VIRGINIA DSS, VOLUME XIII

MEDICAID ELIGIBILITY MANUAL

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APPLICATION *FOR* MEDICA*L ASSISTANCE*

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CHAPTER M01

APPLICATION *FOR* MEDICAL *ASSISTANCE*
SUBCHAPTER 10

GENERAL INFORMATION

M0110 Changes

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M0110 General Information

M0110.100 Legal Base and Agency Responsibilities

A. Introduction

Medicaid is an assistance program that pays medical service providers for medical services rendered to eligible individuals. The Medicaid eligibility determination consists of an evaluation of an individual's situation that compares each of the individual's circumstances to an established standard. Requests for Virginia Medicaid must be made in written form on an official Medicaid application or in the Application/Benefit Delivery Automation Project (ADAPT) system.

All activity of the agency in receiving and acting upon an application must be consistent with the objectives of the Medicaid program and be conducted in a manner which respects the personal dignity and privacy of the individual.

B. Legal Base

The Medical Assistance Program (Medicaid) is established under Title XIX of the Federal Social Security Act and is financed by state and federal funds. The State Plan for Medical Assistance (State Plan) is the official body of regulations covering the operation of the Medicaid program in Virginia.

Virginia law provides that the Medicaid program be administered by the Department of Medical Assistance Services (DMAS). Determination of eligibility for medical assistance is the responsibility of local departments of social services under the supervision of the Department of Social Services (DSS).

Exception: DSS carries direct responsibility for the determination of eligibility of certain patients in *Virginia Department of Behavioral Health and Developmental Services (DBHDS)* facilities and for their enrollment in the Medicaid program.

C. Agency Responsibilities

1. DMAS

The administrative responsibilities of DMAS are:

- the development of the State Plan to cover eligibility criteria and scope of services, in conformity with federal law and regulation,
- the determination of medical care covered under the State Plan,
- the handling of appeals related to medical assistance,
- the approval of providers authorized to provide medical care and receive payments under Medicaid,

- the processing of claims and making payments to medical providers, and
- the recovery of Medicaid expenditures in appropriate cases. Suspected applicant fraud is a combined responsibility of both DMAS and DSS.

2. DSS

The responsibilities of DSS are:

- the determination of initial and continuing eligibility for Medicaid and
- the enrollment of eligible persons in the Medicaid program.

M0110.110 Confidentiality

***A.* Confidentiality**

Medicaid applicants and recipients are protected by federal and state confidentiality regulations, 42 CFR 431.300 and 12VAC30-20-90. These regulations were established to protect the rights of clients to confidentiality of their Medicaid information.

***B.* Release of Client Information**

Except as otherwise indicated, no person shall obtain, disclose or use, authorize, or permit the use of any client information that is directly or indirectly derived from the records, files or communications of the agency, except for purposes directly connected with the administration of the Medicaid program, which includes but is not limited to:

- establishing eligibility,
- determining the amount of medical assistance,
- providing services for recipients, and
- conducting or assisting in an investigation, prosecution or a civil or criminal proceeding related to the administration of the program.

***C.* Use of System Searches**

Searches of online information systems, including but not limited to the State Online Query-Internet (SOLQ-I) and the State Verification Exchange System (SVES) are permitted **only** for applicants and family members whose income and/or resource information is required to determine eligibility for the applicant or patient pay for an enrollee. This includes spouses of applicants and parents of child applicants.

***D.* Release of Information to Medical Providers**

Although certain individuals are authorized to receive information about an applicant's/recipient's case, only the minimum data necessary to respond to the request is to be released. Federal regulations stipulate that the disclosure of information about an applicant or recipient can only be for purposes related to administration of the Medicaid State Plan.

Information in the case record related to an individual's medical treatment, or method of reimbursement for services may be released to Virginia Medicaid providers by DMAS without the applicant's/enrollee's consent. Enrollee consent is not needed for the DSS agency to provide confirmation of an individual's eligibility, the dates of eligibility, and any patient pay responsibility if the medical provider is unable to obtain that information from the member verification system or from DMAS staff. The provider **is not** entitled to specific information about an applicant's/recipient's income or resources without a release of information because the provider does not need that information for medical treatment or payment.

Provider contractors, such as application assistance companies, operate under the authority of the provider. A patient's consent is not required for the agency to provide the contractor with information related to reimbursement for services rendered or medical treatment. Provider contractors **are not** entitled to receive detailed financial or income information contained in an applicant's or recipient's case record without the person's consent to release the information.

Local agencies may release Medicaid enrollee identification numbers to medical providers by telephone if the provider cannot contact the DMAS provider/recipient verification telephone number. This procedure does not conflict with federal or State confidentiality regulations, if the local agency is satisfied that the number is being released to an identifiable provider.

E. **Release to Authorized Representatives**

Individuals not determined to be incapacitated by a court can designate whomever they choose to be their authorized representatives, including a provider or a provider's contractor (such as an application assistance company). The designation must be in writing, with the applicant or recipient specifying the information to be released to the authorized representative.

It is not sufficient to indicate that any information in the case record may be released; the designation must state the specific information to be released (i.e. notices, the ability to make application or provide information necessary to determine eligibility, and what, if any, other information can be released to the authorized representative). The authorized representative designation is valid for the life of the application.

F. **Safeguarding Client Information**

All information associated with an applicant or recipient that could disclose the individual's identity is confidential and shall be safeguarded. Such information includes but is not limited to:

- name, address, and all types of identification numbers assigned to the client;
- medical services provided to the client;

- social and economic conditions or circumstances of the client;
- agency evaluation of the client's personal information;
- medical data about the client, including diagnoses and past histories of disease or disabilities;
- information received for verifying income, eligibility, and amount of medical assistance payments;
- information received in connection with identification of legally liable third party resources; and
- information received in connection with processing and rendering decisions of recipient appeals.

G. **Ownership of Records**

All client information contained in the agency records is the property of the agency, and employees of the agency shall protect and preserve such information from dissemination except as indicated.

Original client records are not to be removed from the premises by individuals other than authorized staff of the agency, except by court order. The agency may destroy records pursuant to records retention schedules.

H. **Release of Client Information with Consent**

As part of the application process for Medicaid, the client shall be informed of the need to consent to the release of information necessary for verifying eligibility. Whenever a person, agency or organization that is not performing one or more of the functions described in 3.a above requests client information, the agency must obtain written permission to release the information from the client or the personal legally responsible for the client whenever possible. A release for information obtained from the client by the requesting agency also satisfies this requirement.

I. **Release of Client Information without Consent**

Information from the applicant/recipient's case record may not be released to other agencies, such as public housing agencies, legal services, private organizations, the U.S. Citizenship and Immigration Services (USCIS), Virginia Employment Commission (VEC), school lunch programs, health departments or elected officials without the client's consent. An exception applies to agencies with which there is an agreement for specific types of sharing of information, such as wage information from the VEC, Systematic Alien Verification for Entitlements (SAVE) with USCIS, the State Verification Exchange System (SVES) with the Social Security Administration, etc.

Client information may be disclosed without client consent in the *following* situations:

1. Social Services Employees

to employees of state and local departments of social services for the purpose of program administration;

2. Program Staff in Other States to program staff in other states when a client moves or when there is a question of dual participation, or to verify the status of assistance in Virginia for applicants in another state;

3. DMAS & LDSS Staff between state/local department of social services staff and DMAS for the purpose of supervision and reporting;

4. Auditors to federal, state and local employees for the purposes of auditing, monitoring, and evaluation; and

5. For Recovery Purposes for the purpose of recovery of monies for which third parties are liable for payment of claims.

***J.* Client's Right of Access to Information** Any client has the right to obtain personal information held by the agency. Upon written or verbal request, the client shall be permitted to review or obtain a copy of the information in his record with the following exceptions:

- Information that the agency is required to keep confidential from the client pursuant to §2.2-3704 and §2.2-3705, Code of Virginia, Virginia Freedom of Information Act, Public Records to be open to Inspection; and
- Information that would breach another individual's right to confidentiality

1. Freedom of Information Act (FOIA) Consistent with the Virginia Freedom of Information Act, §2.2-3704 and §2.2-3705, Code of Virginia, the agency shall provide access within five working days after the receipt of the request. The agency shall make disclosures to applicants and recipients during normal business hours. Copies of the requested documents shall be provided to the client or a representative at reasonable standard charges for document search and duplication.

2. Client May Be Accompanied The client shall be permitted to be accompanied by a person or persons of the client's choice and may grant permission verbally or in writing to the agency to discuss the client's file in such person's presence. Upon request and proper identification of any client or agent of the client, the agency shall grant to the client or agent the right to review the following:

- All personal information about the client except as provided in §2.2-3704 and §2.2-3705,
- The identity of all individuals and organizations not having regular access authority that request access to the client's personal information.

3. Client May Contest Information Pursuant to the Code of Virginia §2.2-3800, a client may contest the accuracy, completeness or relevancy of the information in his record. Correction of the contested information, but not the deletion of the original information if it is required to support receipt of state or federal financial

participation, shall be inserted in the record when the agency concurs that such correction is justified. When the agency does not concur, the client shall be allowed to enter a statement in the record refuting such information. Corrections and statements shall be made a permanent part of the record and shall be disclosed to any entity that receives the disputed information.

M0110.120 Address Confidentiality Program (ACP)

A. Purpose

The Virginia Attorney General's Office's ACP was created to help a victim of domestic violence who has recently moved to a new location that is unknown to the abuser. The victim wants to keep the new address confidential. Effective July 1, 2011, this program was made available statewide.

