary to court order.

6. Generally, a court order for restitution affects only the fraudulent overpayment amount. This order does not affect a local agency's obligation to recover all benefit overpayments under state and federal law. The basic obligation exists to recover all incorrectly paid amounts.

3.3.5.9 Court Order Disqualification/IPV Reporting in CARES

When a FS IPV has been determined by a court order, pre-charge agreement, disqualification consent agreement or a pre-trial agreement, enter the IPV information immediately into CARES on screen AIIP to help ensure that the FS disqualification period begins within 45 days of the date of determination. Enter the FS IPV in CARES within 10 days of the date of the IPV determination. See the CARES Guide Section 1 Chapter 10.7 for further direction.

CARES will automatically calculate the disqualification period for a FS IPV when CARES Screen AIIP is used. However if the court specifies a disqualification

period different from the default disqualification periods in CARES, override the default period with the court ordered sanction period.

W-2 and MA do not have screens similar to AIIP that automatically calculate the disqualification period. This procedure must be done manually by the caseworker. However, entering IPV and other information on fraud investigation tracking screens (e.g. BVIR, BVIT, BVIT, BVPI, BVCC) for W-2 and MA is necessary for Fraud program data collection and funding allocations.

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3.3.6 Administrative Cost Reimbursement

DHFS will reimburse local Income Maintenance agencies for their actual cost of fraud activities or allowable costs up to the funding allocations for Fraud Prevention and Fraud Investigation Services. The funding allocations are established by contract and identified in the Fraud Plan Budget. Additional federal matching dollars, in excess of the allocated amounts, are available for FoodShare and Medicaid fraud activities with county participation. No matching dollars are available under the Temporary Assistance for Needy Families (TANF) program for W-2 and Child Care.

Funding has been included in the W-2 administrative budget of all W-2 agencies to conduct fraud prevention and overpayment collection. The W-2 contract requires the operation of a fraud prevention and overpayment collection program. The amount of funds to operate prevention and collection programs is at the discretion of W -2 agencies. However, the W-2 agency is expected to allocate sufficient funds to achieve the goals of the fraud prevention and collections program.

To receive reimbursement for fraud investigation administrative costs, the investigative agency must perform a satisfactory investigation. A satisfactory completed investigation is defined in 3.3.3.5.

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3.3.7 FRAUDULENT Benefit RECOVERY

Fraud overpayments are those benefit overpayments determined as a result of an IPV finding by:

1. A court of jurisdiction.
2. An administrative disqualification hearing (ADH) or a signed ADH waiver agreement by the accused recipient and the head of household (if not the accused) waiving the right to an ADH.
3. A signed pre-charge agreement (Section 3.3.5.4), pre-trial agreement (Section 3.3.5.5), or deferred prosecution agreement (Section 3.3.5.6).

The referral agency may recover only the amount incorrectly paid to the recipient for the public assistance programs they manage. However, if fraud is suspected in more than one public assistance program, the referral agency initiating the fraud investigation will ensure that the fraud investigator will review all affected program violations. To accomplish this, the agency should take actions to alert case workers from other affected programs so recovery of all program benefit overpayments can be made.

3.3.7.1 CARES and CRES Fraud Overpayment Recovery Actions

Entering disqualification information in CARES screens will generate an automatic overpayment collection notice through the CARES benefit recovery system. If the first overpayment notice doesn't bring about repayment, CARES will automatically generate a total of three notices over a preset time period. If no response information is entered in CARES, the collection issue will be automatically referred to the State Central Recovery Enhanced System (CRES) which will continue collection actions. Questions on the State CRES collection system operation can be referred to 1(800) 943-9499.

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3.3.8 Local Agency REtention Portion of Claims

Federal FS regulation CFR 273.18(a)(ii) and 273.18(c)(2) authorizes the establishment of claims against a household for the value of FS benefits when an IPV for trafficking is established. Local agencies may establish a claim on the amount of FS benefits determined to have been trafficked during the IPV determination process. Local agencies can retain 15% of the amount of these claims that are recovered.

