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# Introduction

The Auxiliary Grant Program (AG) is a financial assistance program that provides supplemental income to low-income individuals who are aged, blind, or disabled and reside in assisted living facilities (ALF) adult foster care homes (AFCH), or supportive housing (SH). To be eligible for this program, individuals must meet the eligibility requirements specified in this manual. The AG payment is a money payment that is issued directly to the eligible individual.

## 1. Background

Virginia's AG program is an outgrowth of the federally mandated State SSI Supplementation Program that began when SSI was implemented to replace Old Age Assistance (OAA), Aid to the Permanently and Totally Disabled (APTD), and Aid to the Blind (AB) Programs that had existed under Titles I, X, and XIV of the Social Security Act. Those benefits were paid at a higher rate than was to be paid under SSI, meaning that individuals who were transferred from them to SSI would have received a cut in benefits. To prevent this, the Mandatory State SSI Supplementation Program began.

States were required to develop a program that would supplement the SSI payments of those who would have been negatively impacted or the states would lose Medicaid funding. Virginia's response was to establish the AG program. AG initially covered only those that were mandated to be covered SSI recipients. It was later expanded to include individuals who were ineligible for SSI due to excess income but who met all other SSI eligibility requirements.

### 1.1. Legal Base

1. In 1972 Public Law 92-603 abolished the Old Age Assistance (OAA), Aid to the Permanently and Totally Disabled (APTD), and Aid to the Blind (AB) Programs that had existed under Titles I, X, and XIV of the Social Security Acts and established the Supplemental Security Income (SSI) Program under Title XVI. The SSI program was implemented in 1974.

2. A later amendment to Title XVI required that the individual income of aged, blind, or disabled persons be maintained at December 1973 levels. Section 212 of PL 93-66 addressed the loss of Medicaid funds. These cases were called "mandatory supplementation cases". States were given the option of having their supplementation program administered by the federal government or administering their own program. Virginia opted for self-administration.

3. In 1973, the Virginia General Assembly passed legislation permitting the Departments of Social Services and the Visually Handicapped to establish an Auxiliary Grants (AG) Program (*Code of Virginia*, Section 63.1-25.1).

4. The Virginia Department of Social Services' State Board and the Department for the Visually Handicapped expanded the Auxiliary Grants Program in July 1974 to include (no later than November 1, 1974) aged, blind, or disabled persons in assisted living facilities who had insufficient funds to meet their needs as established by the State Board. This part of the program was called "optional supplementation" to distinguish these cases from the December 1973 cases.

   - It is no longer necessary to distinguish mandatory supplementation cases from optional ones as Virginia has increased its supplemental payments to a level that exceeds the mandated level.

5. In 1984, the Virginia General Assembly passed legislation, which gave the Department of Social Services sole responsibility for operating the program.

6. Effective October 1, 2002, the Virginia General Assembly passed legislation repealing the *Code of Virginia,* Section 63.1-25.1 and replaced it with Section 63.2-800.

7. In 2012, the Virginia General Assembly passed legislation repealing the Code of Virginia, Section 63.2-800 and replacing it with Section 51.5-160 which gave the Department for Aging and Rehabilitative Services administrative authority to operate the program.

In 2016, the Virginia General Assembly passed legislation adding a third setting, supportive housing, to the AG program.

## 2. Funding

The AG program is funded by a combination of state and local funds. State funds comprise 80% of the funds and local funds comprise the remaining 20%. State funds are authorized by the General Assembly and the local funds are authorized by the governing body of each locality.

## 3. Applicable Policy

This manual addresses the eligibility requirements and determination procedures. The procedures differ for the two groups that are potentially eligible for AG, SSI recipients and non-SSI individuals. SSI recipients are those who receive an SSI money payment. Non-SSI individuals are those who are ineligible for SSI due to excess income. The primary differences are in the income and resource eligibility requirements.

To address those differences, separate income and resource chapters were developed. The titles of the chapters are the key to which the chapters apply. If the title includes SSI Recipient in the title it applies only to SSI recipients, i.e., Chapter D - SSI Recipients' Eligibility. If the title includes Non-SSI, it applies only to those individuals who do not

receive SSI, i.e., Chapter E - Non-SSI Resource Eligibility. If the title does not include either of those phrases it applies to both groups.

## 4. Eligibility Rules

As a federally mandated program established to supplement the SSI program, the AG program is required to use SSI policy to determine eligibility. Some variations do exist as state law can establish additional eligibility requirements. Virginia law has established some variances in both non-financial and financial eligibility criteria but most of the eligibility rules are the same as SSI's.

One of Virginia's variances is to allow AG eligibility to those who live in supportive housing, in addition to Assisted Living Facilities (ALF) and Adult Foster Care Home (AFCH).

## 5. Eligibility Process

Determining eligibility for AG is a multiple step process. The following chart summarizes those steps. Detailed information is given in the subsequent chapters of this manual.

| STEPS | ELIGIBILITY DETERMINATION ACTIONS |
|---|---|
| **Step 1** | Chapter B - 1.3 A written application document is received.<br><br>Is the application signed?<br><br>Yes – Continue<br><br>No – The application is invalid. Return the application to the applicant.<br>Stop. Review Medicaid eligibility. |
| **Step 2** | Chapter B – 7.3 Review the application and issue a written request for required verifications. Continue |
| **Step 3** | Evaluate the verifications that were provided.<br><br>Did the individual provide all required non-financial and financial verifications? |

| STEPS | ELIGIBILITY DETERMINATION ACTIONS |
|---|---|
| | Yes – Continue<br><br>No – Deny the application and send the individual a Notice of Action (for AG).<br>Stop. Review Medicaid eligibility. |
| **Step 4** | Chapter C Evaluate individual's non-financial eligibility.<br><br>Did the individual meet all non-financial eligibility criteria?<br><br>Yes – The individual is eligible non-financially. Continue<br><br>No – Deny the application and send the individual a Notice of Action. ~~Update the case status in AGTrak.~~<br>Stop. Review Medicaid eligibility. |
| **Step 5** | Chapter D Is the individual an SSI recipient?<br><br>Yes – The individual is income and resource eligible. Determine his/her grant amount.<br><br>Go to Step 9.<br><br>No – Continue |
| **Step 6** | Chapter G Evaluate any resource transfers the individual made from 36 months prior to the date of application through the processing date.<br><br>Did the individual make any resource transfers during this period that impacts his current eligibility?<br><br>Yes – Compute the period of ineligibility and notify the individual of it. Deny the application and send the individual a Notice of Action (for AG) and a Transfer of Resources Notice. ~~Update the case status in AGTrak.~~<br><br>Stop. Review Medicaid eligibility.<br><br>No – Continue |

| STEPS | ELIGIBILITY DETERMINATION ACTIONS |
|---|---|

| | |
|---|---|
| **Step 7** | Chapter E Evaluate the non-SSI individual's resource eligibility.<br><br>A. Determine the individual's net countable resources.<br><br>• Determine the value of each resource.<br><br>• Subtract the appropriate resource exclusion from the full value of the resource. The result is the resource's net countable value.<br><br>• Total the net countable values. The result is the individual's total net countable resource value.<br><br>B. Is the total net countable resource value equal to or less than the regular resource limit ($2000)?<br><br>Chapter E - 5 Yes – The individual is resource eligible. Go to Step 9.<br><br>No – The individual is ineligible for regular AG due to excess resources. Continue. |
| **Step 8** | Chapter F Evaluate the individual's potential eligibility for Conditional Benefits.<br><br>A. Divide the individual's resources into two classifications, liquid and non-liquid.<br><br>• Total the value of the non-liquid resources and<br><br>• Total the value of the liquid resources.<br><br>B. Is the total net countable value of the individual's non-liquid resources greater than the regular resource limit ($2000)?<br><br>Yes - Continue<br><br>Chapter E - 5<br><br>No - Deny application due to excess resources and send a Notice of Action (for AG). ~~Update the case status in AGTrak.~~<br><br>Stop. Review Medicaid eligibility. |

| STEPS | ELIGIBILITY DETERMINATION ACTIONS |
|---|---|
| | C. Is the total net countable value of the individual's liquid resources equal to or less than the current AG resource limit. Yes – Continue.<br><br>No – Deny application due to excess resources and send a Notice of Action (for AG). ~~Update the case status in AGTrak.~~ Stop. Review Medicaid eligibility. |
| **Step 9** | Chapters H & I Evaluate the individual's income.<br><br>A. Determine the individual's net countable unearned income.<br><br>• Total the individual's gross unearned income.<br><br>• Subtract all appropriate income exclusions.<br><br>• The result is the individual's net countable unearned income.<br><br>B. Determine the individual's total net countable earned income.<br><br>• Total the individual's gross earned income.<br><br>• Subtract all appropriate income exclusions.<br><br>• The result is the individual's total net countable earned income.<br><br>C. Add the individual's total net countable unearned income to the individual's total net countable earned income.<br><br>• The result is the individual's total net countable income. Continue. |
| **Step 10** | Chapter J Determine the non-SSI individual's income eligibility and |

| STEPS | ELIGIBILITY DETERMINATION ACTIONS |
|---|---|
| | the amount of unmet need for both SSI and non-SSI recipients.<br><br>A. Determine the appropriate ALF/AFCH rate.<br><br>B. Add the Personal Needs Allowance. The result is the AG Limit.<br><br>C. Subtract the individual's total net countable income.<br><br>• The result is the individual's unmet need.<br><br>Is the result equal to or greater than $.01?<br><br>Yes – The individual is income eligible and in need. Continue<br><br>No – The individual is ineligible for AG. Deny the application and send a Notice of Action (for AG). ~~Update the case status in AGTrak.~~ Stop. Review Medicaid eligibility. |
| **Step 11** | Was the individual resource ineligible for regular AG and potentially eligible for Conditional Benefits? (Step 8)<br><br>Yes - Did he/she sign the Agreement To Sell Property?<br><br>Yes - He/she is eligible for Conditional Benefits. Continue<br><br>No – He/she is ineligible for AG due to excess resources. Deny the application and send a Notice of Action (for AG). ~~Update the case status in AGTrak.~~<br><br>No – He/she is eligible for regular AG benefits. Continue. |
| **Step 12** | Chapter J Determine the individual's grant amount.<br><br>A. Round the individual's unmet need to the nearest dollar.<br><br>• The rounded amount is the grant amount.<br><br>B. Complete the documents necessary to issue the check.<br><br>C. Approve the application and send a Notice of Action (for AG) or |
| **STEPS** | **ELIGIBILITY DETERMINATION ACTIONS** |

| | |
|---|---|
| | the Conditional Benefits Notice, as appropriate.<br><br>D. ~~Update case status in AGTrak and~~ Enroll the individual in VaCMS AG Medicaid. |

## 6. Payments/Reconciliation

The AG payments are issued monthly at the beginning of the month for the month of issuance. The payment amounts are based on projected income and then are reconciled periodically thereafter. Reconciliation requires the recomputation of prior months' payment amounts using the actual income received in those months and correcting any over or underpayments. Reconciliation is required as AG is a means tested program.