B. All Mail Goes to Richmond P.O. Box Address

The ACP offers a substitute mailing address for the individual in a high risk situation. An individual participating in the ACP will have an ACP authorization card that can be used to verify participation in the program; a participant will use a post office box address in Richmond as his address. This address is to be accepted as a mailing address. No locality, FIPS code, or other geographic identification is included on the ACP authorization card.

*The actual physical address of the participant **MUST NOT** be entered in into any of the VDSS automated systems. Only the mailing address (which is P.O. Box 1133, Richmond, Virginia, 23218) is entered into the computer systems as the participant's residence address; no separate mailing address is entered.*

C. Accept Participant's Verbal Statement of Residency

Virginia state residency and locality residency is established by the participant's verbal statement that he is residing in the locality where he is applying for assistance.

D. Refer to Local Domestic Violence Program

Please refer any victims of domestic violence to the local Domestic Violence Program for consideration of the ACP, for safety planning, and other services. Local domestic violence advocates are currently receiving training about the ACP. In most localities, the applications for the ACP program will be completed with the DV advocates as a part of in depth safety planning.

M0110.200 Definitions

A. Adult Relative means an individual who is age 18 or older, who is not a parent, but who is related to a child by blood or marriage and who lives with and assumes responsibility for day-to-day care of the child in a place of residence maintained as his or their own home.

B. Applicant means an individual who has directly or through his authorized representative made written application for Medicaid at the local social services department serving the locality in which he is a resident, or if institutionalized, the locality in which he last resided outside an institution.

C. Application for Medical Assistance means an official form prescribed by DMAS for requesting medical assistance that is used for initial eligibility determinations and redeterminations. An application for medical assistance is an application for the Medicaid, State and Local Hospitalization (SLH), Family Access to Medical Insurance Security (FAMIS) and FAMIS MOMS programs.

D. Attorney-In-Fact (Named in a Power of Attorney Document)

means a person authorized by a power of attorney document (also referred to as a "POA") to act on behalf of another individual, either for some particular purpose or for the transaction of business in general. **A power of attorney document does not necessarily authorize the attorney-in-fact to apply for Medicaid on behalf of the applicant.** The eligibility worker must read the power of attorney document to determine (1) if the person has the power to act as the applicant in any of the applicant's business and (2) whether or not the document grants durable power of attorney. If the document is a general power of attorney or includes the power to conduct the applicant's financial business, the attorney-in-fact is considered the applicant's authorized representative as long as the person for whom the attorney-in-fact is authorized to act is not legally incapacitated.

If the individual on whose behalf the attorney-in-fact is acting is incapacitated and not able to act on his own behalf, the eligibility worker must examine the document to determine that it grants a durable power of attorney. The contents of the document must indicate that the power of attorney does not stop upon the incapacity of the person. **If the power of attorney is not durable, it is no longer valid when the individual on whose behalf it is executed becomes legally incapacitated.**

E. Authorized Representative

An authorized representative is a person age 18 years or older who is authorized to conduct business for an individual. A competent individual age 18 years or older must designate the authorized representative in a written statement. The authorized representative statement is valid until:

- the application is denied;
- medical assistance coverage is canceled; or
- the individual changes his authorized representative.

The authorized representative of an incompetent or incapacitated individual is the individual's spouse, parent, attorney-in-fact (person who has the individual's power-of-attorney), legally appointed guardian, legally appointed conservator (committee), or family substitute representative.

EXCEPTION: Patients in DBHDS facilities may have applications submitted by DBHDS staff.

F. Child

means an individual under age 21 years.

G. Competent Individual

means an individual who has **not** been judged by a court to be legally incapacitated.

H. Conservator

means a person appointed by a court of competent jurisdiction to manage the estate and financial affairs of an incapacitated individual.

I. Family Substitute Representative means a spouse *age 18 or older* or designated relative *age 18 or older* who is willing and able to take responsibility for the individual's personal or financial affairs. Designated relatives other than the spouse who may be substitute representatives are, in this preferred order, the individual's child, parent, sibling, grandchild, niece or nephew, aunt or uncle.

J. Guardian means 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.

K. Incapacitated Individual means an individual who, pursuant to an order of a court of competent jurisdiction, has been found to be incapable of receiving and evaluating information effectively or responding to people, events, or environments to such an extent that the individual lacks the capacity to (1) meet the essential requirements of his health, care, safety, or therapeutic needs without the assistance or protection of a guardian; or (2) manage property or financial affairs or provide for his or her support or the support of his legal dependents without the assistance or protection of a conservator.

L. Legal Emancipation of a Minor means a minor who has been declared emancipated by a court of competent jurisdiction. A married minor is not emancipated unless a court has declared the married minor emancipated from his parents.

M. Medical Assistance *means any program administered by DMAS jointly with the Department of Social Services (DSS) that helps individuals or families pay for medical, dental and related health services. These programs are Medicaid, State and Local Hospitalization (SLH), Family Access to Medical Insurance Security (FAMIS) and FAMIS MOMS.*

M0110.300 Availability of Information

A. Information Required to be Given to the Applicant

1. Explanation of Medicaid Program The agency must inform the applicant about Medicaid eligibility requirements, covered services, use of the Medicaid card, recovery (3rd party, lawsuits and estate) of funds paid, and the applicant's rights and responsibilities. This information must be given to the applicant in written form and verbally, if appropriate.

The following materials must be given to the individuals specified below:

- The booklet "Virginia Social Services Benefit Programs," form # 032-01-002, contains information about the Medicaid Program and must be given to all applicants;

- The Division of Child Support Enforcement (DCSE)'s booklet "Child Support and You," form #032-01-945 must be given to applicants who are applying on behalf of a child who has an absent parent; *and*

- The "Virginia Medicaid Handbook" must be given to all recipients and must be given to others upon request.

Applicants may also be given Medicaid Fact Sheets as appropriate.

2. Early Periodic Screening, Diagnosis and Treatment (EPSDT)

All Medicaid applicants who are under age 21 are eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services. Information on the availability and benefits of EPSDT must be provided for all applicants under age 21 within 60 days of the date that eligibility is determined. EPSDT information is included in the booklet "Virginia Social Services Benefit Programs."

3. Voter Registration

The National Voter Registration Act of 1993 (NVRA) requires local social services agencies to offer each TANF, Food Stamp, and Medicaid applicant an opportunity to apply to register to vote at initial application and at each review of eligibility. Additionally, voter registration application services must be provided any time a change of address is reported in person to the local agency.

In complying with the requirements of the NVRA, local agency staff must provide each applicant and *enrollee* the same degree of assistance in completing his/her voter registration application as they do in completing the application for public assistance.

a. Exceptions to Offering Voter Registration

The only exception to offering voter registration application services is when the *individual*:

- has previously indicated that he is currently registered to vote where he lives,

- there is a completed agency certification form in the *individual's* case record indicating the same, and

- the *individual* has not moved from the address where he stated that he was registered to vote.

b. *Prohibitions*

Local social services agencies and agency staff are prohibited from the following activities when providing voter registration application services:

- *seeking to influence an individual's political preference;*

- *displaying any political preference or party affiliation;*

- *making any statement to the or taking any action the purpose or effect of which is to discourage the individual from applying to register to vote; or*

- *making any statement to an individual or taking any action the purpose of which is to lead the individual to believe that a decision to register or not register has any impact on the individual's eligibility for assistance or the benefit level that they may be entitled to receive.*

c. Voter Registration Services

Each local social services agency must provide the following voter registration services:

- *distribution of voter registration application forms;*

- *assistance to individuals in completing the registration application form, unless such assistance is refused, and ensuring that all spaces on the form are completed;*

- *ensuring that the certification statement on the application for benefits or statement of facts is completed; and*

- *acceptance of voter registration application forms for transmittal to the local general registrar.*

  1) *Each completed registration application must be submitted to the local general registrar every Friday (if Friday is a holiday, the forms must be forwarded to the local registrar on the last working day before Friday.) Completed forms are to be forwarded to the local registrar in an envelope, notated with an "A" in the upper left-hand corner and listing the number of completed registration applications included in the envelope.*

  2) *For split/combined agencies, all voter registration applications are to be transmitted to the general registrar in the locality where the local social services agency is located.*

  3) *If the individual chooses, he may take a voter registration application to be mailed to the State Board of Elections at his own cost.*

d. Voter Registration Application

In Virginia, one voter registration application form will be used to serve a twofold purpose:

- *the voter registration application will be completed by the individual with necessary assistance from local agency staff during the*

application/review process and left at the local agency for transmittal to the local general registrar; or

- *for individuals who do not wish to complete the voter registration during the application process, they may take a voter registration form for mail-in registration.*

e. Individuals Required to be Offered Voter Registration Services

In order to be offered voter registration services, an individual must:

- *be a member of the Medicaid family unit.*

- *be at least 18 years old by the next general election. General elections are held in all localities on the Tuesday after the first Monday in November or on the first Tuesday in May to fill offices regularly scheduled by law to be filled at those times.*

  If any question arises as to whether the individual will turn 18 before the next general election, complete the registration application and the local registrar will determine if the individual may be registered.

- *be present in the office at the time of the application or renewal interview if an interview takes place, or when a change of address is reported in person. If a change of address is not reported in person, a registration application will be sent to the individual upon request. Any change in the Medicaid family unit composition that does not occur concurrent with an application, renewal or change of address will be handled at the next scheduled renewal.*

Any individual accompanying the applicant/enrollee to the local agency who is not a member of the assistance unit (including payees and authorized representatives) will not be offered voter registration services by the local agency. However, a registration application is to be provided to the non-unit member upon request.