Local Agencies may retain 15% of the amount of an overpayment the state is authorized to retain for FS overissuance claims recovered under State Stat. §49.793(2),, and 15% for MA under State Stat. §49.497(2).

Agencies may retain 15% of money collected from benefit overpayments distributed under(Wis. Stats §49.19 *AFDC) Wis Stats §49.49, Medicaid.

> **Note**: Local Agencies may not retain 15% of the amount of an overpayment if the overpayment was the result of state, county or tribal governing body error.

3.3.8.1 Fraud Program Payment Procedures

See DHFS Accounting Manual for reporting procedures necessary for agencies to retain payments recovered.

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3.3.9 FAIR HEARINGS, Appeal AND BENEFIT RECOVERY

The recipient may request a fair hearing concerning the IM agency's determination of ineligibility and/or calculation of the amount of FS and MA benefits improperly paid. If a hearing is requested, suspend all recovery actions until a decision is rendered in that appeal.

If benefits are continued while a decision on the fair hearing is pending, add those payment amounts to the collection total:

1. If the hearing decision is not favorable to the recipient; and,
2. The recipient wasn't otherwise eligible for these benefits at the time the benefit/services were provided.

3.3.9.1 W-2 Fact Finding Appeal and Benefit Recovery

In accordance with Wisconsin Statute §49.152, the W-2 process provides a two level appeal process, a W-2 agency fact finding and a state agency review process that fulfills the requirement under PRWORA (the Personal Responsibility and Work Opportunity Reconciliation Act of 1996) (PL 104-193). For detailed guidance on the two level appeal process, refer to the fact finding process described in Chapter 19 of the W-2 Program Manual.

If W-2 payments were affected and the Fact Finding Review restores the W-2 payment, a retroactive adjustment may need to be made to the date that benefit payments were improperly calculated, reduced, or terminated. However, the payment must be based on completed participation. See Chapter 19 of the W-2 manual for more information.

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3.3.10 Administrative Penalties

3.3.10.1 When to Use an Administrative Disqualification Hearing (ADH)
3.3.10.2 ADH Relationship to Fair Hearing
3.3.10.3 ADH Required Evidence
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3.3.10.5 Administrative Disqualification Hearing Notice
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3.3.10.9 ADH Decision
3.3.10.10 Notice of ADH Disqualification Findings
3.3.10.11 Consent Agreement Disqualification Notice
3.3.10.12 FoodShare Penalties
3.3.10.13 CARES FoodShare Penalties Reporting
3.3.10.14 W-2 Penalties
3.3.10.15 Certain Convictions On Or After 10/14/97

An administrative disqualification hearing (ADH) is the administrative process for determining an intentional program violation (IPV) in the AFDC, W-2, and FS programs

3.3.10.1 When to use an Administrative Disqualification Hearing (ADH)

A referral agency may request an ADH when there is sufficient documentary evidence that a person or group has intentionally violated the program requirements. An ADH may be initiated regardless of the individual's current eligibility for the W-2 and/or FS Program.

Consider initiating an ADH when at least one of these conditions is met:
|

1. The facts of the case don't warrant criminal prosecution.
2. The case does not meet the local prosecution referral criteria.
3. The DA declines to prosecute the referred individual.
4. The same person was previously referred for prosecution but no action was taken (within a reasonable period of time) and the referral was formally withdrawn.

3.3.10.2 ADH Relationship to Fair Hearing

An ADH, like a fair hearing is held by the Department of Administration (DOA), Division of Hearings and Appeals (DHA). An ADH differs from a fair hearing in

these ways:

1. The referral agency, not the accused individual, requests the hearing.
2. A representative of the agency will present the evidence supporting the request for the ADH and the alleged IPV.
3. There is no time limit within which an ADH must be requested.
4. The timely notice (Notice of Administrative Disqualification Hearing) is measured from the date of the hearing.