## 7. Computer Systems

VaCMS is the system of record for Medicaid applications. Workers will process AG applications outside of the VaCMS system only inputting information required for AG Medicaid. Auxiliary Grant application is a paper process where all criteria of eligibility will be reviewed and documented on the Evaluation of Eligibility for AG form and kept in the case record. ~~The system of record for the AG Program is AGTrak. Workers must enter approved cases and update changes in residence and eligibility in AGTrak. AGTrak is accessible via the DARS HCBS Data Warehouse page at https://www.vadars.org/HCBSWarehouse. If you have not acquired your AGTrak logon information, please complete an AGTrak Access Request Form. The form can be found in the Help section on the DARS HCBS Data Warehouse page without having to log in or in the forms section for AG located on FUSION website under Auxiliary Grant.~~

## 8. Appendix A: FORMS

The following forms may be used during eligibility determination for AG. Unless otherwise indicated, these forms are located on the FUSION website.

**Affidavit of United States Citizenship or Legal Presence in the United States**
This form is used to attest that the individual meets the status of Citizenship or legal presence in the United States.

**Agreement to Sell Non-Liquid Resources**
This form is used to notify an individual of the requirements he/she must meet to be eligible for conditional benefits and to obtain the individual's agreement to accept Conditional Benefits.

**Burial Resource Statement**
This form is to be used by individuals to indicate resources that are set-aside for burial.

**Conditional Benefits Notice**
The Conditional Benefits Notice is used as an advance notice of proposed action to notify an individual that he/she is no longer eligible for Conditional Benefits.

**Eligibility Communication Document**
This form is used by the assessor to notify EW of the results of the annual reassessment for redetermination.

**Eligibility Worker Referral**
This form is used by the EW to make a referral to the APS worker to request assessment for guardianship.

**Notice of Action (for AG)**
This form is used to inform individuals the action taken by the LDSS. Used for application approvals, denials, redeterminations, changes and advance notices.

**Provider/DSS Communication Form**
This form is used by both provider and the LDSS to exchange information regarding eligibility, payment, admissions and discharges, death or any other pertinent information known to the provider that might cause a change in the eligibility status.

**Transfer of Resources Notice**
This form is used to notify individuals the actions taken by the LDSS regarding resource transfers**.**

**Statement of Funds Provided to Another**
This form is used by the individual to report funds given to another person.

**Statement of Funds You Received**
This form is used by the individual to report funds received from another person**.**

**Statement of Virginia Residency and Intent to Remain in Virginia**
This form is used by the individual to attest Virginia residency and intent to remain in Virginia.

## 9. ~~Appendix B : DARS - APS DIVISION - CONTACT LIST~~

~~**Home Office:**~~

| | | |
|---|---|---|
| ~~Paige McCleary, Director~~ | ~~804-662-7605~~ | ~~Paige.mccleary@dars.virginia.gov~~ |
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~~**Home Office Address:**~~

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~~Adult Protective Services Division~~
~~8004 Franklin Farms Drive~~
~~Henrico, VA 23229~~

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# Application Processing - Introduction

Applicants for an Auxiliary Grant (AG) must file a written request for assistance, report changes in their situation and provide verification of eligibility factors. An individual's eligibility must be renewed each year. Workers are required to evaluate the applications and to take action on them within certain time frames. This chapter addresses procedures for submitting and processing applications from the point of initial submission through renewals and changes in the individual's situation. It also specifies the time frames in which actions must be taken and individual's rights and reporting responsibilities.

## 1. Request for Assistance

A written and signed application is required for all initial applications, reapplications, and renewals. The application form to be used is the Application for Benefits. The Supplemental Renewal application 032-03-729A, and form 032-03-729 C, may be used for renewals.

### 1.1. Interview Not Required

A personal interview is not required to determine AG eligibility. The individual or his representative may be contacted to clarify or request additional information.

### 1.2. Application For AG is an Application For Medicaid

An application for AG is also an application for Medicaid and, if the individual incurred medical expenses in the three months prior to the month of application, it is also an application for retroactive Medicaid.

#### 1.2.1. Medicaid Evaluation

1.2.1.1. **Retro Medicaid**

Determine retroactive Medicaid eligibility based on the Medicaid Manual.

1.2.1.2. **Ongoing Medicaid – AG Approval**

An individual that is found eligible for AG is eligible for Medicaid. No separate Medicaid evaluation is required.

Exceptions:

If an individual fails to assign his rights to medical support and payment for medical care to the Department of Medical Assistance Services (DMAS), he/she is not eligible for

Medicaid. The failure to assign rights does not impact AG eligibility.

1.2.1.3. **Ongoing Medicaid – AG Denial**

If AG is denied, determine Medicaid eligibility based on the Medicaid Manual.

## 1.3. Right to Apply for Assistance

An individual cannot be refused the right to complete an application for him/herself (the applicant) or any other individual for whom he/she is authorized to apply, and under no circumstances can an individual be discouraged from asking for assistance for him/herself or any person for whom he/she is legally responsible or authorized to represent. An individual may be assisted with the application by an individual of his choice.

## 1.4. Applications

When an AG application is received it must be reviewed to determine if it is a complete application. An application may be complete, incomplete or invalid.

### 1.4.1. Complete Applications

A complete application is one that includes answers to all questions relevant to the AG program and is signed by the applicant or the applicant's representative. The application is accepted and an eligibility determination is made.

### 1.4.2. Incomplete Applications

An incomplete application is one that is signed by the applicant or the applicant's representative but does not include answers to any or all of the relevant questions. The application is accepted and the individual is contacted to obtain the missing information. It is not necessary to return the application to the individual. The information may be obtained in writing or verbally. If the information is obtained verbally, the date of the contact and the information received must be documented in the case record.

### 1.4.3. Invalid Applications

An invalid application is one that is not signed or is signed by someone that is not authorized to apply for the individual. The application is not accepted and must be returned to the individual for whom assistance is

requested. A letter of explanation must be included with the returned application.

**Note:** The application has multiple spaces for signatures. The application is valid if the individual or his/her representative signs in either the space labeled "Applicant's or Authorized Representative's Signature or Mark" or the one labeled "Name of Person Completing Application". The application must be signed in one of these spaces to be valid. A signature on the front of the application is not sufficient.

## 2. Who Can Sign the Application

The application must be signed by the individual for whom assistance is requested unless the individual's condition precludes him/her from doing so or he/she has designated an authorized representative to apply for him/her. If the individual is unable to sign the application the individual's guardian, conservator or a family substitute relative may apply for him/her.

**Note:** Under no circumstances may an employee of, or an entity hired by a medical service provider who stands to obtain Medicaid payment file an AG/Medicaid application on behalf of an individual who cannot designate an authorized representative.

### 2.1. Signature By Mark

If the individual cannot sign his or her name but can make a mark, the mark must be correctly designated (the individual's first and last name and the words "his mark" or "her mark" must be printed adjacent to the mark) and witnessed by one person as in the example below.

Example: John Doe, his mark

Witness's signature: _____

### 2.2. Designated Authorized Representative

The individual may authorize any adult to serve as his/her authorized representative to apply for AG. The statement designating the authorized representative must be in writing and is valid until (1) the application is denied, or (2) AG enrollment is cancelled, or (3) the individual changes his authorized representative by submitting a written statement revoking the prior designation or naming a new representative.

### 2.3. Individual Cannot Sign

When an individual cannot sign an initial or renewal application follow the procedure in the chart below. Detailed information follows.

| STEPS | WHEN AN INDIVIDUAL CANNOT SIGN AN APPLICATION ACTIONS |
|---|---|
| **Step 1** | Has the individual been judged legally incapacitated by a court of law, as evidenced by a copy of the conservator or guardian certificate of appointment in the record?<br><br>**YES:** The authorized representative is the appointed conservator or guardian. **STOP**<br><br>**NO:** The individual is competent. **CONTINUE** |
| **Step 2** | Does the individual have an attorney in fact who has the power of attorney to apply for AG for the individual as evidenced by a copy of the power of attorney document in the record?<br><br>**YES**: The authorized representative is the attorney in fact. **STOP**<br><br>**NO:** **CONTINUE** |
| **Step 3** | Has the individual signed a written statement authorizing a person (or staff of an organization) to apply for AG on his behalf?<br><br>**YES:** The authorized representative is the person or organization authorized by the individual to represent him. **STOP**<br><br>**NO:** **CONTINUE** |
| **Step 4** | Is the individual able to sign or make a mark on an AG application form?<br><br>**YES:** Ask the individual for his signature or mark on the application form or for a written statement authorizing someone to apply for AG on his behalf.<br><br>Give the individual 10 working days to return the completed and signed application. If the completed and correctly signed |

| STEPS | WHEN AN INDIVIDUAL CANNOT SIGN AN APPLICATION ACTIONS |
|---|---|
| | application is not returned by the specified date, the application is invalid. Deny AG. **STOP**<br><br>**NO:** **CONTINUE** |
| **Step 5** | Does the individual have a family substitute representative?<br><br>**YES:** The authorized representative is the relative identified above who is willing and able to act on the individual's behalf. **STOP**<br><br>**NO:** **CONTINUE** |
| **Step 6** | Does the individual have a diagnosis or condition that causes him/her to be unable to sign the application?<br><br>**YES:** Verify the inability through a written statement from the individual's doctor. **CONTINUE**<br><br>**NO:** The individual must sign or make a mark on the application or designate an authorized representative in writing. **STOP** |
| **Step 7** | Has anyone started guardian proceedings?<br><br>**YES:** If action has been initiated to obtain a guardian for the individual, request verification that the action is on the court docket. Give 10 days for this verification to be provided.<br><br>If the verification is provided within the 10 day period, continue to pend the application/ the individual's eligibility until the guardian or conservator is appointed. |

| STEPS | WHEN AN INDIVIDUAL CANNOT SIGN AN APPLICATION ACTIONS |
|---|---|
| | **NO:** Submit an "Eligibility Worker Referral - Medicaid Referral to APS to Request Assessment for Guardianship" form to the Adult protective Services (APS) unit. Continue pending the application/renewal until an APS decision has been made. **CONTINUE** |
| **Step 8** | Was a guardian/conservator appointed?<br><br>**YES:** Give the guardian/conservator 10 days to return the completed and signed application. If the completed and correctly signed application is not returned by the specified date, the application is invalid.<br><br>**NO:** The individual must sign or make a mark on the application or designate an authorized representative in writing.<br><br>Give the individual 10 days to return the completed and signed application. If the completed and correctly signed application is not returned by the specified date, the application is invalid. |

## 2.4. Guardian/Conservator

A guardian is a person appointed by a court of competent jurisdiction to be responsible for the personal affairs of an incapacitated individual, including responsibility for making decisions regarding the person's support, care, health, safety, habilitation, education, and therapeutic treatment, and if not inconsistent with an order of commitment, residence.