Any request for a mail-in application for assistance must include a mail-in voter registration application. When an authorized representative is applying on another individual's behalf, the local agency is to offer a mail-in voter registration application. In both situations, the bottom of the certification form is to be completed accordingly.

***f.* Voter Registration Application Sites**

Local social services agencies are required to offer voter registration application services at each local office (including satellite offices) for applicants/recipients of TANF, Food Stamp, and Medical Assistance. Voter registration application services are also offered by out-stationed staff taking Medicaid applications at hospitals or local health departments and by

Medicaid staff at the state's Mental Health, Mental Retardation, and Substance Abuse facilities.

B. Information Made Available to the Public in General

1. Availability of Manual

Federal regulations require copies of the State Plan and eligibility rules and policies to be available in agency offices and other designated locations. Policy manuals must be made available in agency offices and other designated locations to individuals who ask to see them.

Upon request, copies of program policy materials must be made available without charge or at a charge related to the cost of reproduction. Copies of manual pages may be made at the local departments of social services, or Medicaid manuals may be ordered from:

Virginia Department of Social Services
Division of General Services
7 North Eighth Street,
Richmond, Virginia 23219

2. Medicaid Handbook and Fact Sheets

Federal regulation 42 CFR 435.905 requires the state agency to publish bulletins or pamphlets describing eligibility in easy to understand language. The "Virginia Medicaid Handbook" includes basic information about the program and provides a listing of rights and responsibilities. To supplement the "Virginia Medicaid Handbook," fact sheets that explain specific policy areas are available to local social services agencies from the state department of social services. The “Virginia Medicaid Handbook” will be given to all recipients at initial approval and to other individuals upon request. The handbook is also available on the internet at www.dmas.state.va.us.

C. Inquiries

1. General Inquiries

The following information has been developed to give guidance to employees of the State and local departments of social services about how to respond to inquiries:

- Limit verbal and written information to explaining the written materials provided. Those written materials may include copies of manual pages, the “Virginia Medicaid Handbook,” or fact sheets. The individual may also be referred to the Virginia Department of Social Services website at www.dss.state.va.us and the Virginia Department of Medical Assistance Services website at www.dmas.state.va.us for additional information.

- Do not go beyond the scope of the written materials. Questions about hypothetical situations, such as (but not limited to) "what would happen if a certain value of resources were transferred?" or "what would be the effect on Medicaid if a trust were written in a certain way?" *should not* be answered.

Medicaid rules and policies are applied to the facts of a specific application after an application is received. Prior to receipt, do not give hypothetical advice or answers to hypothetical questions to applicants, their attorneys or anyone applying on behalf of the applicant. Answering hypothetical questions is inappropriate for two reasons:

- Until a complete application is received, the local agency cannot be sure it has all the relevant facts. An attempt to be helpful could be futile or lead to incorrect advice. In the event of a dispute, the applicant may then assert that the agency is bound by the incorrect advice. The applicant or other persons affected by the applicant's actions (such as those affected by a property transfer or those otherwise responsible for the care of the applicant) may attempt to hold the agency employee or employees involved individually liable for damages suffered as a result of alleged negligent advice.

- Providing responses to hypothetical questions may under some circumstances constitute the practice of law. The practice of law includes advising another for compensation, direct or indirect, in any matter involving the application of legal principles to facts or purposes or desires. Local agency workers, regional Medicaid consultants, and central office Medicaid employees, even if they are attorneys, are not functioning as legal counsel and must not give legal advice which may affect the rights of applicants, recipients, or others who may not be applying or eligible for Medicaid.

All Medicaid staff are bound by these guidelines for the dissemination of information. Do not refer inquiries from attorneys, applicants or others acting on behalf of the applicant to regional or state Medicaid staff.

2. Case Specific Inquiries

Send questions that occur as a direct result of the receipt of an application to the regional Medicaid consultant. Do not refer questions from attorneys (or legal questions in general) to the Regional Assistant Attorney General. These attorneys are responsible for providing legal advice to the regional Medicaid consultant and are not authorized to give legal advice to the public.

M0110.400 Retention of Case Information

A. Introduction

The agency must maintain case records that contain information necessary to support the facts essential to the determination of initial and continuing eligibility as well as any basis for discontinuing or denying assistance. The case record shall consist of a hard (i.e. paper) record, an electronic record, or a combination of the two. Records of active cases must be maintained for as long as the client receives benefits, while closed records must be maintained for a minimum of three years from the date of closure.

B. Policy

Case records must contain the following elements:

- the date of application,
- the date of and basis for the disposition of the application,

- facts essential to the determination of initial and continuing eligibility,
- the provision of medical assistance (i.e. enrollment),
- the basis for discontinuing medical assistance,
- the disposition of income and eligibility verification information, and
- the name of the agency representative taking action on the case and the date of the action.

The agency must include in each applicant's case record documentation to support the agency's decision on his application and the fact that the agency gave recipients timely and adequate notice of proposed action to terminate, discontinue or suspend their eligibility or to reduce or discontinue services they may receive under Medicaid. Types of documentation that support the agency's decision include evaluations of eligibility, case narratives, and permanent verifications.

The case record must contain a duplicate, either electronically or in writing, of all notices sent to the client. Copies of the documents used for verification of citizenship and identity, such as birth certificates, must also be maintained within the case record.

Active cases may be purged with the exception of documentation that supports the information shown in the paragraphs above. Agencies may wish to retain other information used in future eligibility determinations, such as resource assessments and burial contracts. Closed cases are required to be retained by the agency for a period of no less than three years from the date of closure.

The case record shall be organized as to enable audit and program integrity entities to properly discharge their respective responsibilities for reviewing the manner in which the Medicaid program is being administered.

CHAPTER M01
APPLICATION *FOR* MEDICAL *ASSISTANCE*
SUBCHAPTER 20

MEDICAL* ASSISTANCE *APPLICATION

M0120 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/01/11	Table of Contents pages 6-18
TN #95	03/01/11	pages 1, 8, 8a, 14
TN #94	09/01/10	pages 8, 8a
TN #93	01/01/10	pages 1, 7, 9-16
Update (UP) #1	07/01/09	page 8
TN #91	05/15/09	page 10

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M0120.000 Medical Assistance Application

M0120.100 Right to Apply

An individual cannot be refused the right to complete an application for himself (the applicant) or any other individual for whom he is authorized to apply. Under no circumstances can an individual be discouraged from asking for assistance for himself or any person for whom he is a legally responsible or authorized to represent. An applicant may be assisted with the application by an individual of his choice. A face-to-face interview is not required.

M0120.200 Who Can Sign the Application

A. Patients in DBHDS Facilities

Patients of any age in the Department of Behavioral Health and Developmental Services (DBHDS) facilities may have applications submitted and signed by DBHDS staff. The DBHDS facilities are listed in subchapter M1550.

B. Applicants Age 18 or Older

The applicant must sign the application, even if the form is filled out by another person, unless the application is filed and signed by the applicant's legal guardian, conservator (known as the “committee” for persons declared incompetent prior to the 1997 changes in the guardianship section of the Code of Virginia), attorney in fact, or authorized representative.

EXCEPTION: A parent can submit and sign an application for a child under age 21, when the child is living with the parent. The child does not need to authorize the parent to apply or conduct Medicaid business on his behalf.

If the applicant 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:

E.g.: (X) John Doe, his mark

Witness's signature:_____

1. Authorized Representative

An authorized representative is a person age 18 years or older who is authorized to conduct business for an individual. A competent individual age 18 years or older must designate the authorized representative in a written statement. The authorized representative statement is valid until:

- the application is denied;
- medical assistance coverage is canceled; or
- the individual changes his authorized representative.

The authorized representative of an incompetent or incapacitated individual is the individual’s spouse, parent, attorney-in-fact (person who has the individual’s power-of-attorney), legally appointed guardian, legally appointed conservator (committee), or family substitute representative.

EXCEPTION: Patients in the DBHDS facilities may have applications submitted by DBHDS staff.

2. **Family Substitute Representative**

When it is reported that an applicant cannot sign the application and the applicant does not have a guardian, conservator, attorney in fact or designated authorized representative, one of the individuals listed below who is *age 18 years or older and is* willing to take responsibility for the applicant's Medicaid business will be the applicant's "family substitute" representative. The family substitute representative will be, in this preferred order, the applicant's:

- spouse,
- child,
- parent,
- sibling,
- grandchild,
- niece or nephew, or
- aunt or uncle.

3. **No Family Substitute Representative**

If the applicant is unable to sign the application and does not have an attorney in fact, authorized representative, or family substitute representative, the applicant's inability to sign the application must be verified. Verification is by a written statement from the applicant's doctor that says that the applicant is not able to sign the Medicaid application because of the applicant's diagnosis or condition. Follow these procedures:

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

b. If action has been initiated to obtain a guardian for the applicant, 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.

   If the verification is provided within the 10 day period, continue to pend the application until the guardian or conservator is appointed. If the application pends for 45 days, send a Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs (NOA), form #032-03-003, to the applicant to extend the pending application.

   Once the guardian/conservator has been appointed, request verification of the appointment and that the application be signed by the guardian or conservator. Retain a copy of the application and mail the original application to the guardian/conservator. Allow 10 days for the signed application and guardian/conservator papers to be returned. If the application form and guardian/conservator papers are not returned to the agency by the specified date, deny the application because it is invalid.

c. If guardianship/conservator procedures have not begun or have not been verified as being on the court docket, refer the applicant to Adult Protective Services (APS) in the local agency.

If the report to APS meets all criteria for a valid report, an investigation will be conducted to learn whether protective services are needed and, if so, what services are needed. The protective services identified will be provided or arranged by APS.