3.3.10.3 ADH Required Evidence

The evidence for a finding of IPV in an ADH is the same as for determining an issue in a fair hearing. The level of proof for the evidence in both hearings must be "clear and convincing."

"Clear and convincing" means:

1. Explicit in detail;

2. So clear as to leave no substantial doubt;

3. Sufficiently strong to demand the unhesitating assent of every reasonable mind; or

4. Provides reasonable certainty of issues and findings.

3.3.10.4 Combined ADH Hearing

An ADH to determine an IPV in all benefit programs can be combined into a single ADH if the alleged IPV results from the same eligibility factors.

If the AG requests a fair hearing for current case actions the Fair Hearings and the ADH may be combined. The time limits for ADH take precedence when a fair hearing is combined with an ADH. The AG may waive the 30 day notice. In spite of differences between them, a FS or MA Fair Hearing and an ADH, they may be combined into a single hearing if:

1. The factual issues arise out of the same, or related circumstances; and,
2. The AG head of household and/or the individual accused of committing the IPV are given prior notice that the hearings will be combined.

Note: A W-2 fact finding review by DHA cannot be combined with an ADH or fair hearing.

3.3.10.5 Administrative Disqualification Hearing Notice

The referral agency must provide a written notice to the individual alleged to have committed the program violation at least 30 days prior to the date of the disqualification hearing.

To determine when the hearing will be held,

1. Call the Department of Administration, Division of Hearings and Appeals, telephone (608) 267-4587 and ask for the name and phone number of the Administrative Hearing Officer for your agency to contact.
2. Contact the Hearing Officer and request the dates s/he will be in the area.
3. Based on the 30 day advanced notice the agency provide the client with the date and time of the Administrative Disqualification Hearing.

If the case is currently open and the fraud investigation report causes the IM/W-2 Agency to take negative action toward the case, the agency may send the Administrative Disqualification Hearing Notice (HCF 16038) with the Negative Notice of Decision.

The written Administrative Disqualification Hearing Notice shall include the following items:

1. Date, time and location of the hearing.

2. Allegation(s) against the individual, including a statement that the agency believes benefits were received by the accused individual (or that the individual attempted to receive benefits) by intentionally violating a benefit program rule.

3. A summary of the evidence, along with appropriate documentation, supporting the allegation(s) of an IPV, including:

    a. The period of time or date(s) during which an overpayment was received or benefits misused.
    b. The amount of the overpayment or amount of misused benefits involved.
    c. A statement informing the individual of his/her right to examine the evidence and instructions on how and where the evidence can be examined.

4. A warning that the individual's failure to appear at the ADH without good cause will result in a decision by the hearing officer based solely on the information provided by the local agency at the hearing;

5. A statement that the individual may request a postponement of the hearing provided that such request is made to the Department of Administration, Division of Hearings and Appeals (DHA) at least 10 days in advance of the scheduled hearing, with the following restrictions. The hearing shall not be postponed for more than a total of 30 days.

6. A statement that the individual will have 10 days from the date of the scheduled hearing to present to the Division of Hearings and Appeals (DHA) good cause for failure to appear in order to receive a new hearing.

7. A description of the penalties that can result from a determination that the individual has committed an intentional program violation and a statement of which penalty is applicable to the individual.

8. A statement that the hearing does not preclude the District Attorney from prosecuting the individual for an intentional program violation in a civil or criminal court action, or from the agency collecting an overpayment.

9. A statement that the individual and remaining members of the Assistance Group will be responsible for repayment of the overpayment.
10. A listing of individuals or organizations that provide free legal representation to individuals alleged to have committed intentional program violations.

11. A statement that the accused individual and the head of household for the AG may sign an attached waiver agreement to waive his/her rights to appear at an ADH.

12. A statement of the accused individual's right to remain silent concerning the charge(s) and that anything said or signed by the individual concerning the charge(s) may be used against him or her in a court of law.