A conservator is a person appointed by a court of competent jurisdiction to be responsible for the financial affairs of an incapacitated individual.

When an individual has been determined to be incompetent, his/her guardian or conservator must complete and sign the application for AG.

### 2.4.1. Verification

Request a copy of the guardian or conservator documents for the case record.

## 2.5. Family Substitute Representative

When it is reported that an individual cannot sign the application and the individual does not have a guardian, conservator, attorney in fact or designated authorized representative, one of the relatives listed below who is willing to take responsibility for the individual's AG business will be the individual's "family substitute" representative. The family substitute representative will be, in this preferred order, the individual's:

- Spouse,
- Adult child,
- Parent,
- Adult sibling,
- Adult grandchild,
- Adult niece or nephew, or
- Aunt or uncle.

### 2.5.1. Verification

Verification of relationship and inability to sign are not required.

## 2.6. No Substitute Representative Exists

If the individual is unable to sign the application and does not have an attorney in fact, authorized representative, or family substitute representative, steps must be taken to determine if the individual is in need of a guardian.

### 2.6.1. Verification

The individual's inability to sign the application must be verified by a written statement from the individual's doctor that says that the individual is not able to sign the AG application because of the individual's diagnosis or condition.

### 2.6.2. Pursuit of Guardianship

Determine if anyone has begun the process to have a guardian or conservator appointed for the individual.

2.6.2.1. **Action Has Been Initiated**

If action has been initiated to obtain a guardian for the individual meaning a court guardianship hearing is scheduled on the court docket, request verification that the action is on the court docket. Give 10 days for this verification to be provided.

**2.6.2.1.1. Verification Provided**

If the verification is provided within the 10 day period,

- **Intake**

  Continue pending the application until the guardian or conservator is appointed. If the application is still pending after 45 days, send a Notice of Action to the individual to extend the pending application.

- **Renewals**

  If all other eligibility factors continue to be met, continue the individual's eligibility until the guardian or conservator is appointed.

**2.6.2.1.2. Verification Not Provided**

If the verification is not provided within the 10 day period, assume action has not been initiated and follow the procedures below.

2.6.2.2. **Action Has Not Been Initiated**

If guardianship/conservator procedures have not begun or have not been verified as being on the court docket, use the "Eligibility Worker Referral - Medicaid Referral to APS to Request Assessment for Guardianship" form to refer the

individual to the Adult Protective Services (APS) unit in the local agency.

Continue an individual's eligibility or to pend an initial application until the APS investigation is completed.

**2.6.2.2.1. Guardianship Will Not Be Pursued**

If the completed APS investigation concludes that guardianship proceedings will not be initiated, the application must be signed by the individual, or the individual must sign a statement designating an authorized representative. Give the individual 10 days to return the signed application to the agency.

If the application form is not signed by the individual or the authorized representative and returned to the agency by the specified date, deny the application because it is invalid.

**2.6.2.2.2. Guardianship Will Be Pursued**

Continue an individual's eligibility or to pend the initial application until a guardian is appointed.

**2.6.2.2.2.1. Guardian Appointed**

Give the guardian/conservator 10 days to return the completed and signed application. If the completed and correctly signed application is not returned by the specified date, the application is invalid.

## 3. Place of Application

Initial applications and renewals are to be filed in the Virginia locality in which the individual last resided outside of an institution or an AFC home.

**Note:** Both public and private pay ALFs are considered institutions for AG purposes. ALFS are facilities licensed by Virginia Department of Social Services, Division of Licensing Programs for four or more individuals. Institutions also include hospitals, mental health facilities, nursing facilities, etc.

### 3.1. Filed In Wrong Locality

If the application is filed in a locality in which an individual does not have residence, the receiving agency must immediately forward the application to the locality of residence.

- Ms. Smith lived in Hampton prior to going into the ALF. The locality that is responsible for eligibility is Hampton DSS.

- Ms. Smith moved in temporarily with her son who lives in Newport News before relocating to the ALF. Hampton DSS is responsible for determining eligibility for AG.

- Ms. McCoy lived with her daughter in Virginia Beach for about a year and has no other residence in Virginia Beach. She has abandoned her home in Hampton with the intent to live in Virginia Beach with her daughter before going into an ALF. Virginia Beach DSS is responsible for determining eligibility for AG.

### 3.2. Non-Virginia Resident

If the person did not have a prior residence in a Virginia locality or it cannot be determined where the individual last resided, the agency that serves the area in which the individual's ALF/AFC home is located will be responsible for determining initial and continuing eligibility.

## 4. Date of Application

The date of application is the date the signed application is received by a local department of social services. If the application is filed in a locality in which an individual does not have residence, the receiving agency must immediately forward the application to the locality of residence. The date received in the original locality will be the date of application.

Note: If the receiving locality fails to transfer the application to the correct locality within 10 business days, the receiving locality will assume responsibility of processing the application prior to transferring the case to the proper locality.

## 5. Information To Be Given To Individual

At the initial determination and at each renewal the individual must be given the following information.

- The individual must be given the "Virginia Department of Social Services Benefit Programs" booklet at initial application and reapplication. It does not have to be given at renewal.

- It is the individual's responsibility:

  - To provide accurate and complete information to the best of his/her ability.

  - To report changes in his/her situation within 10 days of the date the change occurred. The individual must be given a Notification of Change form.

- Failure to provide accurate and complete information or to report a change within ten days of the date the change occurs may result in prosecution for fraud.

- If the individual appears to meet SSI income standards, he/she must make application to SSI within fifteen calendar days.

- If the individual appears to be eligible for other financial benefits, he/she must make application for those benefits within a specified timeframe.

- The name of the social services agency responsible for providing social services.

- The eligibility requirements for AG and how the grant is computed.

- The requirement to verify all eligibility factors within the specified time frame.

- If eligibility factors cannot be verified, he/she will be ineligible.

- The right to dispute the current market value established for real and personal property if ineligibility results.

## 6. Assistance Unit (AU)

The composition of the AU determines whose income and resources will be used in determining financial eligibility. The assistance unit consists of the AG applicant only.

**Exception:** The AU contains both the applicant and his/her spouse when:

- **As of the first moment of the month of application**

  - They were married to each other; and

  - They lived in the same household.

- **Each entered an ALF/AFCH in that month;**

- **Each applied for AG in that month; and**
- **Each were determined eligible for AG for that month.**

This situation can exist only in the month of application.

A **household** is common living quarters and facilities under domestic arrangements that create one economic unit. Sharing a room in an institution is not living in the same household.

# 7. Processing Applications

An eligibility determination begins with the receipt of a written application, continues through the verification, evaluation and documentation of each eligibility factor, and is completed at the point an eligibility decision is made, all appropriate notices are sent, and computer systems are updated.

AG and Medicaid eligibility are determined from the month of application forward. If appropriate, eligibility for retro Medicaid is determined using the Medicaid manual. There is no retro eligibility for AG.

## 7.1. Eligibility Established

Eligibility is established when it is determined that the individual meets all eligibility requirements. Ineligibility is established at the point it is determined the individual does not meet an eligibility requirement. The worker must use the Evaluation of Eligibility *for AG* to document the evaluation of each eligibility requirement.

## 7.2. Application Time Standards

Action to approve or deny a case must be taken within 45 days of receipt of an application. The 45-day processing period begins on the date a signed application is received in the agency. The date the approval or denial notice is mailed to the individual must be within that period. If action to approve or deny an application is not taken within 45 days the timely processing requirements have not been met.

### 7.2.1. Early Processing

The agency may take action prior to the 45$^{th}$ day of the processing period. However, an early decision will have to be reevaluated in the following situations.

- The application was denied for failure to provide verifications and the individual provides the verification prior to the end of the 45th day.

- The application was denied due to the inability to locate the individual and the individual contacts the agency prior to the 45th day.

### 7.2.2. Exceptions To The 45-Day Processing Timeframe

Applications whose processing is delayed beyond the 45-day processing period due to one of the following situations is not considered untimely but must be processed within the time frames noted below.

- The agency is unable to take action through no fault of its own. The pending status of the application must be continued for an additional 15 days. Final action must be taken at the end of the 15-day extension.

  Examples – Case held pending the determination of Conditional Benefit eligibility; case held pending the licensure of the ALF or approval of the AFCH.

- A guardianship determination is pending. Action must be taken when a guardian is established, or it is determined one is not needed.

### 7.2.3. Notice of Action To Extend The Pending Period

When an application will not be processed by the 45th day, a Notice of Action must be mailed to the individual on the 45th day. The notice must state that the application is still pending, and the reason action was not taken within the 45-day processing period.

### *7.2.4. Notice of Action for 30 Day Placement Eligibility Period*

When an applicant meets all eligibility criteria except residence in the ALF, AFCH home or Supportive Housing; the worker must notify the individual of the AG approval pending residency within 30 days from the date of the notice. If placement does not take place within the 30 days of the Notice of Action for AG, the individual can no longer be considered having met the residency requirement and continued eligibility must be re-evaluated. When calculating the 30 days from notice include 5 days for mailing out the Notice of Action for AG.

***Note: AG payments are not disbursed to the individual during this time. Payments are not made until the worker verifies approved placement in the facility or home.***

## 7.3. Verification Requirements

The individual is responsible for providing verification of all eligibility factors. The Manual addresses each eligibility factor and the appropriate source for the verification.

- The individual must be notified in writing of the items that must be verified and the date by which the verifications must be received.
- The individual must be given a minimum of ten calendar days to return the verifications. Additional time may be allowed in situations where the individual may have difficulty in obtaining the required verifications in the ten day time frame.
- If the individual asks for help in obtaining the required verifications, the eligibility worker must attempt to obtain them.
- If the required verifications are not provided and the eligibility worker is unable to obtain them, eligibility cannot be determined and the application must be denied.

## 7.4. Eligibility Decisions on Applications

An AG and Medicaid eligibility decision must be made on each application and the individual and his representative must be notified of that decision.

Possible decisions include:

- **Withdrawal**
  - Individual requests that the application be withdrawn.
  - The agency is unable to locate the individual.
- **Denial**
  - The agency determines the individual is ineligible based on his failure to meet one or more of the non-financial or financial eligibility requirements.
- **Approval**

- The agency determines the individual meets all eligibility requirements.

### 7.4.1. Withdrawals

#### 7.4.1.1. Voluntary Withdrawal

An individual may voluntarily withdraw his application at any time prior to an eligibility decision being made on the application. This may be done by verbal request or by a signed statement indicating the wish to withdraw the application.