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

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

***4.* Procedure for Who Can Sign the Application**

When preparing to determine the Medicaid eligibility of an individual age 18 or older, examine the application to determine if the applicant can complete and sign the application form or if the applicant has an authorized representative. Ask the following questions:

Has the applicant 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?

YES: The authorized representative is the appointed conservator or guardian. STOP.

NO: The applicant is competent. Does the applicant have an attorney in fact who has the power of attorney to apply for Medicaid for the applicant as evidenced by a copy of the power of attorney document in the record?

YES: The authorized representative is the attorney in fact. STOP.

NO: Has the applicant signed a written statement authorizing a person (or staff of an organization) to apply for Medicaid on his behalf?

YES: The authorized representative is the person or organization authorized by the applicant to represent him. STOP.

NO: Is the applicant able to sign or make a mark on a Medicaid application form?

YES: Ask the applicant for his signature or mark on the application form or for a written statement authorizing someone to apply for Medicaid on his behalf.

Give the applicant 10 working days to return the completed and signed form(s). If the completed and correctly signed form(s) are not returned by the specified date, DENY MEDICAID because of an invalid application.

NO: Does the applicant have at least one of the following *who is age 18 or older*:

- spouse,
- child,
- parent,
- sibling,
- grandchild, niece or nephew, or
- aunt or uncle?

YES: The authorized representative is the individual identified above who is willing and able to act on the applicant's behalf.

NO: Verify the inability of the applicant to sign the application because of a diagnosis or condition through a written statement from the applicant's doctor. Refer to APS. Pend the application. At the conclusion of the APS investigation, if APS concludes that guardianship proceedings will not be initiated, the applicant must sign or make a mark on the application or designate an authorized representative in writing. If the signed application form is not received by the specified date, deny Medicaid.

C. Applicants Under Age 18

1. Child Applicant

A child under age 18 years is not legally able to sign his own Medicaid application unless he is legally emancipated from his parents. If the child is not legally emancipated, one of the following individuals *who is age 18 or older* must sign the application:

- his parent,
- legal guardian,
- authorized representative, or
- an adult related by blood or marriage with whom the child lives (documentation of the relationship is not required).

If the child under 18 years of age is married and living with his spouse who is age 18 or older, the child's spouse may sign the application.

a. No Guardian or Legal Custody

If the child does not live with a parent or an adult relative and no adult is the child's guardian or has legal custody of the child, whomever the child is living with is responsible for seeking custody or guardianship of the child in the Juvenile and Domestic Relations court. Determine if the person submitting the application, or another person, has begun the process to obtain legal guardianship or custody of the child applicant.

b. Action Is Initiated To Appoint Guardian/Award Custody

If action has been initiated to appoint a guardian for or seek legal custody of the child, meaning a court guardianship or custody hearing is scheduled on the court docket, request verification that the action is on the court docket. Give 10 calendar days for this verification to be provided.

If the verification is provided within the 10-calendar-day period, continue to pend the application until a guardian is appointed or custody is awarded. If the application pends for 45 calendar days, send a notice to the applicant explaining that the application pending period will be extended.

Once the guardian has been appointed or custody awarded, request verification of the appointment or award and that the application be signed by the guardian or adult who was awarded custody. Allow 10 calendar days for the signed application and guardianship or custody papers to be returned.

If the court refuses to appoint a guardian or custodian and there is no adult who is legally able to sign an application for the child, deny the application as invalid.

c. Action Not Initiated – Refer to Child Welfare Services

If guardianship or custody procedures have not begun or have not been verified as being on the court docket, refer the child to the appropriate Family Services worker.

Continue to pend the application until the service investigation is completed and any court proceedings are completed. Once the guardian has been appointed or custody awarded, request verification of the appointment or award and that the application be signed by the guardian or adult who was awarded custody. Retain a copy of the application and mail the original application to the guardian or custodian. Allow 10 calendar days for the signed application and guardian or custody papers to be returned.

If the child was emancipated by the court, request the child's signature on the application. If the application is mailed to the child, allow 10 calendar days for the signed application form to be returned.

If the application form is not signed by the applicant, the guardian, the custodial adult, or the emancipated child and returned to the agency by the specified date, deny the application because it is invalid.

2. Minor Parent Applying for His Child

A parent under age 18 years may apply for Medicaid for his own child because he is the parent of the child.

3. Foster Care Child

a. IV-E

The Title IV-E Foster Care & Medicaid Application/Redetermination form, *posted on SPARK at* *http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi* is used for the IV-E Foster Care eligibility determination. A separate Medicaid application is **not** required for a child who has been determined eligible for Title IV-E Foster Care. However, if there is a non-custodial agreement for the IV-E eligible child, the parent or legal guardian must sign a Medicaid application for the child.

b. Non-IV-E

The Title IV-E Foster Care & Medicaid Application/Redetermination form, *posted on SPARK at* *http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi* is also used for the **non-IV-E** Foster Care eligibility determination. The Medicaid application for a non-IV-E child who is in foster care must be signed by an authorized employee of the public or private agency that has custody of the child. If there is a non-custodial agreement, a Medicaid application form (Application for Benefits or Health Insurance for Children and Pregnant Women form) must be filed and the parent or legal guardian must sign the Medicaid application.

4. Adoption Assistance & Special Medical Needs Children

a. IV-E

A separate Medicaid application is not required for a child who has been determined eligible for Title IV-E Adoption Assistance, regardless of which state has the adoption assistance agreement with the adoptive parents. IV-E Adoption Assistance children who have been placed for adoption through the Interstate Compact for Adoption and Medical Assistance (ICAMA) should have an ICAMA form 6.01 which verifies their Title IV-E eligibility for Medicaid. The ICAMA form 6.01 serves as the Medicaid application form.

b. Non-IV-E

Non-IV-E Adoption Assistance children include Non-IV-E Special Medical Needs children.

1) Placed by a Virginia agency

A Medicaid application is required for all non-IV-E Adoption Assistance and Non-IV-E Special Medical Needs children whose parents have adoption assistance agreements with a Virginia public or private child-placing agency. The child's adoptive parent signs and files the Medicaid application for the child.

2) Placed by another state

Non-IV-E Adoption Assistance children who have been placed for adoption through the Interstate Compact for Adoption and Medical Assistance (ICAMA) should have an ICAMA form 6.01 which verifies their adoption assistance status (IV-E or non-IV-E). The ICAMA form 6.01 serves as the Medicaid application form and a separate Medicaid application is not required when:

- the other state is an ICAMA member state, and
- the ICAMA member state **reciprocates** Medicaid coverage of Virginia Non- Title IV-E Adoption Assistance children.

All states and territories EXCEPT Vermont, Wyoming, Puerto Rico and Virgin Islands are members or associate members of ICAMA. A list of the ICAMA member states and whether they reciprocate Medicaid coverage for Non-IV-E Adoption Assistance children is in M0120, Appendix 3.

A Medicaid application must be filed for Non-IV-E Adoption Assistance children from non-member states and ICAMA member or associate member states which do NOT reciprocate. The child's adoptive parent signs and files the Medicaid application for the child.

D. Deceased Applicant

An application may be made on the behalf of a deceased person within a three-month period subsequent to the month of his death if both of the following conditions were met:

- the deceased received a Medicaid-covered service on or before the date of death, and
- the date of service was within a month covered by the Medicaid application.

If the above conditions were met, an application may be made by any of the following:

- his guardian or conservator,
- attorney-in-fact,
- executor or administrator of his estate
- his surviving spouse, or
- his surviving family member, in this order of preference: adult child, parent, adult brother or sister, adult niece or nephew, or aunt or uncle.

Under no circumstances can an employee of, or an entity hired by, the medical service provider who stands to obtain Medicaid payment file a Medicaid application on behalf of a deceased individual.

Medicaid coverage can begin no earlier than three months prior to the application month. The entitlement rules for retroactive coverage apply to the application's retroactive period.

E. Unsigned Application

An application that bears no signature is invalid. Return the application to the applicant with a letter requesting a signature.

F. Invalid Signature

An application that is signed by an individual who is not authorized to sign on behalf of the applicant is invalid. Return the application with a letter indicating who must sign the application to the individual who filed the application on behalf of the applicant. See M0120, Appendix 1 for a sample letter.

G. Enrollee Turns 18

When a child who is enrolled in Medicaid turns 18, it is not necessary to obtain a new application signed by the enrollee.

As long as the enrollee is under age 21, he does not need to authorize a parent with whom he lives for the parent to continue to conduct the enrollee's Medicaid business.

M0120.300 Medical Assistance Application Forms

A. General Principle – Application Required

A signed application is required for all initial requests for medical assistance, except for:

- IV-E Foster Care/Adoption Assistance children
- Auxiliary Grant (AG) applicants
- Newborn children under age 1 born to a Medicaid-eligible mother.

1. Exception for Certain Newborns

EXCEPTION: A child born to a mother who was Medicaid eligible at the time of the child's birth (including a child born to an emergency-services-only alien mother) is deemed to have applied and been found eligible for Medicaid on the date of the child's birth (see M0320.301). An application for the child is not required. The child remains eligible for Medicaid to age 1 year.

If the child was born to a mother who was covered by Medicaid outside Virginia at the time of the child's birth, verification of the mother's Medicaid coverage must be provided by the parent or authorized representative or an application must be filed for the child's eligibility to be determined in another covered group.