13. A telephone number and, if possible, the name of the person to contact for additional information.

3.3.10.5.1 Mailing Notice of ADH

All hearings are scheduled by the Division of Hearings and Appeals (DHA). A Notice of Administrative Disqualification Hearing should be sent to the accused individual by the referral agency so that it is received 30 days prior to the date for which the hearing is scheduled. The notice should be mailed using certified mail, restricted delivery, return receipt requested. Proof of mailing should be kept in the case record. Send a Waiver of Administrative Disqualification Hearing Agreement (HCF 16039) with the Administrative Disqualification Hearing Notice

in case the individual decides to waive hearing attendance and accept the findings. A copy of the Notice of ADH should also be sent to DHA.

For FS-only cases, the agency has the option to mail the advance notice by first class mail or by certified mail return receipt. If the notice is sent by first class mail and is undeliverable, the ADH may still be held.

3.3.10.6 Waiver of Administrative Disqualification Hearing

The Administrative Disqualification Hearing Notice (HCF 16038) must include a statement that s/he and the head of household (if different than the accused) may waive the right to appear at an ADH. Send a copy of the Waiver of Administrative Disqualification Hearing Agreement (HCF 16039) with the Notice of ADH Hearing

The Waiver Agreement of Administrative Disqualification Hearing must include:

1. The date that the signed waiver must be received by the agency.
2. A signature block for the accused individual.
3. A statement that the head of household must also sign the waiver if the accused individual is not the head of household.
4. A signature block for the head of household.
5. A statement of the accused individual's right to remain silent concerning the charge(s) and that anything said or signed by the individual concerning the charge(s) may be used against him or her in a court of law.
6. The fact that waiver of the individual's right to appear at a disqualification hearing will result in a disqualification penalty and a reduction in the assistance payment for the appropriate period even if the accused individual does not admit to the facts as presented by the agency.
7. An opportunity for the accused individual to specify whether or not he or she admits to the facts as presented by the agency.
8. A statement of the fact that the remaining adult members of the household or AG, if any, will be responsible for repayment of the resulting AFDC, W-2 and/or FoodShare claim amount.

3.3.10.7 CARES ADH Disqualification Reporting

When the accused individual waives his or her right to appear at a disqualification hearing, the disqualification and appropriate reduction of assistance shall result regardless of whether this individual admits or denies the charges. Designated agency staff shall immediately enter on *CARES* FIT screens BVPI and BVCC the ADH waiver agreement or ADH determination information.

For FS disqualifications, also enter the information on screen AIIP. CARES will calculate the appropriate disqualification period and impose that disqualification within 45 days from the date of the IPV determination that is entered on the AIIP screen in CARES.

3.3.10.8 Administrative Disqualification Hearing

The ADH is scheduled by the Department of Administration, Division of Hearings and Appeals (DHA). The ADH will be presided over by a hearing officer from the Department of Administration, Division of Hearings and Appeals.

3.3.10.8.1 ADH Client Rights and Privileged Information

The accused individual, or his/her representative must be given adequate opportunity to:

1. Examine the contents of his/her case file, and all documents and records to be used by the agency at the hearing, at a reasonable time before the date of the hearing, and during the hearing; and to receive a copy of material pertinent to the case from the file at no charge.
2. Present his/her case for him/herself or with the aid of a representative;
3. Bring witnesses;
4. Submit evidence to establish all pertinent facts and circumstances;
5. Advance any arguments without undue influence; and
6. Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

Also, keep in mind the privileged information provisions of §905.15, Wis. Stats. Employees of IM/W-2 agencies who are authorized to have access to federal tax return information in performance of their job duties cannot disclose the federal tax information.

3.3.10.8.2 ADH Burden of Proof

A representative of the agency must attend the ADH to submit clear and convincing evidence to prove the allegations of Intentional Program Violation against the accused AG member.