The worker must:

- Document the withdrawal in the case record.
- ~~Update the AGTrak system, using "W" as the case disposition code.~~
- Send the Notice of Action (for AG) to the individual and his representative to confirm the individual's decision to withdraw. Cite this manual reference.

#### 7.4.1.2. Unable to Locate

If reasonable efforts to locate the individual are unsuccessful and the individual does not contact the agency so that an eligibility decision can be made within the 45-day processing period, the application will be considered withdrawn.

Reasonable efforts have been made when the agency is unable to reach the individual by phone and agency mail to the individual has been returned by the post office indicating no known forwarding address.

The worker must:

- Document the agency's attempts to locate the individual and the withdrawal in the case record.
- ~~Update the AGTrak system, using "W" as the case disposition code.~~

- Send the Notice of Action (for AG) to the individual and his representative to confirm the individual's decision to withdraw the AG and Medicaid applications. The Notice of Action (for AG) must include the agency's attempts to locate the individual and request that he contact the agency. Cite this manual reference.

#### 7.4.1.2.1. Individual Contacts Agency

If the individual contacts the agency prior to the 45th day, the application must be reopened, and eligibility determined.

### 7.4.2. Denial of AG

Action to deny an application is taken at the point an eligibility determination finds the individual does not meet one or more of the eligibility requirements.

If the individual is ineligible in the application month and/or subsequent months but is eligible in the processing month, deny the appropriate months and approve for the processing month. See Chapter B - 7.4.3 for approval procedures.

#### 7.4.2.1. Denial Procedures

The worker must:

- Document the denial and the reason for it in the case record.
- Assure substantiation of ineligibility is included in the case record.

  **Example:** If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.

- ~~Update the AGTrak system, using "D" as the case disposition code.~~
- Evaluate retro and ongoing Medicaid eligibility based on the Medicaid Manual.

- **If eligible for Medicaid**
  - Document the approval in the case record assuring that each eligibility factor is addressed.
  - Assure that all supporting verifications are in the case record.
  - Enroll the individual for Medicaid using the VaCMS system.
- **If ineligible for Medicaid**
  - Document the denial and the reason for it in the case record.
  - Assure substantiation of ineligibility is included in the case record.

    **Example:** If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.

- Send a Notice of Action (for AG) to the individual and his representative to notify them of the AG and the Medicaid denial or approval. State the reason the AG and Medicaid applications were denied and cite the appropriate AG and Medicaid manual references.
  - If the application is denied due to the implementation of a period of ineligibility due to an uncompensated transfer of resources, a Transfer of Resources notice must be sent with the Notice of Action.
- Send the Provider/DSS Communication Form to the ALF/AFCH to notify the provider that the AG has been denied.

### 7.4.3. Approval of AG

Action to approve an application is taken at the point an eligibility determination finds that all eligibility requirements are met.

### 7.4.3.1. Entitlement Begins – Regular AG

Entitlement to regular AG begins the first month in which all eligibility factors are met. Entitlement cannot begin prior to the month of application. There is no retroactive period for AG.

- If the individual entered the ALF or AFCH in the application month, entitlement will begin on the date the individual entered the ALF or AFCH.
- If the individual entered the ALF or AFCH prior to the month of application, entitlement will begin on the first of the month of application.
- If the individual does not meet all eligibility criteria within the month of application but meets all criteria in a subsequent month, entitlement will begin the first of the month in which all eligibility criteria are met.
- If the individual entered the ALF or AFCH in a month subsequent to the month of application, entitlement will begin on the date the individual entered the ALF or AFCH.

### 7.4.3.2. Entitlement Begins – Conditional Benefits

Entitlement to Conditional Benefits begins the first month after the individual receives written notification that his Agreement to Sell Property has been received and accepted.

- The date of acceptance is 5 days from the date the Conditional Benefits Notice is mailed unless the individual shows that he/she did not receive it within the 5-day period.
- If the Conditional Benefits Notice is handed to the individual, the date of acceptance is that date.

### 7.4.3.3. Approval Procedures

The worker must:

- Document the approval in the case record assuring that each eligibility factor is addressed.

- Assure that all supporting verifications are in the case record.
- Enter the appropriate data in the local payment system.
- Evaluate retro Medicaid eligibility based on the Medicaid Manual.
- Evaluate Medicaid Eligibility. Eligibility for AG equals eligibility for ongoing Medicaid if the individual met the Declaration of Citizenship and the **Assignment of Rights requirements.**
    - **Met**
        - Enroll the individual for Medicaid using the VaCMS system.
    - **Not met**
        - Document the denial and the reason for it in the case record.
- ~~Update the AGTrak system, using "G" as the case disposition code.~~
- Send the "Notice of Action" or the "Conditional Benefits Notice", as appropriate, to the individual and their representative to notify them of the AG and Medicaid decisions.
    - If Medicaid is denied, state the reason the Medicaid application was denied and cite the appropriate manual reference.
- Send the Provider/DSS Communication Form to the ALF/AFCH to notify the provider that the AG has been approved.

## 7.5. Notices

The individual, his representative, and the ALF/AFCH provider must be notified in writing of the application decision.

Section 63.2-501 of the Code of Virginia was amended during the 2017 Session of the Virginia General Assembly. Effective July 1, 2017, LDSS shall obtain the applicant's alternative contact information, in addition to the applicant's best available address and telephone number such as email or cell phone number, and the applicant's preferred method of contact, including direct mail, email or text message. Eligibility workers (EW) shall review the application for this information.

The eligibility worker shall use the applicant's preferred method of contact to communicate general information about the applicant's eligibility for the AG Program. However, the EW is still required to mail the written Notice of Action (NOA) for AG to inform the individual of specific action on the case. Follow this guidance when communicating with the AG applicant:

- Email message guidance:

Dear Jane.Doe@yahoo.com,

An action was taken on Auxiliary Grant Case #123456. A written notice was mailed to-your address on file. Please check your mail for the notice.

This electronic communication may contain confidential or privileged information for an intended recipient. If the reader of this message is not the intended recipient, or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution or copying of this communication is strictly prohibited.

- Text message guidance:

Written notice of action on your AG case has been mailed to your address on file. Please check your mail for this notice.

- Direct Mail guidance:

No changes to current policy. Mail Notice of Action for AG by the application deadline or extended deadline, if applicable, based on policy in the AG Manual Chapter B, 7.2.2.

## 8. Processing Renewals

Eligibility for all AG and Medicaid recipients must be renewed annually and all eligibility factors subject to change must be reverified. If a renewal is not completed, continuing eligibility cannot be determined and the case must be closed.

A renewal begins with the receipt of a written application from a non-SSI individual or the review of SVES *or SOLQ* data for an SSI recipient, continues through the verification, evaluation and documentation of each eligibility factor, and is completed at the point an eligibility decision is made, all appropriate notices are sent, and computer systems are updated.

Eligibility is established when it is redetermined that the individual meets all eligibility requirements. Ineligibility is determined at the point the individual does not meet one of the eligibility requirements. The worker must use the Evaluation of Eligibility *for AG* to document the evaluation of each eligibility requirement.

## 8.1. Renewal Date

The initial renewal date is twelve months from the month of application. (The month of application is counted as the first month in the twelve-month period.) Subsequent renewal dates will be twelve months from the last renewal month.

**Example:** Application was filed in March 2016. The renewal date will be February 2017. The renewal process must be completed and the MMIS system updated by the system cutoff date in February. SSI Recipients

An SSI recipient does not have to file a written application to complete his/her annual renewal. The renewal process for an SSI recipient is completed by verifying continued receipt of SSI through SVES or SOLQ, verifying the individual's residence in an ALF/AFCH, documenting the case record, and notifying the individual of the results of the renewal.

The renewal must be completed by the MMIS cutoff date in the renewal month.

## 8.2. Non- SSI Recipients

A written application is required to complete an annual renewal for a non-SSI individual. "Supplemental Renewal Application Forms A & C" must be mailed to the individual in sufficient time to allow for the return of the application, the provision of all required verifications, and the completion of an eligibility determination by the MMIS cutoff date in the renewal month. The individual must be given a minimum of ten days to return the completed renewal application.

### 8.2.1. Renewal Application Received Late

If the renewal application is not returned timely, but is received:

- Prior to the effective date of closure due to failure to complete a renewal, the application must be processed as a renewal.

  If the renewal is completed after the scheduled renewal date, the next renewal date will be twelve months from the month the renewal application was received by the agency. (The month the renewal application is received is counted as the first month in the twelve month period.)

- After the effective date of closure, a complete Application for Benefits must be submitted and the application must be processed as a reapplication. If the individual submitted Supplemental Renewal forms A and C, send the individual an Application for Benefits giving him/her 10 days to return the completed document. If the application is returned within 10 days, use the date from the Supplemental Renewal forms A & C were received as the individual's application date.

### 8.2.2. Verifications Requirements

All eligibility factors subject to change must be reverified. The Manual addresses each eligibility factor and the appropriate source for the verification.

- Blindness and disability do not have to be reverified unless it is reported that the individual is no longer blind or disabled.

- The individual must be notified in writing of the items that must be verified and the date by which the verifications must be received.

- The individual must be given a minimum of ten calendar days to return the verifications. Additional time may be allowed in situations where the individual may have difficulty in obtaining the required verifications in the ten day time frame.

- If the individual asks for help in obtaining the required verifications, the eligibility worker must attempt to obtain them.

If the required verifications are not provided and the eligibility worker is unable to obtain them, eligibility cannot be determined and the case must be closed.

## 8.3. Eligibility Decisions on Renewals

An AG and Medicaid eligibility decision must be made on each application for renewal and each failure to submit a renewal application. The individual and his representative must be notified in writing of that decision.

Possible decisions include:

- **Failure to comply**
  - The individual did not submit a renewal application. Case will be closed.
- **Closure**
  - The agency determines the individual is ineligible based on his failure to meet one or more of the non-financial or financial eligibility requirements. The case must be closed.
- **Suspension**

An individual's grant is suspended when

- The individual is ineligible for one month only.

- **Approval/Eligibility Continues**
  - The agency determines the individual meets all eligibility requirements and eligibility will continue.

### 8.3.1. Failure to Comply

If an individual does not submit a renewal application, continuing eligibility cannot be determined. The case must be closed.

#### 8.3.1.1. **Procedures**

The worker must:

- Retain a copy of the cover letter that was sent to the client that stated the date by which the renewal application was to be returned.
- Document the closure and the reason for it in the case record.
- Close the case in the local payment system.
- Close the case in VaCMS.

- ~~Close the case in AGTrak.~~

- Send the "Notice of Action (for AG)" to the individual and his representative to notify them of the AG and Medicaid closures. State the reason the AG and Medicaid cases were closed and cite the appropriate AG and Medicaid manual references.