2. Forms That Protect the Application Date

a. ADAPT Request for Assistance

The Request for Assistance – ADAPT, form #032-03-875 available at: http://localagency.dss.virginia.gov/divisions/bp/files/fs/forms/general/032-03-0875-08-eng.pdf may be used to establish and preserve the application date for 30 calendar days, but a signed application must be submitted within 30 calendar days in order for eligibility to be determined.

b. Model Application for Medicare Premium Assistance Form

The model Application for Medicare Premium Assistance is a form developed by the federal Centers for Medicare & Medicaid Services (CMS) that states can choose to use for the Medicare Savings Program applicants. The model application is **NOT** a prescribed Virginia Medicaid application form at this time.

Should a local department of social services (LDSS) receive a model application form, the agency is to send a Virginia Application for Adult Medical Assistance (form # 032-03-0022), or an Application for Benefits (form #032-03-0824), to the applicant with a request that it be completed, signed, and returned to the agency within 30 calendar days. The date of application on the model Application for Medicare Premium Assistance is to be preserved as the application date for purposes of Medicaid entitlement.

The processing time for the LDSS begins when the agency receives the Virginia application form back from the applicant. If the Virginia application form is not returned within 30 days, no further action is necessary on that application. The agency does not send a Notice of Action because no Virginia application was received. The model application date is not preserved beyond 30 calendar days. Should the person later submit a valid Virginia application, the date the Virginia application is received by the LDSS is the application date.

The model application form may be viewed on the SSA web site at: http://www.socialsecurity.gov/prescriptionhelp/MSP-Model-Application-ENG.pdf.

B. Application Forms

Medical assistance must be requested on a form prescribed (published) by the Department of Medical Assistance Services (DMAS) and the Virginia Department of Social Services (VDSS).

An applicant may obtain a prescribed application form from a number of sources, including a variety of human service agencies, hospitals, and the internet.

1. Forms for Specific Covered Groups

There are specialized forms intended for use with certain covered groups, including pregnant women, children, SSI recipients, *Plan First* and women who have been screened under the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA). These forms should be used whenever possible because they do not ask the applicant to provide information that is not used in the eligibility determination for those specific covered groups.

2. Applicant Use of Incorrect Form

Applicants may not know for which covered group they should apply, so they may apply using an incorrect application form. Another application form is ***not*** *to be requested of the applicant if the incorrect form is used.*

If additional information is required to determine an applicant's eligibility in another covered group, send the applicant the appropriate pages from the Application for Benefits or the other application form that asks for the information and give the applicant at least 10 business days to return the pages and the required verifications to the agency.

The following forms have been prescribed as application forms for Medicaid and FAMIS:

3. Application For Benefits

Application for Benefits, form #032-03-824, also referred to as the Combined Application, may be used by any applicant (available at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi). Eligibility for all medical assistance programs, except BCCPTA, can be determined with this application form.

4. Application/Re-determination For SSI Recipients

The Application/Redetermination for Medicaid for SSI Recipients, form #032-03-091 (available at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi) is used for SSI recipients. If the applicant is not eligible for Medicaid in the SSI recipients covered group, his eligibility in other Medicaid covered groups, for FAMIS and for SLH can be determined using this application form.

5. Medicaid Application/Re-determination For Medically Indigent Pregnant Women

The Medicaid Application/Redetermination for Medically Indigent Pregnant Women, form #032-03-040 (available at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi) is acceptable if submitted for pregnant women. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown or for SLH), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant.

6. Health Insurance For Children and Pregnant Women

The Health Insurance for Children and Pregnant Women, form FAMIS-1 (available at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi) is an application form for children and/or pregnant women. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown or for SLH), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant.

7. BCCPTA Medicaid Application

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application, form #032-03-384, is used only by women screened under the Breast and Cervical Cancer Early Detection Program. **This form is not to be given to applicants by the local departments of social services** (M0120, Appendix 2 is provided for reference purposes only).

8. ADAPT Statement of Facts

A signed ADAPT Statement of Facts (SOF) is a valid application for anyone in an ADAPT case, including ABD Medicaid applicants who are in an ADAPT case, EXCEPT for Plan First and BCCPTA. The SOF cannot be used as a Plan First or BCCPTA application. If any additional information is necessary (individual requires a resource evaluation), the appropriate pages from an Application for Benefits or Eligibility Review Form Part B if that form was obtained for Food Stamps can be used to collect the additional information. The pages must be signed by the applicant and attached to the SOF.

9. Title IV-E Foster Care & Medicaid Application/Re-determination

The Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636 (available at: http://spark.dss.virginia.gov/divisions/dfs/fc/files/forms/032-03-0636-02-eng.doc is used for foster care or adoption assistance children who are eligible under Title IV-E of the Social Security Act. If any additional information is necessary (individual requires a resource evaluation for medically needy spenddown or for SLH), the appropriate pages from an Application for Benefits can be used to collect the information. The pages must be signed by the applicant's guardian.

For a IV-E FC child whose custody is held by a local department of social services or a private FC agency, or for a IV-E adoption assistance (AA) child, the Title IV-E Foster Care & Medicaid Application/Redetermination, form #032-03-636, is used to determine if the child meets Medicaid IV-E eligibility requirements. This form is also used to determine Medicaid eligibility for IV-E FC and IV-E AA children, and for non-IV-E FC children in the custody of a local agency in Virginia. This form is **not** used for children in non-custodial agreement cases or non-IV-E AA. When a child enters care through a non-custodial agreement, or when a child is a non-IV-E AA child, a separate Medicaid application must be completed and signed by the parent or guardian.

For IV-E FC children in the custody of another state's social services agency and for IV-E AA children, a separate Medicaid application is not required. The worker must verify the IV-E maintenance payment (for FC) or the IV-E status (for AA). Virginia residency (by declaration) and current third party liability (TPL) information must be obtained. This information may be supplied by the foster/adoptive parent or obtained from the agency that entered into the FC or AA agreement.

10. Application for Adult Medical Assistance

The Application for Adult Medical Assistance is intended for adults who are aged, blind or disabled or who need long-term care. The paper form is available online at: www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi. The online application is available at: https://jupiter.dss.state.va.us/VDAMedicaid. In addition to the online

Application for Adult Medical Assistance that individuals may submit on their own behalf, starting in January 2010, LDSS will receive online Applications for Adult Medical Assistance that are generated as a result of Extra Help low-income subsidy (LIS) data on individuals received by VDSS from the Social Security Administration (SSA). These Adult Medical Assistance Applications are designated in the SPARK Adult Medical Assistance Application administrative web site by the term "LIS." The Medicare Patient and Provider Improvement Act (MIPPA) requires LIS application data submitted by SSA to states to be treated as an application for Medicaid if the LIS applicant agrees.

11. Auxiliary Grant (AG)

An application for AG is also an application for Medicaid. A separate Medicaid application is not required.

12. Plan First Application Form

Individuals who wish to apply for *Plan First* family planning services *may apply on the Application for Benefits or* the Plan First Application *form*. The Plan First application is for men and women who wish to apply for Medicaid coverage of family planning services only. The Plan First Application form is available on SPARK at: http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi.

For applicants who are determined not eligible for full-benefit Medicaid in any other covered group, it is appropriate to process the applicant's eligibility in the Plan First family planning services covered group. If eligible for Plan First, enroll the applicant in Plan First and send the Notice of Action indicating that he has been enrolled in Plan First coverage for family planning services only. On the notice, state that if he does not wish to remain covered by Plan First, to contact the eligibility worker and request that the Plan First coverage be cancelled. Include a Plan First Fact Sheet, available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi, with the notice of action.

13. SLH Application Form

The following form has been prescribed as the application form for SLH:

- Application for Benefits, form #032-03-824, also referred to as the Combined Application.

M0120.400 Place of Application

A. Principle

The place of application is ordinarily the office of the local social service department serving the locality in which the applicant resides. Verification of locality residence is not required. Medicaid applications are also taken at designated hospitals and health clinics (Medicaid outstationed sites). If an applicant is homebound and needs assistance with completing the application, the agency, upon request, must arrange to have the application taken where he resides or is a patient.

1. Locality of Residence

Medical assistance applications that are completed and filed online are sent to the LDSS in the applicant's locality of residence.

2. Joint Custody Situations

A child whose residence is divided between two custodial parents living in different localities is considered to reside in the locality in which he attends school. If the child is not enrolled in school, the parents must decide which locality is the child's residence for Medicaid application/ enrollment purposes.

B. Foster Care, Adoption Assistance, Department of Juvenile Justice

1. Foster Care

Responsibility for taking applications and maintaining the case belongs as follows:

a. Title IV-E Foster Care

Children in the custody of a Virginia local department of social services or private foster care agency who receive Title IV-E maintenance payments apply at the agency that holds custody. Title IV-E foster care children in the custody of another state's social services agency apply in the Virginia locality where they reside.

b. State/Local Foster Care

Non-Title IV-E (state/local) children in the custody of a Virginia local department of social services or a private child placing agency apply at the agency that holds custody.

Children in the custody of another state's social services agency who are not Title IV-E eligible do not meet the Virginia residency requirement for Medicaid and are not eligible for Medicaid in Virginia (see M0230).

2. Adoption Assistance

Children receiving adoption assistance through a Virginia local department of social services apply at the agency that made the adoption assistance agreement.

Children receiving adoption assistance through another state's social services agency apply at the local department of social services where the child is residing.

3. Virginia Department of Juvenile Justice/Court (Corrections Children)

Children in the custody of the Virginia Department of Juvenile Justice or who are the responsibility of a court (corrections children) apply at the local agency where the child is residing.

C. Institutionalized Individual (Not Incarcerated)

When an individual of any age is a resident or patient in a medical or residential institution, except DBHDS facilities and the Virginia Veteran's Care Center, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in Virginia in which he last resided outside of an institution.