Even if the accused AG member or his/her representative fails to attend the ADH, the agency must present clear and convincing evidence that the accused AG member committed an Intentional Program Violation in order for the Hearing Officer to determine that an IPV was committed.

The burden of producing evidence is on the agency.

3.3.10.8.3 Selecting and Presenting ADH Evidence

The agency must determine the essential facts in a case. This is best done by asking, "What facts need to be shown in order to prove the case?"

1. Review program policy to determine what is required.
2. Analyze the case to see if there are any other facts that must be established.
3. Obtain the best evidence to prove each fact.

The agency's evidence on each and every essential fact must meet the test of clear and convincing. The burden of proof is placed only on the agency; the client has no burden of proof that has to be met. If the agency fails to meet the level of clear and convincing proof on each and every fact, the hearing officer is likely to rule against the agency.

Also, remember to present evidence chronologically, clearly, and concisely.

3.3.10.9 ADH Decision

Decisions made by the hearing officer shall be based exclusively on evidence and other material introduced at the hearing. The transcript or recording of testimony, exhibits, or official reports introduced at the hearing, together with all papers and requests filed in the proceeding, and the decision of the hearing office shall be made available to the individual or to his or her representative at a reasonable time and place.

Decisions made by the hearing officer will:

1. Include a decision summarizing the facts and identifying the regulations supporting the decision.
2. Be made within 90 days of the date of the Notice of Administrative Disqualification Hearing.

3.3.10.10 Notice of ADH Disqualification Findings

If the ADH hearing officer finds that the accused individual committed an IPV, the agency will enter the IPV and any related benefit recovery information in CARES as soon as possible following the determination. CARES will help to generate the necessary written program notices to the primary case contact prior to disqualification. The agency will ensure that disqualification notices inform the case contact of the negative decision and the reason for the decision.

In addition, for non W-2 programs the notice shall inform the individual of the period of disqualification (which shall begin no later than the first day of the second month which follows the date of notice), and the amount of benefits the assistance group will receive during the disqualification period.

Designated agency staff shall immediately enter on CARES FIT screens BVPI and BVCC the IPV or court order information.

For FS disqualifications, also enter the information on screen AIIP. CARES will calculate the appropriate disqualification period and impose that disqualification within 45 days from the date of the IPV determination that is entered on the AIIP screen in CARES.

3.3.10.11 Consent Agreement Disqualification Notice

A person referred to the county District Attorney's Office to be prosecuted for committing a W-2, or FS IPV may be disqualified from W-2 or FS after signing a consent agreement. The consent agreement typically may be a "Deferred Prosecution Agreement", (3.3.5.4) "Pre-trial Agreement" (3.3.5.5), "Pre-charge Agreement" (3.3.5.6).

A copy of the consent agreement should be given or sent to the individual by the DA's office at least 10 days prior to any face-to-face meeting between the individual and the DA's office. The written notice should include the following:

1. A statement for the accused individual to sign stating that he or she understands the consequences of signing the agreement, along with a statement that the head of household must also sign the agreement if the accused individual is not the head of household;

2. A statement that signing the agreement will result in a reduction in benefits and/or FoodShare allotments for the appropriate period(s); and

3. A statement of the disqualification period(s) that will be imposed as a result of the accused individual signing the agreement.

3.3.10.12 FoodShare Penalties

A person who, on the basis of a plea of guilty or no contest or otherwise, is found to have committed a FoodShare intentional program violation (IPV) by an ADH or by a State or Federal court, or a consent agreement will be treated in the following manner:

1. Any resources and *income* of the disqualified individual will be considered available to the assistance unit. Disqualify only the person found guilty of the FS IPV. Other members of the group may continue to be eligible.

   The individual will be ineligible for FoodShare benefits for:

   a. 12 months with the first offense
   b. 24 months upon the second offense.
   c. Permanently upon the third offense.

2. Any period for which a disqualification penalty is imposed shall remain in effect unless the finding upon which the penalty was based is subsequently reversed by a court, but in no event shall the duration of the period for which such penalty is imposed be subject to review.