- Send the "Provider/DSS Communication Form" to the ALF/AFCH to notify the provider that the AG has been closed.

### 8.3.2. AG Closure

When the worker determines the individual is ineligible based on his failure to meet one or more of the non-financial or financial eligibility requirements the case must be closed.

#### 8.3.2.1. **Closure Procedures**

The worker must:

- Document the closure and the reason for it in the case record.

- Assure substantiation of ineligibility is included in the case record.

  **Example:** If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.

- Evaluate Medicaid eligibility based on the Medicaid Manual.

  - **If eligible for Medicaid**

    - Document the approval in the case record assuring that each eligibility factor is addressed

    - Assure that all supporting verifications are in the case record.

- Close the individual's coverage in the MMIS system as an AG individual and reopen it under the individual's new covered group.
- Send a "Notice of Action (for AG)" to the individual and his representative to notify them that Medicaid eligibility continues.

- **If ineligible for Medicaid**
  - Document closure and reason in the case record
  - Assure substantiation of ineligibility is included in the case record.

    **Example:** If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.

- Send a "Notice for Action (for AG)" to the individual and his representative to notify them of the AG and, if appropriate, Medicaid closures. State the reason the AG and Medicaid applications were closed and cite the appropriate AG and Medicaid manual references
- At the end of the 10-day advance notice period,
  - Close the case in the local AG payment system
  - Close the AG case in VaCMS
  - ~~Close the AG case in AGTrak~~
- Send the Provider/DSS Communication Form to the ALF/AFCH to notify the provider that the AG has been closed.

### 8.3.3. AG Suspension

An individual's grant will be suspended when the worker determines the individual is ineligible for one month only. A grant will be suspended for the reasons and the time periods listed below.

- The individual's receipt of a one-time payment will cause ineligibility for a month.

- Inability to verify eligibility for a month.

- An individual who is required to apply for reinstatement of SSI has applied but SSI has not made a decision. The grant will be suspended until an SSI decision is made or 30 days from date of renewal application, at which time the case will be closed. (Be sure to evaluate all other covered groups for eligibility prior to denial.)

**Note:** Suspension procedures do not apply to situations in which an individual's payment amount is reduced to zero but remains AG eligible. Zero payment might occur due to payment reconciliation, application of penalties for misuse of burial funds, etc.

8.3.3.1. **Suspension Procedures – Ineligible for One Month Only**

The worker must

- Document the ineligibility, the suspension, and the reason for it in the case record

- Assure substantiation of ineligibility is included in the case record

  **Example:** If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.

- Evaluate Medicaid eligibility based on the Medicaid Manual, Volume XIII.

  - **If eligible for Medicaid**

    - Document the change in the case record assuring that each changed eligibility factor is addressed

    - Assure that all supporting verifications are in the case record

- Close the AG Medicaid case in VaCMS
- Reopen the individual in his new Medicaid covered group in VaCMS
- Update the renewal date in VaCMS.
- Send a "Notice of Action (for AG)" to the individual and his representative to notify them that Medicaid eligibility continues.

- **If ineligible for Medicaid**
  - Document the closure and the reason for it in the case record.
  - Assure substantiation of ineligibility is included in the case record.
  - Example: If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.
  - Send a "Notice of Action (for AG)" to the individual and his representative to notify them of the Medicaid closure. State the reason Medicaid was closed and cite the appropriate Medicaid manual references.
  - At the end of the 10-day advance notice period, close the case in VaCMS.

- Send a "Notice of Action (for AG)" to the individual and his representative to notify them of the AG suspension. State the reason for the suspension, cite the appropriate AG manual reference, and state the date the grant will be reinstated.
- At the end of the 10-day notice period, suspend the case in the local AG payment system.
- Send the Provider/DSS Communication Form to the ALF/AFCH to notify the provider that the AG has been suspended.

- Reinstate AG and Medicaid for the following month. Send a "Notice of Action (for AG)" to the individual and his representative to notify them of the reinstatement.

- Send the Provider/DSS Communication Form to the ALF/AFCH to notify the provider that the AG has been reinstated.

8.3.3.2. **Suspension Procedures –**

The worker must

- Document the suspension and the reason for it in the case record.

- Assure the case record contains substantiation of the reason for the suspension; Send a "Notice of Action (for AG)" to the individual and his representative to notify them of the AG suspension. State the reason for the suspension, and cite the appropriate AG manual reference.

- At the end of the 10-day notice period, suspend the case in the local AG payment system.

- Set a special review, to check the status.

- Evaluate Medicaid eligibility based on the Medicaid Manual.

    - **If eligible for Medicaid**

        - Document the change in the case record assuring that each changed eligibility factor is addressed.

        - Assure that all supporting verifications are in the case record.

        - Close the AG Medicaid case in VaCMS

        - Reopen the individual in his new Medicaid covered group in VaCMS.

- Update the renewal date in VaCMS.
- Send a "Notice of Action (for AG)" to the individual and his representative to notify them that Medicaid eligibility continues.

- **If ineligible for Medicaid**
  - Document the closure and the reason for it in the case record.
  - Assure substantiation of ineligibility is included in the case record.
  - Example: If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.
  - Send a "Notice of Action (for AG)" to the individual and his representative to notify them of the Medicaid closure. State the reason Medicaid was closed and cite the appropriate Medicaid manual references.
  - At the end of the 10-day advance notice period, close the case in VaCMS.

- Send the Provider/DSS Communication Form to the ALF/AFCH to notify the provider that the AG has been suspended.
- Upon receipt of an SSI reinstatement decision, evaluate the change.

### 8.3.4. AG Approval/Continuing Eligibility

The agency determines the individual meets all eligibility requirements and eligibility will continue.

#### 8.3.4.1. **Grant Amount Remains Unchanged**

No financial changes have occurred.

The worker must:

- Document the continuing eligibility in the case record assuring that each eligibility factor is addressed
- Assure that all supporting verifications are in the case record.
- Update the appropriate data in the local payment system
- Update the renewal date and other data in the VaCMS system
- Send a "Notice of Action (for AG)" to the individual and his representative to notify them of continued AG and Medicaid eligibility.

#### 8.3.4.2. **Grant Increases**

There has been a decrease in the individual's income or level of need.

The worker must:

- Document the approval in the case record assuring that each eligibility factor is addressed.
- Compute the new grant.
- Assure that all supporting verifications are in the case record.
- Enter the appropriate data in the local payment system.
- Update the renewal date in VaCMS system.
- Send a "Notice of Action (for AG)" to the individual and his representative to notify them of continued AG and Medicaid eligibility.

#### 8.3.4.3. **Grant Decrease**

The individual's income increased or there was an increase his level of need.

The worker must:

- Document the approval in the case record assuring that each eligibility factor is addressed.
- Compute the new grant.
- Assure that all supporting verifications are in the case record.
- Enter the appropriate data in the local payment system.
- Update the renewal date in the MMIS system.
- Send the "Notice for Action (for AG)" to the individual and his representative to notify them of continued AG and Medicaid eligibility and the decrease in the grant amount.

### 8.4. Notices

The individual or his representative must be notified in writing of the renewal decision. The type of action to be taken determines the specific notice to be used.

## 9. Processing Changes (Partial Reviews)

When a change in an eligibility factor occurs between renewals, a partial review of the individual's case is required to determine if eligibility continues and if the amount of the grant is correct.

The evaluation of a change begins with the receipt of information that a change has occurred and continues through the verification and evaluation of the change, documentation in the case record, updating of appropriate computer systems, and the mailing of a notice to the individual.

### 9.1. Reporting Changes

The individual must report changes in his/her situation within 10 days of the date the change occurred. The report may be verbal or in writing.

- If the individual has more than one agency worker and reports a change to any one of them, the responsibility to report has been met.

  Information that appears in the Medicaid MMIS system, VaCMS system, in an IVES report, or that is available through the SVES or SOLQ inquiry

system is considered to be changes that have been reported to the agency and the individual's requirement to report has been met.

The eligibility worker is responsible for identifying these changes and must take action on them within the time frames noted in Chapter B - 9.2.

### 9.1.1. Failure To Report Timely

If the individual fails to report a change timely, a change that was not otherwise known to the agency, determine if the change resulted in an increase or decrease in the individual's grant.

#### 9.1.1.1. Grant Increase

Implement the change as instructed in Chapter B - 8.3.4.2.

- The individual is entitled to supplements from the month of change forward. The supplements will be addressed at the point the impacted months are reconciled. See Reconciling Payments Chapter J – 7.

#### 9.1.1.2. Grant Decrease

Determine if an overpayment has occurred. Implement the change as instructed in Chapter B - 8.3.4.3.

- Determine the month in which the change occurred and should have been reported.

- Use the Change Time Standards in Chapter B - 9.2 below to determine the month the change should have been implemented had it been reported timely.

Overpayments occurred in the month the change should have been implemented and each subsequent month that occurred prior to the actual implementation of the change.

**Example:** Individual's support income increased on January 1st. He reported the change in April. A Notice for Action (for AG) was mailed notifying him that his grant would be decreased effective June.

The individual should have reported the change by January 11th. The change would have been implemented for March, the second month following the month in which the change was to

be reported. Overpayments occurred in March, April, and May.

- Determine the total amount of the overpayment.
- Take action to recover the total overpayment as directed in Chapter L.

## 9.2. Change Time Standards

Action must be taken on reported changes within a timeframe that permits the worker to meet the effective date guidelines given below.

### 9.2.1. Increase In Grant Amount

#### 9.2.1.1. Increase in Grant Amount Due to Income Change

Action must be taken within 30 days of the date the change was reported. The individual will be due supplements for each month impacted by the change. The supplements will be issued at the point the impacted period is reconciled. See Reconciling Payments Chapter J – 7.

#### 9.2.1.2. Increase in Grant Amount Due to Increase in AG Rate

Increases made necessary by an increase in the monthly rate must be made retroactive to the effective date of the rate increase. The supplements must be issued at the point the determination is made. Do not wait until the impacted months are reconciled.

**Example:** The AG rate increases effective January 1. Case action is taken on February 5. The increase must be effective January 1. A supplement is required for January and February and is initiated on February 5.

### 9.2.2. Termination/Decrease In the Grant

If a decrease in the amount of the grant or termination of assistance is required, the reduced payment or nonpayment of assistance must be effective as soon as administratively possible, the first of the month following the end of the 10-day notice period, but no later than the second month following the month in which the change is reported.

**Example**: A change is reported on July 26. Action must be taken by the August MMIS cutoff date (approximately August 16) to make the decrease effective September 1.

9.2.2.1. **Advance Notice**

The individual must be given 10 days advance notice of a proposed decrease or termination of his grant. Unreduced payments issued during the advance notice period are not over payments.