Exception: If the applicant is applying for or receives Food Stamps, responsibility for processing the Medicaid application and determining Medicaid eligibility rests with the department of social services in the locality in which the institution where he is receiving care is located.

If the individual did not reside in Virginia prior to entering an institution, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in which the institution where he is receiving care is located.

D. Individuals in DBHDS Facilities

1. Patient in a DBHDS Facility

If an individual is a patient in a state DBHDS institution, is not currently enrolled in Medicaid, and is eligible in an Aged, Blind or Disabled (ABD) covered group, responsibility for processing the application and determining eligibility rests with the state department of social services' eligibility technicians located in DBHDS facilities. A listing of facilities and technicians as well as further information on the handling of cases of Medicaid applicants and recipients in DBHDS facilities is located in Subchapter M1550.

If an individual is a patient in a State DBHDS Institution, is not currently enrolled in Medicaid, and is eligible in a Families and Children's (F&C) covered group, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in Virginia in which he last resided outside of an institution.

2. Patient Pending Discharge (Pre-release Planning)

a. General Policy

For DBHDS facility patients who will be discharged, local agencies will take the applications received on behalf of these patients and process them within the established time frames. Eligibility will be determined based on the type of living arrangement to which the patient will be discharged.

If the patient was not Medicaid eligible in the DBHDS facility but Medicaid eligibility in the patient's new circumstances needs to be determined, an application must be sent to the appropriate local department of social services. The facility physician or discharge planning authority must attach a written statement that includes the following information:

- the date of the proposed discharge,

- the type of living arrangement and address to which the patient will be discharged (nursing facility, adult care residence, private home, relative's home, etc.), and

- the name and title of the person who completed the statement.

The discharge planner or case manager must follow up the application and statement with a telephone call to the agency worker on or after the patient's actual discharge to confirm the discharge date and living arrangement. The agency cannot enroll the patient without the confirmation of the discharge date and living arrangement.

b. Pending Discharge to a Facility

If a patient who was not Medicaid eligible in the DBHDS facility is being discharged to an assisted living facility or nursing facility, an application for Medicaid will be filed with the department of social services in the locality in which the patient last resided prior to entering an institution.

c. Pending Discharge to the Community

If a patient who was not Medicaid eligible in the DBHDS facility will live outside of an institution, the responsibility for processing the application and determining eligibility rests with the locality in which he will be living.

d. Eligibility Determination and Enrollment

The local agency determines the patient's Medicaid eligibility BEFORE actual discharge, based on the type of living arrangement to which the patient will be discharged. If the patient is found eligible for Medicaid in the locality, he is not enrolled in Medicaid until the day he is discharged from the DBHDS institution.

When the individual is discharged, the DBHDS discharge planner, or the individual, may call the local agency worker on the discharge date. The worker can then enroll the patient in the MMIS and give the enrollee number to the discharge planner.

e. Coverage Begin Date

The eligible individual's coverage Begin Date cannot be earlier than the date of discharge from the DBHDS institution.

E. Individuals In Virginia Veteran's Care Center

Medicaid applications for patients in the Virginia Veteran's Care Center in Roanoke may be filed, processed and maintained at the Roanoke City Department of Social Services.

F. Incarcerated Individuals Pre-release Planning

Inmates of state correctional facilities may apply for Medicaid as part of pre-release planning. Responsibility for processing the application and determining eligibility rests with the local department of social services in the locality where the inmate was living prior to incarceration. Applications

are to be processed in the same manner and within the same processing time standards as any other Medicaid application, but if the incarcerated individual is found eligible, he is **not** enrolled in the Medicaid program until after he has been released from the correctional facility.

Applications are not to be refused because an applicant is an inmate of a public institution at the time of application.

If the individual did not reside in Virginia prior to becoming incarcerated, responsibility for processing the application and determining eligibility rests with the department of social services in the locality in which correctional facility is located.

1. **Department of Corrections Procedures**

The following procedures will be followed by correctional facility staff when an inmate in a Virginia Department of Corrections facility will require placement in a nursing facility upon release:

- The correctional facility staff will complete the Medicaid application and, if a disability determination is needed, the disability report and medical release forms. The correctional facility staff will notify the assigned Medicaid consultant and mail the forms to the local department of social services in the locality where the inmate was living prior to incarceration.

- The correctional facility staff will request a pre-admission screening for nursing home or community-based care from the health department or local department of social services in the locality where the correctional facility is located. This screening is to be done simultaneously with the determination of disability and determination of Medicaid eligibility. The staff will coordinate with nursing facilities in order to secure a placement.

2. **Eligibility Determination and Enrollment**

The local department of social services determines the patient's Medicaid eligibility BEFORE actual release, based on the type of living arrangement to which the applicant will be released. If the applicant is found eligible for Medicaid in the locality, he is not enrolled in Medicaid until the day he is released from the Department of Corrections facility.

The Corrections facility's pre-release planner or the individual may call the local agency worker on the release date. The worker can then enroll the eligible applicant in the MMIS and provide the enrollee number.

3. ***Coverage Begin Date***

The eligible individual's coverage Begin Date cannot be earlier than the date of discharge from the correctional facility.

M0120.500 Receipt of Application

A. General Principle

An applicant or authorized representative may submit a written application for Medicaid only or may apply for Medicaid in addition to other programs.

An applicant may be assisted with completing the various aspects of the application by an individual(s) of his choice and may designate in writing that such individual(s) may represent him in subsequent contacts with the agency.

B. Qualified Individuals (QI)

Eligibility for Medicaid as a QI begins the first day of the application month, and ends December 31 of the calendar year, if funds are still available for this covered group. *New a*pplications for QI coverage for an upcoming year may not be taken until January 1 of that year (see M0320.208).

If the initial QI application is processed in November or December, the QI coverage may be renewed for the following year without obtaining a separate renewal form. See section M1520.200 C.11.

C. Application Date

The application date is the earliest date the signed, written application for Medicaid or the Request for Assistance is received by the local agency, an outstationed site, or an entity contracted with DMAS to accept applications. The application must be on a form prescribed by DMAS and signed by the applicant or person acting on his behalf.

The application may be received by mail, fax, or hand delivery. The date of delivery to the agency must be stamped on the application. If an application is received after the agency's business hours, the date of the application is the next business day. The date of application for foster care children in the custody of a local department of social services is the date the application is received by the eligibility worker.

If an application for a pregnant woman or child is denied due to excess income, the applicant must be given the opportunity to complete an Application for Benefits in order to request a medically needy evaluation. If the Application for Benefits is submitted within 10 days of the date the notice of denial was mailed, the application date is protected, and the date of application is the date the denied application was received.

M0120.600 When An Application Is Required

A. New Application Required

A new application is required when there is:

- an initial request for medical assistance, or
- a request to add a person to an existing case.

When an application is received because there is a new person in the family for whom medical assistance is requested, the annual renewal for the existing enrollees is done using the same application form. See subchapter M1520 for renewal policy and procedures.

B. Application NOT Required

A new application is not required when an individual is already an active Medicaid enrollee or is enrolled in another medical assistance program. Changes in the enrollee's circumstances do not require a new application. Changes that do not require a new application include, but are not limited to, the following:

- a change in the case name,
- a change in living arrangements, and
- a change in income.

A change in living arrangements may require a partial review of the individual's eligibility when the change results in a change to the assistance unit. Whenever the change requires verifications that can be used to complete a renewal, the annual renewal should be completed at the time the change is reported.

Commonwealth of Virginia
Department of Social Services

NOTICE REGARDING MEDICAID APPLICATION REQUIREMENTS

A Medicaid application has been filed on the behalf of _____ (name of applicant). However, the application is not valid and cannot be processed because the application must be signed by one of the following persons:

- the parent of a person under age 18,
- the adult who is the legal guardian or has legal custody of a person under age 18,
- any adult related by blood or marriage with whom a person under age 18 lives,
- the person for whom Medicaid is requested if the person is over age 18 or an emancipated minor,
- the authorized representative for the person who is requesting assistance, who may be
  - any person to whom he/she has legally given power of attorney, or
  - any person who he/she has designated by a signed written statement to apply on his/her behalf for Medicaid or public benefits, or
- the guardian, conservator, or committee of a person over age 18 who has been judged legally incapacitated by a court of law.

Please return the signed application and the authorized representative statement (if needed) by _____ so that the application may be processed. Thank you.
(date)

_____ _____
Signature Date

_____
Title

_____
Agency Name

_____
Phone Number

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Application

AGENCY USE ONLY

DATE RECEIVED:

CASE NAME/NUMBER:

LOCALITY: WORKER

Please complete all sections. If you need assistance, please contact an eligibility worker at your local Department of Social Services.