3. A disqualification penalty imposed by one county/tribal agency must be used to determine the appropriate disqualification penalty for the individual by another county/tribal agency. Where an individual with a prior violation(s) moves from one state to another and has been found to have committed an intentional program violation(s), the local agency may impose the penalty based on the number of such violations committed in other states.

4. The disqualification penalties shall be in addition to, and cannot be substituted for, any other sanctions or penalties which may be imposed by law for the same offenses.

5. The agency must provide all applicants with a written notice of the disqualification penalties for fraud at the time of application.

6. Disqualify only the person who was found to have committed the IPV or who signed the waiver and, not the entire household for FoodShare.

3.3.10.13 CARES FoodShare Penalties Reporting

Enter the IPV information into CARES, which will then provide a written notice to the individual specifying the period of disqualification (which begins no later than the first day of the second month following the date of notice), and the amount of benefits the group will receive during the disqualification period. See Section 3.3.5.9 for additional CARES processing information.

If the court specifies the date for initiating the disqualification period, the agency shall enter the court ordered date into CARES to override the system's default calculations regarding the disqualification period.

With respect to imposing FS disqualifications, CARES will impose the disqualification period within 45 days of the IPV decision or as ordered by the court.

Along with the Notice of Disqualification, CARES will automatically send an agreement letter for restitution that will provide the following:

1. The amount owed.
2. The reason for the claim.
3. The period of time the claim covers.
4. The amount of any offsetting you did that reduced the claim.
5. The types and terms of each restitution schedule you offer the group.
6. The date by which the group must report its restitution choice to you.
7. A statement that the group's failure or refusal to make a restitution choice will result in your collection by a reduction of their benefits.
8. An area for the group to indicate its choice of restitution schedule with an area for a representative signature.
9. The group's right to a fair hearing if the individual disagrees with the claim amount.
10. A statement that the group may request re-negotiation of its chosen restitution schedule if its' financial circumstances change.

CARES also uses the data entered for FS IPV's through a data exchange system to update the national Disqualified Recipient System maintained by USDA's Food and Nutrition Service (FNS)

3.3.10.14 W-2 Penalties

In addition to a 10 year suspension noted in Section 3.3.10.15 below, Wis. Stats §49.151(2) provides guidance on W-2 IPV. W-2 agencies may permanently deny W-2 benefits to individuals determined through court or administrative hearings to have committed an IPV on three separate ocasisions. After 3 separate findings, the W-2 agency may also permanently deny payments to the entire assistance group. There is no "child-only" grant provision under W-2 for children of adults found guilty of IPV.

Previous AFDC Disqualification and IPV's do not carry over into the W-2 program as W-2 disqualifications or IPVs. However, W-2 benefit payments could possibly be affected due to previous AFDC overpayments, depending on agreements or other legal actions where the participant provides consent.

3.3.10.15 Certain Convictions On Or After 10/14/97

Suspend a person from participation in W-2 and/or FS for a period of 10 years if that person is convicted of fraudulently misrepresenting his/her identity or residence for the purpose of receiving FS or TANF (W-2) from one or more states simultaneously.

1. The conviction must be on or after 10/14/97 in a federal or state court.
2. The violation of which the person is convicted must be misrepresentation, misstatement, or knowingly or willfully making a false statement or representation of material fact, or having knowledge of such an occurrence and concealing or failing to disclose that knowledge, with respect to a person's identity or place of residence for the purpose of receiving simultaneously from Wisconsin and at least one other state benefits under any of these programs:

    a. TANF block grant
    b. Medicaid
    c. FoodShare
    d. Supplemental Security Income (SSI)

    See the W-2 Manual, 11.4.1, and the FSHB, Appendix 6.1.3, for a more detailed description of this violation. This 10 year disqualification for W-2 is entered in CARES and counted as an IPV towards the three IPVs used for permanent disqualification from W-2 participation eligibility.

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