**Example**: On July 10th the individual reported that his income increased effective July 1st. On July 23rd the EW computes the new grant amount and prepares a "Notice for Action (for AG)". The advance notice period is 10 days, July 24th through August 2nd. The notice will state the reduced grant will be effective September 1st. The EW can take action to reduce September's grant on August 3rd. The August grant is not an overpayment.

**Exception** to the 10-day advance notice requirement

- The individual requests the case be closed.
- The individual's death has been verified.
- The individual was discharged from the facility.

## 9.3. Verification Requirements

All changes in eligibility requirements must be verified.

- A request for a case to be closed must be made in writing and be signed and dated by the individual or his representative.
- The individual must be notified in writing of the items that must be verified and the date by which the verifications must be received.
- The individual must be given a minimum of 10 days to return the verifications. Additional time may be allowed in situations where the individual may have difficulty in obtaining the required verifications in the ten day time frame.
- If the individual asks for help in obtaining the required verifications, the eligibility worker must attempt to obtain them.

#### 9.3.1. Verification Not Provided

If the required verifications are not provided and the eligibility worker is unable to obtain them, continued eligibility cannot be determined and the case must be closed.

### 9.4. Eligibility Decisions on Changes

An eligibility decision must be made on each reported change. The individual and his representative must be notified in writing of that decision.

Possible decisions include:

- **Ineligibility/Closure**
  - The agency determines the individual is ineligible based on his failure to meet one or more of the non-financial or financial eligibility requirements and the case must be closed.
  - The agency receives information verifying the death of the individual.
  - The individual requests his case be closed.
- **Suspension**

  An individual's grant is suspended when
  - The individual is ineligible for one month only.
  - The worker is unable to determine the individual's continuing eligibility while awaiting an SSI eligibility reinstatement decision.
- **Eligibility Continues**

  The agency determines the individual meets all eligibility requirements and eligibility will continue.

### 9.5. Ineligibility/Closure

When the agency determines the individual is ineligible based on his failure to meet one or more of the non-financial or financial eligibility requirements, the individual requested the case closed, or the individual died, the case must be closed.

The worker must

- ~~Close AG case in AGTrak~~

- Assure substantiation of ineligibility is included in the case record.

  **Example:** If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.

- Evaluate Medicaid eligibility based on Medicaid Manual.

  - **If Medicaid eligible**

    - Document the change in the case record assuring that each changed eligibility factor is addressed.

    - Assure that all supporting verifications are in the case record.

    - Close the AG Medicaid case in VaCMS.

    - Reopen the individual in his new Medicaid covered group in VaCMS

    - Send a "Notice of Action (for AG)" to the individual and his representative to notify them that Medicaid eligibility continues.

  - **If Medicaid ineligible**

    - Document the closure and the reason for it in the case record

    - Assure substantiation of ineligibility is included in the case record.

      - Example: If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.

- Send a "Notice of Action (for AG)" to the individual and his representative to notify them of the AG and, if appropriate, Medicaid closures. State the reason AG and Medicaid were closed and cite the appropriate AG and Medicaid manual references.

- At the end of the 10-day advance notice period close the case in the local AG payment system, ~~the AGTrak system~~, and, if appropriate, VaCMS.

  - **Exception: A 10-day advance notice period is not required when an individual requests his case closed.**

- Send the Provider/DSS Communication Form to the ALF/AFCH to notify the provider that the AG has been closed.

## 9.6. Suspension

An individual's grant will be suspended when the worker determines the individual is ineligible for one month only. A grant will be suspended for the reasons and the time periods listed below. Medicaid eligibility based on AG eligibility ends at the point the AG payment is suspended. Medicaid eligibility for the suspension period will have to be evaluated based the Medicaid Manual.

**Reasons for suspension:**

- The individual's receipt of a one-time payment will cause ineligibility for a month.
- Inability to verify eligibility for a month.

### 9.6.1. Suspension Procedures – Ineligible for One Month Only

The worker must:

- Document the ineligibility, the suspension, and the reason for it in the case record.
- ~~Update AGTrak to reflect the suspension of the case.~~
- Assure substantiation of ineligibility is included in the case record.

  **Example:** If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.
- Evaluate Medicaid eligibility based on the Medicaid Manual.
  - **If Medicaid eligible**
    - Document the change in the case record assuring that each changed eligibility factor is addressed.
    - Assure that all supporting verifications are in the case record.
    - Close the AG Medicaid case VaCMS.
    - Reopen the individual in his new Medicaid covered group in VaCMS.
    - Send a "Notice of Action (for AG)" to the individual and his representative to notify them that Medicaid eligibility continues.

- **If Medicaid ineligible**
  - Document the closure and the reason for it in the case record.
  - Assure substantiation of ineligibility is included in the case record.

    **Example:** If the individual is ineligible due to excess income, the case record must include verification of the income and the calculations used to determine ineligibility.
  - Send a "Notice of Action (for AG)" to the individual and his representative to notify them of the Medicaid closure. State the reason Medicaid was closed and cite the appropriate Medicaid manual references.
  - At the end of the 10-day advance notice period close the case in VaCMS.

- Send a "Notice of Action (for AG)" to the individual and his representative to notify them of the AG suspension. State the reason for the suspension, and cite the appropriate AG manual reference.
- At the end of the 10-day advance notice period, suspend the case in the local AG payment system.
- Send the Provider/DSS Communication Form to the ALF/AFCH to notify the provider that the AG has been suspended.
- Reinstate AG and Medicaid for the following month. Send a "Notice of Action (for AG)" to the individual and his representative to notify them of the reinstatement.
- Send the Provider/DSS Communication Form to the ALF/AFCH to notify the provider that the AG has been reinstated.

## 9.7. Continuing Eligibility

The agency determines the individual meets all eligibility requirements and eligibility will continue.

### 9.7.1. Grant Amount Remains Unchanged

No financial changes have occurred.

The worker must:

- Document the change in the case record assuring that each changed eligibility factor is addressed on the evaluation of eligibility for AG form.
- Assure that all supporting verifications are in the case record.
- Send a "Notice of Action (for AG)" to the individual and his representative to notify them of continued AG and Medicaid eligibility.

### 9.7.2. Grant Increases

There has been a decrease in the individual's income or level of need.

The worker must:

- Document the change in the case record assuring that each changed eligibility factor is addressed.
- Compute the new grant.
- Assure that all supporting verifications are in the case record.
- Enter the appropriate data in the local payment system.
- Send a "Notice of Action (for AG)" to the individual and his representative to notify them of the increased grant amount.

### 9.7.3. Grant Decreases

The individual's income increased or there was a decrease his level of need.

The worker must:

- Document the change in the case record assuring that each eligibility factor is addressed.
- Compute the new grant.
- Assure that all supporting verifications are in the case record.

- Send the "Notice of Action (for AG)" to the individual and his representative to notify them of the decrease in the grant amount.

- At the end of the 10 day advance notice period, enter the appropriate data in the local payment system. The effective date of a decrease will be the first of the month following the expiration of the advance notice period.

### 9.8. Notice to Individual and Provider

The individual and his representative must be notified in writing of the results of the change evaluation. The type of action to be taken determines the specific notice to be used. The provider must be notified if the change results in the individual's ineligibility. See Chapter B – 9.5.

## 10. Notices

The individual and his representative must be notified in writing of decisions on applications, renewals, and the results of change evaluations. The type of action to be taken determines the specific notice to be used.

The provider must be notified of initial eligibility decisions and any changes that result in the individual's ineligibility. The Provider/DSS Communication Form is used to notify the providers. This form is located on FUSION website.

### 10.1. AG Notice of Action

The "Notice of Action (for AG)" is used to notify an individual of the approval or denial of his/her initial application or reapplication for regular AG and when his/her annual renewal or change evaluation results in continued eligibility at the same or higher payment level and/or termination and suspended eligibility.

#### 10.1.1. Initial Application/Reapplication

The notice must be mailed at the time a decision is made on the application and within the 45-day processing period.

- If a decision has not been made by the 45th day, a "Notice of Action (for AG)" must be mailed to the individual on the 45th day. The notice must state that the application is still pending, and the reason action was not taken within the 45-day processing period.

#### 10.1.2. Renewal or Change

The notice must be mailed at the time a decision is made.

## 10.2. Conditional Benefits Notice

The "Conditional Benefits Notice" is a multipurpose form. It is used to notify an individual of his/her potential eligibility for Conditional Benefits, approval of Conditional Benefits, and the termination of Conditional Benefits. See Chapter F.

### 10.2.1. Initial Application/Reapplication

The "Conditional Benefits Notice" is used at two points in the application eligibility determination process.

#### 10.2.1.1. **Potential Eligibility**

The "Conditional Benefits Notice" must be mailed within the 45-day processing period to inform the individual of his ineligibility for regular AG due to excess non-liquid resources and his potential eligibility for Conditional Benefits. An "Agreement to Sell Non-Liquid Resources" must be sent with the notice.

#### 10.2.1.2. **Eligibility Approved**

The "Conditional Benefits Notice" must be mailed at the point it is determined the individual is eligible for Conditional Benefits. It must be mailed within 60 days from the date of application.

### 10.2.2. Renewal or Change

The "Conditional Benefits Notice" is used as an advance notice of proposed action to notify an individual that he/she is no longer eligible for Conditional Benefits.

#### 10.2.2.1. **Time Frames**

The individual must be given a minimum of 10 days advance notice before his/her case can be closed.

- The "Conditional Benefits Notice" must be completed and mailed at least 11 days prior to the effective date of the proposed case closure. The notice must state the effective date, the reason for the action, and cite the supporting manual reference.

- The effective date of the closure will be the first of the

month following the expiration of the advance notice period.

### 10.3. Advance Notice of Proposed Action

The "Advance Notice of Proposed Action" is the Notice of Action (for AG) mailed out 10 days in advance to notify an individual that his/her renewal or change has been evaluated and that

- Eligibility continues but the grant amount will be reduced,
- The grant is being suspended, or
- Eligibility no longer exists.

#### 10.3.1. Time Frames

The individual must be given a minimum of 10 days advance notice before an adverse action can be taken on the case.

**Exception:** A 10-day advance notice period is not required when an individual requests case closure.

- The "Notice of Action (for AG)" form must be completed and mailed at least 10 days prior to the effective date of the proposed decrease or case closure. The notice must state the effective date, the reason for the action, and cite the supporting manual reference.
- The effective date of an adverse action will be the first of the month following the expiration of the advance notice period.

### 10.4. Transfer of Resources Notice

The Transfer of Resources Notice is used to notify an individual that they are ineligible for a period of time due to the uncompensated transfer of resources, to inform them of their right to claim undue hardship and to notify them of any adjustments made to the period of ineligibility. See Chapter G.