1. IDENTIFYING INFORMATION

LAST NAME: FIRST NAME: MI: SOCIAL SECURITY NUMBER:

ADDRESS: CITY: STATE: ZIP: STATE OF RESIDENCE:

MAILING ADDRESS (If different): CITY: STATE: ZIP: HOME PHONE #: DAYTIME PHONE #:

2. ADDITIONAL INFORMATION

RACE: ☐ WHITE ☐ AMERICAN INDIAN/ALASKA NATIVE ☐ BLACK ☐ ASIAN/PACIFIC ISLANDER ☐ HISPANIC ☐ OTHER

MARITAL STATUS: ☐ NEVER MARRIED ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

DATE OF BIRTH: _____ PLACE OF BIRTH: _____

U. S. CITIZEN? YES ☐ NO ☐ IF NO, ALIEN NUMBER:

DO YOU RECEIVE SSI? YES ☐ NO ☐ ARE YOU PREGNANT? YES ☐ NO ☐ DO YOU HAVE A CHILD(REN) UNDER AGE 19 LIVING WITH YOU? YES ☐ NO ☐

DO YOU HAVE HEALTH INSURANCE? YES ☐ NO ☐ IF YES, COMPANY NAME: _____

POLICY #: _____ EFFECTIVE DATE: _____ TYPE OF COVERAGE: _____

DID YOU RECEIVE MEDICAL CARE IN ANY OF THE THREE MONTHS BEFORE THIS APPLICATION? YES ☐ NO ☐ IF YES, LIST MONTHS: _____

3. BCCPTA CERTIFICATION

I CERTIFY THAT THE ABOVE NAMED INDIVIDUAL IS A VIRGINIA BREAST AND CERVICAL CANCER EARLY DETECTION PROGRAM (BCCEDP) PARTICIPANT (TITLE XV) AND IS ELIGIBLE FOR MEDICAID UNDER THE BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT OF 2000.

SCREENING DATE: _____ DIAGNOSIS DATE: _____ FACILITY/SERVICE SITE: _____ PHONE #: _____

SIGNATURE OF BCCEDP CASE MANAGER : _____ DATE: _____

YOUR RIGHTS AND RESPONSIBILITIES

By signing below, I agree to the following:
I have the right to:

- Be treated fairly and equally regardless of my race, color, religion, national origin, gender, political beliefs or disability consistent with state and federal law and to file a complaint if I feel I have been discriminated against.
- Have my eligibility for Medicaid benefits determined within 10 working days of receipt of my application at my local department of social services or be notified of the reason for any delay.
- Appeal and have a fair hearing if I am: (1) not notified in writing of the decision regarding my application; (2) denied benefits from the Medicaid program; or (3) dissatisfied with any other decision that affects my receipt of Medicaid benefits.

I have the responsibility to:

- Not purposely withhold information, or give false information and understand if I do so my Medicaid coverage may be denied or ended.
- Report any changes in information provided on this form within 10 days to my local department of social services.
- Cooperate with a review of my Medicaid eligibility by Quality Control and understand that refusing to cooperate will make me ineligible for Medicaid until I cooperate with a review.

I further understand and agree that:

- This application is used only to apply for Medicaid under the Breast and Cervical Cancer Prevention and Treatment Act coverage group and that in order to apply under other coverage groups I must complete another application.
- The Department of Medical Assistance Services and the Department of Social Services are authorized to obtain any verification necessary to establish my eligibility for Medicaid.
- The Department of Medical Assistance Services has the right to receive payments for services and supplies from insurance companies and other liable sources as reimbursement for medical services received by me.
- Each provider of medical services may release any medical records pertaining to any services received by me.
- I am assigning my rights to medical support and other third party payments to the Department of Medical Assistance Services in order to receive benefits from the Medicaid program.

I declare that all information I have given on this application is true and correct to the best of my knowledge and belief. I understand that if I give false information, withhold information or fail to report a change promptly or on purpose I may be breaking the law and could be prosecuted for perjury, larceny and/or fraud. I understand that my signature on this application signifies, under penalty of perjury, that I am a U.S. citizen or alien in lawful immigration status.

_____ _____
Signature or Mark **Date**

_____ _____
Witness/Authorized Representative **Date**

VOTER REGISTRATION

Check one of the following:

( ) I am not registered to vote where I currently live now, and I would like to register to vote here today. I certify that a voter registration form was given to me to complete. (If you would like help in filling out the voter registration, we will help you. The decision to have us help you is yours. You also have the right to complete your form in private.)
( ) I am registered to vote at my current address. (If already registered at your current address, you are not eligible to register to vote.)
( ) I do not want to apply to register to vote.
( ) I do want to apply to register to vote, please send me a voter registration form.

Applying to register or declining to register to vote will not affect the assistance or services that you will be provided by this agency. A decision not to apply to register to vote will remain confidential. A decision to apply to register to vote and the office where your application was submitted will also remain confidential and may only be used for voter registration purposes. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register to vote, or your right in applying to register to vote, you may file a complaint with: Secretary of Virginia State Board of Elections, Ninth Street Office Building, 200 North Ninth Street, Richmond, VA 23219-3497. The phone number is (804) 786-6551.

Interstate Compact on Adoption and Medical Assistance (ICAMA) Member States and Reciprocity

STATE	COBRA OPTION*	RECIPROCITY**	COMMENT
Alabama	Yes	Yes	Reciprocity with ICAMA member states only
Alaska	Yes	Yes	Reciprocity with all states
Arizona	Yes	Yes	Reciprocity with all states
Arkansas	Yes	Yes	Reciprocity with all states
California	Yes	Yes	Reciprocity with all states
Colorado	Yes	Yes	Reciprocity with all states
Connecticut	Yes	Yes	Reciprocity with ICAMA member states only
Delaware	Yes	Yes	Reciprocity with all states
District of Columbia	Yes	**No**	
Florida	Yes	Yes	Reciprocity with ICAMA member states only
Georgia	Yes	Yes	Reciprocity with all states
Hawaii	Yes	**No**	
Idaho	Yes	Yes	Reciprocity with all states
Illinois	Yes	**No**	
Indiana	Yes	Yes	Reciprocity with all states
Iowa	Yes	**No**	
Kansas	Yes	Yes	Reciprocity with all states
Kentucky	Yes	Yes	Reciprocity with ICAMA member states only
Louisiana	Yes	Yes	Reciprocity with all states
Maine	Yes	Yes	Reciprocity with all states
Maryland	Yes	Yes	Reciprocity with all states
Massachusetts	Yes	Yes	Reciprocity with all states
Michigan	Yes	Yes	Reciprocity with all states
Minnesota	Yes	Yes	Reciprocity with all states
Mississippi	Yes	Yes	Reciprocity with all states
Missouri	Yes	Yes	Reciprocity with all states
Montana	Yes	Yes	Reciprocity with ICAMA member states only
Nebraska	Yes	**No**	
Nevada	Yes	**No**	
New Hampshire	Yes	**No**	
New Jersey	Yes	Yes	Reciprocity with ICAMA member states only
New Mexico	No	**No**	
New York ***	Yes	**No**	
North Carolina	Yes	Yes	Reciprocity with ICAMA member states only
North Dakota	Yes	Yes	Reciprocity with ICAMA member states only
Ohio	Yes	Yes	Reciprocity with all states
Oklahoma	Yes	Yes	Reciprocity with all states
Oregon	Yes	Yes	Reciprocity with all states

STATE	COBRA OPTION*	RECIPROCITY**	COMMENT
Pennsylvania	Yes	Yes	Reciprocity with all states
Rhode Island	Yes	Yes	Reciprocity with ICAMA member states only
South Carolina	Yes	Yes	Reciprocity with all states
South Dakota	Yes	Yes	Reciprocity with all states
Tennessee	Yes	Yes	Reciprocity with all states
Texas	Yes	Yes	Reciprocity with all states
Utah	Yes	Yes	Reciprocity with ICAMA member states only
Vermont			
Virginia	Yes	Yes	Reciprocity with ICAMA member states only
Washington	Yes	Yes	Reciprocity with all states
West Virginia	Yes	Yes	Reciprocity with all states
Wisconsin	Yes	Yes	Reciprocity with all states
Wyoming			

* *per COBRA 1985 law, the ICAMA member state's Medicaid program covers its own Non-IV-E (state-local) Adoption Assistance [AA] children).*

** *the ICAMA member state's Medicaid program covers Non-IV-E AA children who have adoption assistance agreements with another state and move to the state.*

*** *ICAMA Associate Member State*
ICAMA Non-Member State (Vermont, Wyoming)

CHAPTER M01
APPLICATION *FOR* MEDICAL *ASSISTANCE*
SUBCHAPTER 30

APPLICATION PROCESSING

M0130 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	pages 6-8
TN #95	3/1/11	page 8
TN #94	9/1/10	pages 2-6, 8
TN #93	1/1/10	pages 4-6, 8
Update (UP) #2	8/24/09	pages 8, 9

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M0130.100 Processing Time Standards

A. General Principle

Agencies are required by the State Plan to adhere to prescribed standards for the processing of medical assistance (Medicaid and FAMIS/FAMIS MOMS) applications. The amount of time allowed to process an application is based on the covered group under which the application must be evaluated.

B. Processing Time Standards

1. 10 Day Requirement (Expedited Application)

a. Pregnant Women

Applications for pregnant women must be processed within 10 working days of the agency's receipt of the signed application form.

If the pregnant woman also applies for other children or other persons in her family and the agency cannot determine the other persons' eligibility within 10 working days, the agency must determine just the Medicaid eligibility of the pregnant woman within the working 10 days.

The agency must have all necessary verifications within the 10 working days in order to determine eligibility. If the agency does not receive the verifications within the 10 working days, the worker must send the applicant a Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs (NOA), form #032-03-008 (http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi) on the 10th day. The NOA must state why action on the application was not taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 days by which to submit the documentation.

Once all necessary verifications for the pregnant woman are received, an eligibility decision must be made immediately and the applicant must be immediately notified of the decision. If the pregnant woman applied for other persons in the family, and the eligibility determination for those persons has not been completed, the NOA must state that the application is still pending.

If all necessary verifications are not received, the application continues to pend until the 45-day processing time limit is reached.

b. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) Medicaid Applications

BCCPTA Medicaid applications filed by women who do not meet the description of an individual in the LIFC, MI pregnant women, or the SSI recipients covered groups must be processed within 10 working days of the agency’s receipt of the signed application.