#### 10.4.1. Initial Application/Reapplication

The "Transfer of Resources Notice" is to be sent with the Notice of Action (for AG)".

#### 10.4.2. Renewal or Change

The "Transfer of Resources Notice" is to be sent with the "Notice of Action (for AG)"

## 10.5. Provider/DSS Communication Form

The Provider/DSS Communication Form is used to notify the provider of the eligibility decision. The form is also used as means of communication between the local DSS and the assisted living facility or adult foster care home provider. They can exchange information regarding:

- The AG and Medicaid eligibility status of an individual;
- Admission or discharge of an individual to home, hospital, another ALF/AFCH, or an institution, or to report the death of an individual;
- Other information known to the provider that might cause a change in the eligibility status.

### 10.5.1. Use of the Form

The form may be initiated by either the local DSS or the provider of care. The local DSS must complete the form for each applicant at the time initial eligibility is determined. A new form must be prepared by the local DSS whenever there is any change in individual's circumstances that results in the individual's ineligibility.

The provider must use the form to show admission date, to request information on AG or Medicaid eligibility status, to request a Medicaid recipient I.D., or to notify the local DSS of changes in the individual's circumstances, discharge or death.

**Note:** There is no separate form labeled "Advance Notice of Proposed Action." Sending the "Notice of Action (for AG)" 10 days prior to action **is the Advance Notice**. Make sure that all notification of changes are mailed out 10 days prior to action where indicated.

# Chapter K

## Supportive Housing

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# Chapter K

Supportive Housing

## 1.1 Introduction

Supportive Housing (SH) was added as an approved setting to the Auxiliary Grant (AG) program in 2016. SH is defined as a residential setting with access to supportive services for an AG recipient in which tenancy as described in § 51.1-1200 of the Code of Virginia is provided or facilitated by a provider licensed to provide mental health community support services, intensive community treatment, programs of assertive community treatment, supportive in-home services, or supervised living residential services that has entered into an agreement with the Department Behavioral Health and Developmental Services (DBHDS) pursuant to §37.2-421.1 of the Code of Virginia.

The definitions below appear in 22 VAC 30-80-10 unless otherwise specified:

| Term | Definition |
|---|---|
| **Adult Foster Care or AFC** | A locally optional program that provides room and board, supervision, and special services to an adult who has a physical or mental health need. Adult foster care maybe provided for up to three adults by any one provider who is approved by the local department of social services. |
| **Assisted Living Level of Care** | A level of service provided by an assisted living facility or a SH provider for adults who may have physical or mental impairments and require at least moderate assistance with the activities of daily living. Included in this level of service are individuals who are dependent in behavior pattern (i.e., abusive, aggressive, and disruptive) as documented on the Uniform Assessment Instrument (UAI). |

| Term | Definition |
|---|---|
| **Assisted Living Facility or ALF** | "Assisted living facility" or "ALF" means any congregate residential setting that provides or coordinates personal and health care services, 24-hour supervision, and assistance (scheduled and unscheduled) for the maintenance or care of four or more adults who are aged~~,~~ or infirm or ~~disabled~~ who have disabilities and who are cared for in a primarily residential setting, except (i) a facility or portion of a facility licensed by the State Board of Health or the Department of Behavioral Health and Developmental Services, but including any portion of such facility not so licensed; (ii) the home or residence of an individual who cares for or maintains only persons related to him by blood or marriage; (iii) a facility or portion of a facility serving individuals who are infirm or ~~disabled persons~~ who have disabilities between the ages of 18 and 21, or 22 if enrolled in an educational program ~~for the handicapped~~ individuals with disabilities pursuant to § 22.1-214 of the Code of Virginia, when such facility is licensed by the Virginia Department of Social Services as a children's residential facility under Chapter 17 (§ 63.2-1700 et seq.) of Title 63.2 of the Code of Virginia, but including any portion of the facility not so licensed; and (iv) any housing project for ~~persons~~ individuals who are 62 years of age or older or ~~the disabled~~ individuals with disabilities that provides no more than basic coordination of care services and is funded by the U.S. Department of Housing and Urban Development, by the U.S. Department of Agriculture, or by the Virginia Housing Development Authority. Included in this definition are any two or more places, establishments or institutions owned or operated by a single entity and providing maintenance or care to a combined total of four or more adults who are aged~~,~~ or infirm or ~~disabled adults~~ who have disabilities. Maintenance or care means the protection, general supervision and oversight of the physical and mental well-being of an individual who is aged~~,~~ or infirm or ~~disabled individual~~ who has a disability. |
| **Authorized Payee** | The individual(s) who may be a court-appointed conservator or guardian, a person with a valid power of attorney or an authorized representative with the documented authority to accept funds on behalf of the individual. An authorized payee for the auxiliary grant shall not be the licensee, owner, employee of or an entity hired by or contracted by the ALF or AFC home. |

| Term | Definition |
|---|---|
| **Authorized Representative** | The person representing or standing in place of the individual receiving the auxiliary grant for the conduct of the auxiliary grant recipient's affairs (i.e., personal or business interests). "Authorized representative" may include a guardian, conservator, attorney-in-fact under durable power of attorney, trustee, or other person expressly named in writing by the individual as his agent. An authorized representative shall not be (i) the licensee or (ii) the owner of, employee of, or an entity hired by or contracted by the ALF, AFC home, or a supportive housing provider unless the auxiliary grant recipient designates such a person to assist with financial management of his personal needs allowance as a choice of last resort because there is no other authorized representative willing or available to serve in this capacity. |
| **Auxiliary Grants Program or AG** | A state and locally funded assistance program to supplement income of an individual receiving Supplemental Security Income (SSI) or adult who would be eligible for SSI except for excess income, who resides in an ALF, an AFC home, or a supportive housing setting with an established rate. The total number of individuals within the Commonwealth of Virginia eligible to receive AG in a supportive housing setting shall not exceed the number designated in the signed agreement between the department and the Social Security Administration. |
| **Department** | The Department for Aging and Rehabilitative Services. |
| **Local Department** | The local department of social services of any county or city in this Commonwealth (§63.2-100 of the Code of Virginia). |
| **Personal Needs Allowance** | A portion of the AG payment that is reserved for meeting the individual's personal needs. The amount is established by the Virginia General Assembly. |
| **Provider** | Means an ALF that is licensed by the Department of Social Services or an AFC provider that is approved by a local department of social services or a SH provider as defined in §37.2-421.1 of the Code of Virginia. |
| **Provider Agreement** | Means a written agreement that ALFs and SH providers must complete and submit to the department when requesting approval to admit individuals receiving AG. |

| Term | Definition |
|---|---|
| **Qualified Assessor** | Means an individual who is authorized by 22VAC30-110 to perform an assessment, reassessment, or change in level of care for an individual applying for AG or residing in an ALF or SH setting. For individuals receiving services from a community services board or behavioral health authority, a qualified assessor is an employee or designee of the community services board or behavioral health authority. |
| **Rate** | Means the established rate. |
| **Residential living care** | Means a level of service provided by an ALF or a SH provider for adults who may have physical or mental impairments and require only minimal assistance with the activities of daily living. Included in this level of service are individuals who are dependent in medication administration as documented on the Uniform Assessment Instrument (UAI). |
| **Virginia Uniform Assessment Instrument or UAI** | The department designated assessment form. It is used to record assessment information for determining the level of service that is needed. |

## 1.2 Funding

The AG program is funded by a combination of state and local funds. State funds comprise 80% and local funds comprise the remaining 20%. State funds are authorized by the Virginia General Assembly and the local funds are authorized by the governing body of each locality.

The AG Program provides income supplements to recipients of SSI and certain other aged, blind, or disabled individuals residing in AGSH that are approved by DBHDS and DARS. LDSS should use the following cost codes when issuing AG payments to individuals living in AGSH setting:

- Aged individuals-80701
- Blind individuals-80702
- Disabled individuals-80703

## 1.3 Eligibility overview

LDSS eligibility workers (EW) should follow the same criteria in evaluating an individual's financial eligibility for AGSH as they would for any SSI or Non-SSI recipient.

However, there are some additional considerations regarding AGSH:

- AGSH is available to individuals who have applied for auxiliary grant and who are assessed using the UAI. AGSH individuals must meet the residential level of care at a minimum, be interested in receiving AGSH, and be determined through an AGSH evaluation to be eligible for AGSH.

- AGSH is only available to individuals who do not require ongoing, onsite, 24-hour supervision and care or recipients who have any of the prohibited conditions or care needs described in subsection D of §63.2-1805 of the Code of Virginia.

- The number of participants in AGSH is limited to 120 individuals pursuant to an agreement between DARS and Social Security Administration (SSA).

- The AGSH provider must be an approved provider with DBHDS and certified by DARS. The AGSH provider list is available ~~at: Https://fusion.dss.virginia.gov/dars/DARS-Home/AUXILIARY-GRANT~~ *on Fusion website.*

- The AGSH settings are regionally designated for Northwestern, Southwestern, and Central Virginia and slots are based on availability and fair market rental rates. There are some special circumstances regarding absences from the AGSH setting that affect case closure. See Section 1.8.2 Residence Ends.

- AGSH recipients are eligible to receive Supplemental Nutrition Assistance Program (SNAP) benefits. SNAP benefits are excluded and will not be considered as countable income to the individual.

- AG cases for SH recipients shall be transferred to the locality where the individual will reside in the SH setting. These cases are not retained by the locality in which the person resided prior to entering the approved ALF setting unless the AGSH setting is also located in that jurisdiction. Exception: If a person leaves SH and returns to an ALF, the AGSH locality remains the locality of jurisdiction for AG.

Note: DBHDS will track AGSH slots in addition to *LDSS using* ~~*AgTrak*~~ *LASER cost code* and provide notification to DARS when applications have reached their maximum capacity.

## 1.4 Eligbility process

The AGSH recipient must have applied for AG or currently is an AG recipient. The qualified assessor will evaluate the individual's level of care and will make a referral to the AGSH provider. The AGSH provider will conduct an SH evaluation and submit an approval letter to the EW and qualified assessor. For individuals who are applying for the AG initially and have selected to go into the SH setting, when all financial and non-financial requirements are met, send the Notice of Action for AG for SH approval. The individual will have 30 days from the date of the notice to find appropriate placement. When calculating the 30 days, allow 5 days for mailing out the Notice of Action for AG. Once housing has been located and a lease is signed, the AGSH provider will send the provider communication document to the EW along with a copy of the lease agreement. The EW will need to verify the SH address and send payment to the individual unless a designated representative payee has been assigned. Additional information should be requested to verify payee status i.e., a letter from SSA or documentation from CSB or Behavioral Health Authority. Payment will not be issued until placement is confirmed. If placement is not verifiable or has not been confirmed within the 30-day period, send Notice of Action for AG to deny the application.

After the AGSH setting has been established, the EW will submit the renewal application to the individual and his representative payee for their annual review. The EW should receive an eligibility communication document (ECD) for reassessment during the annual review from the qualified assessor for AGSH and verify all financial and non-financial requirements for the AG program. (See Chapter B, Section 8 for processing renewals).

The EW will review the following upon the individual's initial entry into AGSH and at each annual review:

- Verify that the individual meets at least residential level of care on the ECD or Medicaid funded long-term care service authorization form (also known as the DMAS 96).

- Verify that the individual is living in or continues to reside in the AGSH setting as described on the paperwork submitted by the AGSH provider.

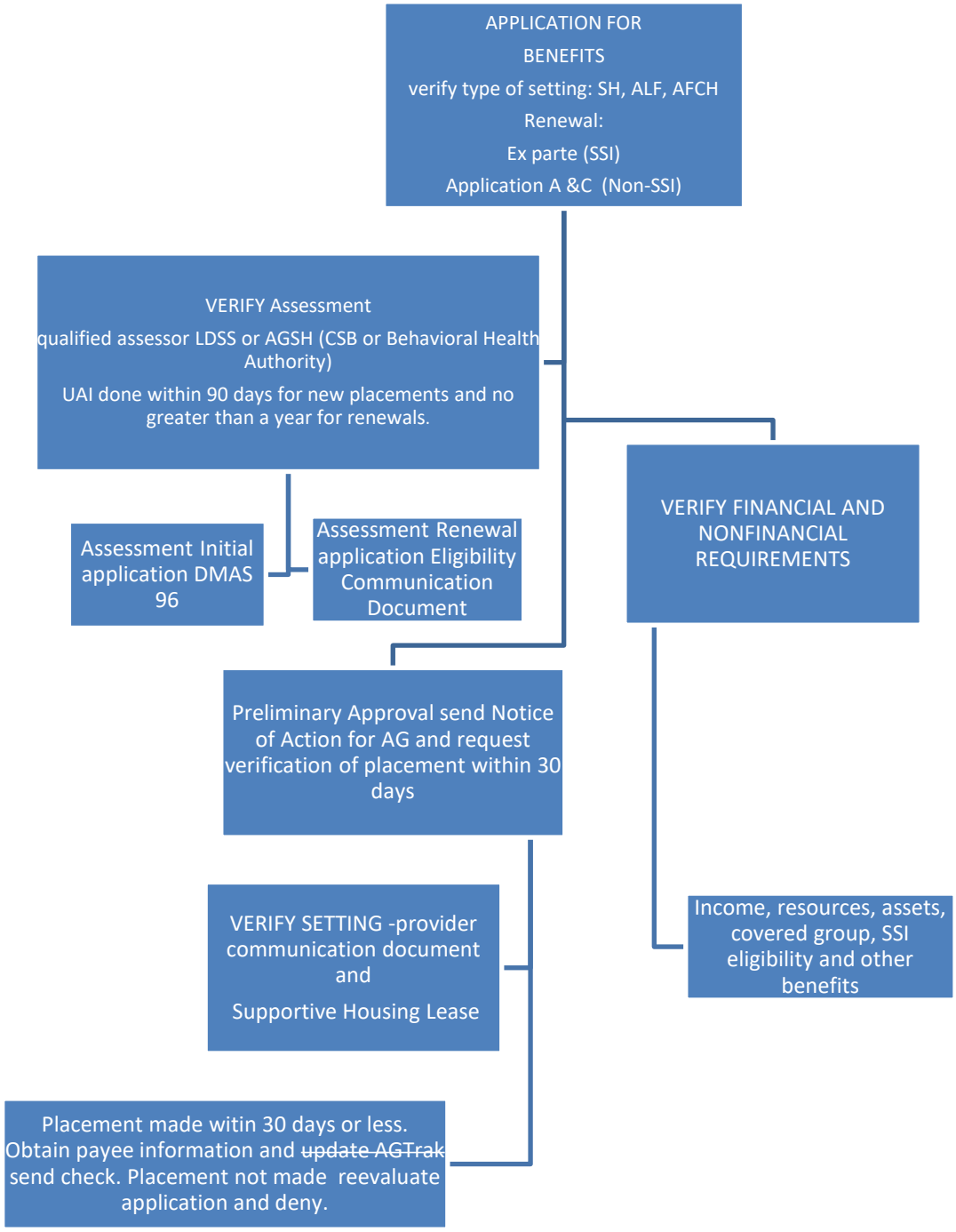
- Verify that the individual meets the income and resource requirements for AG.

Verify that the AGSH provider is certified to take AG clients. A provider list is available ~~at https://fusion.dss.virginia.gov/dars/DARS-Home/AUXILIARY-GRANT on Fusion website.~~

- EW should review the locality to which the case belongs and conduct a case transfer, if applicable.

### 1.4.1 AGSH enrollment workflow

The enrollment process is outlined in the following chart.



## 1.5 ~~AGTrak as a~~ System of record

VaCMS will be the system of record for the Medicaid program that accompanies the AG applications. Workers will process AG applications outside VaCMS system. ~~The system of record for the AG Program is AGTrak.~~ *The AG application is a paper process where eligibility criteria is evaluated and documented on the Evaluation of Eligibility for AG form and kept in the client's case record.* ~~EW must enter approved cases and update the AGTrak as changes in residence and eligibility occur.~~

## 1.6 Forms

Forms used for AG applications or eligibility determinations are located on FUSION ~~https://fusion.dss.virginia.gov/dars/DARS-Home/AUXILIARY-GRANT~~

## 1.7 Applicable policy

This chapter addresses the eligibility requirements and determination procedures for AGSH. The procedures differ for the two groups that are potentially eligible for AG, SSI recipients and non-SSI individuals. SSI recipients are those who receive an SSI money payment. Non-SSI individuals are those who are ineligible for SSI due to excess income or individuals with no income who meets a covered group. The primary differences are in the income and resource eligibility requirements.

To address those differences, separate income and resource chapters were developed. The titles of the chapters are the key to which the chapters apply. If the title includes SSI Recipient in the title, it applies only to SSI recipients, i.e., Chapter D - SSI Recipients' Eligibility. If the title includes Non-SSI, it applies only to those individuals who do not receive SSI, i.e. Chapter E - Non-SSI Resource Eligibility. If the title does not include either of those phrases, it applies to both groups.

## 1.8 Residence in SH

The individual must be residing in a setting that has been licensed by DBHDS to provide AGSH services and certified as an AG provider by DARS. The housing provider also has to enter into an agreement to provide supportive services to the individual.

### 1.8.1 Verification of residence in SH

The EW shall do the following:

- Verify individual is in an SH setting via provider communication documentation and a lease agreement.

- Verify that the AGSH provider is listed on the AGSH provider list.
- Verify that the individual continues to live at the address where he or she was approved to reside via a statement by the appropriate qualified assessor.

### 1.8.2 Residence ends

An individual must maintain eligibility for both AG and for the AGSH setting. AGSH evaluations must be conducted at eligibility determination, annually, and with changes in individual circumstances that jeopardize safety and housing stability.

The individual's eligibility for SH ends when:

- The individual no longer meets AG financial eligibility, or
- The individual no longer meets AGSH non-financial eligibility, including the following:
    - The individual is absent from housing unit for 30 consecutive days or more, or
    - The individual is absent from housing unit over the 90 consecutive days due to hospitalization without a physician's statement, or
    - The individual no longer meets a minimum of residential level of care, or
    - The individual no longer meets AGSH eligibility as determined by AGSH re-evaluation, or
    - The individual refuses or is unable to participate in the annual reassessment or AGSH re-evaluation.

Individuals who no longer meet AGSH criteria will be discharged from the program. The EW will receive a provider communication document from the AGSH provider regarding any residence changes. If the EW receives third party information, then the EW shall obtain additional information from the AGSH provider, the CSB or BHA. In cases where the individual is seeking admission to an ALF or AFC home, the EW must suspend payment until it can be verified that the individual has entered a new setting. In these situations, follow procedures in Chapter C Section 7, Residence in an ALF or AFC home.

For AGSH recipients returning to an ALF:

- If the UAI is less than 12 months old, the assessor may submit an ECD to the EW to indicate continued level of care.

- If the UAI is more than 12 months old, then a DMAS 96 will be submitted.

## 1.9 SH AG rate and approved provider listing

DARS publishes the maximum rate an ALF, AFC home, SH provider can charge an AG recipient via broadcast on FUSION. Two rates are set; one for Planning District 8 (Northern Virginia specified localities) and another for all other areas of Virginia. Planning District 8 consists of the counties of Arlington, Fairfax, Loudoun, Prince William and the cities of Alexandria, Fairfax, Falls Church, Manassas and Manassas Park. Changes to the AG rate usually occur in January to coincide with the SSA's Cost of Living Adjustment. However, the General Assembly occasionally may approve a rate increase that takes effect July 1.

The most current AG rate broadcast is available ~~under the DARS Adult Protective Services page on FUSION~~. *on Fusion website*.

AG rates are to be verified by accessing the ~~DARS Adult Protective Services Auxiliary Grant page on FUSION Resources & Procedures heading page on FUSION at the following address: https://fusion.dss.virginia.gov/dars/DARS-Home/AUXILIARY-GRANT~~. *Fusion website*. ALF and SH providers that are both licensed and approved to accept AG recipients are listed there. If the ALF or AGSH is not listed there, the individuals residing in the ALF or in the SH setting are not eligible for AG. If this situation occurs, contact the DARS AG Program Manager for further guidance.

## 1.10 Covered services

Virginia regulations identify the services that are to be provided for the established AG rate. The established rate must be accepted as full payment for these services. The AGSH payment covers the following services:

- Rental Assistance at HUD Fair Market Rent value
- SH coordinator
- Utilities
- Provision for household needs (i.e., furniture, appliances, supplies)
- Food*
- Medication management
- Supportive services (treatment and skill building)

- Personal needs (i.e., toiletries, clothing, hair care)
- Transportation

*Note: If the individual is no longer residing in a facility with a congregate meal setting, he or she may be able to apply for SNAP benefits as a community resident.

## 1.11 Payment issuance

AG payments are issued by check directly to the individual unless an authorized payee has been designated. If an authorized payee has been designated, the check shall be issued to the authorized payee. An authorized payee maybe an individual's court appointed conservator or guardian, a person with a valid power of attorney with the authority to accept funds on behalf of the individual, or an authorized representative with documented authority from the SSA to accept funds on behalf of the individual. It is the responsibility of the individual or the authorized payee to use the money to pay AGSH service coordinator, household expenses, and personal needs.

Note: An authorized payee shall not be the property owner, or employee of CSB or BHA, other procedures for computation and issuance shall be followed according to Chapter J.