BCCPTA Medicaid applications filed by women who meet the description of an individual in the LIFC, MI pregnant women, or the SSI recipients covered groups must be processed as soon as possible, but no later than 45 days of the agency’s receipt of the signed application.

If the BCCPTA Medicaid application is the only application required and no additional information is required, the eligibility decision must be made

immediately and the applicant must be notified of the decision within 10 working days of the agency's receipt of the application.

If a decision cannot be made within 10 working days of receipt of the BCCPTA application, the worker must send a NOA on the 10th day stating why action has not been taken, specifying what information is needed, and a deadline for submitting the information.

If all necessary verifications are not received, the application continues to pend until the 45-calendar-day processing time limit is reached.

2. 45/90 Day Requirement

Applications, including requests for retroactive coverage, must be processed within 45 calendar days for all applicants other than pregnant women, women in the BCCPTA covered group, or individuals needing a disability determination.

For individuals who require a disability determination to meet the covered group requirement, the time standard for processing an application is 90 calendar days. Other non-financial requirements, however, must be met and verified by the 45th calendar day, or the application must be denied and DDS must be notified to stop action on the disability determination (see M0310.112 E.2). Exception: allow up to the full 90 calendar days when the individual or agency is unable to obtain documentation of citizenship and/or identity within 45 calendar days of the application date (see M0220.100 D.9).

The time standard begins with the date of receipt of a signed application and ends with the date of enrollment or the date the notification of denial of Medicaid is mailed to the applicant. The applicant must be informed of the agency's time standards.

The eligibility worker must allow at least 10 *calendar* days to receive the necessary verifications. If all necessary verifications are not received, the application continues to pend until the 45-day processing time limit is reached.

3. *Early Denial Before Deadline Date*

When the 45-day processing deadline date falls on a weekend or a holiday, the LDSS may deny an individual's application on the last business day before the deadline date if all necessary verifications have not been received. If the early denial action is taken, however, the LDSS must re-open the application if the individual provides the necessary information on or before the 45th day deadline.

If the individual's application is re-opened and he is determined eligible, the LDSS must enroll the individual and send a notice to the individual notifying him of the approval and the begin date of coverage.

4. Processing Priority

Application processing priority must be given to applicants who are in need of Medicaid coverage for nursing facility or community-based long-term care, hospice care, or who are in emergent need of other covered services. These applications must be processed as quickly as possible.

5. Time Standard Exceptions

The specified time standards apply unless the agency cannot reach a decision within the time standard because of one of the following reasons:

- the applicant's inability to furnish necessary information for a reason beyond his/her control,

- a delay in receipt of information from an examining physician,
- a delay in the disability determination process,
- a delay in receiving DMAS decision on property transfer undue hardship claim, or
- an administrative or other emergency beyond the agency's control.

If action is not taken within the time standard, the case record must show the cause for the delay and the applicant must be notified in writing of the status of his application, the reason for the delay, and his right of appeal.

When an application is delayed after 90 days because of a disability decision and the agency has determined that excess resources exist at the time the delay notice is sent, the NOA must inform the applicant that he/she has excess resources and the amount. The notice must also state that:

- a final action cannot be taken until the disability decision is made;
- if the applicant is determined to be disabled, he/she will not be eligible unless the excess resources are reduced; and
- he will be notified when the disability decision is made.

C. Application for Retroactive Coverage

Retroactive Medicaid eligibility must be determined when an applicant for Medicaid or other medical assistance reports that he, or anyone for whom he requests assistance, received a medical service within the retroactive period - the three months prior to application. Eligibility for SLH must be determined when the individual is not eligible for Medicaid if the applicant reports receiving a hospital service within the 30 days prior to the application date.

The retroactive period is based on the month in which the application is filed with the agency. The retroactive period is the three months prior to the application month.

There is no administrative finality on determining retroactive eligibility if eligibility for the months in the retroactive period has not been determined. Retroactive coverage can be requested at any time subsequent to an application even if the application was denied or the applicant signed a statement saying he did not want retroactive coverage. The retroactive period is based on the application month regardless of whether the application was denied or approved.

If the application was denied, the application is reopened for determination of eligibility in the entire retroactive period – all three months prior to the application month – even if a covered medical service was received in only one retroactive month. The applicant must provide all verifications necessary to determine eligibility during the retroactive period.

If the applicant is found eligible for retroactive coverage and a Medicaid-covered medical service was received over one year prior to the date the

retroactive eligibility is determined, the applicant must be given an "Eligibility Delay" letter to give to the medical provider so that Medicaid will pay the claim (use the sample letter on the intranet at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi). Once retroactive eligibility is established, Medicaid coverage begins the first day of the earliest retroactive month in which *retroactive* eligibility exists.

M0130.200 Required Information and Verifications

A. Identifying Information

An application must contain basic identifying information about the applicant. Basic identifying information is the applicant's name, address, Social Security number (SSN) or a statement that the individual applied for the SSN, and date of birth.

1. Name

The name entered in the official case record and computer enrollment systems for an applicant must match the applicant's name on his Social Security card or Social Security Administration (SSA) records verification. *This is important because of the Medicare Buy-in and other computer matches the Medicaid Management Information System (MMIS) performs with SSA.* ***At the time of the initial Medicaid application, the State Verification Exchange System (SVES) must be used to verify the SSA record of the individual's name because SVES verifies the spelling, etc., of the individual's name in the SSA records.*** *For subsequent reapplications, the State Online Query-Internet system (SOLQ-I) may be used.*

If the individual says his name is different from the name on his Social Security card, he must first notify SSA and have his name changed on SSA records. When SSA changes his name and SSA verification of the name change is received, the worker can change his name in the case record and on the eligibility and MMIS computer systems.

For purposes of the case record only, the agency may choose to set up the case in the individual's alleged name before it is changed on the Social Security card.

2. SSN

The SSN of an individual for whom Medicaid or other medical assistance is requested must be provided by the applicant and verified by the worker through SSA. SVES or SOLQ-I *may be used to verify the individual's SSN.*

B. Required Verifications

An individual must provide verifications of most Medicaid eligibility requirements. Before taking action on the application, the applicant must be notified in writing of the required information.

The eligibility worker must allow at least 10 days for receipt of the necessary verifications, but additional time may be allowed depending on the type of information requested. The specific information requested and the deadline for receipt of the verifications must be documented in the case record.

1. Copy Verification Documents

Legal documents and documents that may be needed for future eligibility determinations must be copied and preserved for the record. These include citizenship and identity documents, alien status documentation, verification of legal presence, trusts, annuities, contracts, wills, and life insurance policies.

It is not necessary to retain a copy of verifications of income or the current value of resources in the case record. However, if a copy is not retained, the worker must document electronically or in the case record the date and method used to obtain the information (viewed, telephone call, etc.), the type of verification, the source, and a description of the information.

2. Information Not Provided

If information necessary to make an eligibility determination is requested but not provided by the applicant and cannot be obtained from any other source, the application must be denied (or the coverage cancelled) due to the inability to determine eligibility.

When the deadline date falls on a weekend or holiday, LDSS may choose to deny the application (or cancel coverage) before the deadline date. However, if the early denial or cancel action is taken, LDSS must re-open the application if the individual provides the necessary information on or before the original deadline date. If the individual's application is re-opened and he/she is determined eligible, the LDSS must send a notice to the individual notifying him of the changed action.

C. Verification of Nonfinancial Eligibility Requirements

The applicant's statements on the application may be accepted for the following identifying information and nonfinancial eligibility requirements unless the eligibility worker has reason to question the applicant's statements:

1. Verification Not Required

Verification is not required for:

- Virginia state residency,
- application for other benefits.

2. Verification Required

The following information must be verified:

- citizenship and identity;
- Social Security number (see section D below);
- legal presence in the U.S. of applicants age 19 or older;
- age of applicants age 65 and older;
- disability and blindness; and
- pregnancy.

See item E. below for instructions on the verification of legal presence. See subchapter M0220 for instructions on the verification of identity and citizenship. See subchapter M0310 for instructions on the verification of age, disability and pregnancy.

D. Social Security Numbers

Applicants must provide the Social Security number (SSN) of any person for whom they request Medicaid. An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

1. SSN Verification

SVES or SOLQ-I may be used to verify the individual's SSN. However, to verify the SSA record of the individual's name at the initial Medicaid application, SVES must be used because SVES verifies the spelling, etc., of the individual's name in the SSA records.

2. Exceptions to SSN Requirements

Children under age one born to Medicaid-eligible mothers are deemed to have applied and been found eligible for Medicaid, whether or not eligibility requirements have actually been met. A child eligible in this covered group does not need a Social Security number.

Illegal aliens who are eligible only for Medicaid payment of emergency services are not required to provide or apply for SSNs (see M0220).

3. SSN Not Yet Issued

If an SSN has not been issued, the applicant must cooperate by applying for a number with the local Social Security Administration Office (SSA). *Instruct the applicant to submit form SS-5, the Application for Social Security Number, to the SSA and to obtain a receipt from the SSA verifying that the application was submitted. The SS-5 is available online at: http://www.socialsecurity.gov/ssnumber/ss5.htm.* The applicant must provide the SSN to the local social services department as soon as it is received and the number must be entered in the MMIS. Applicants who refuse to furnish an SSN or to show proof of application for a number will be ineligible for Medicaid.

In the case of a newborn child not eligible in a child under 1 covered group, the applicant can request hospital staff to apply for an SSN for the child through hospital enumeration procedures. Form #SSA-2853 will be given to the applicant as proof of application for an SSN.

When entering the individual in MMIS or MedPend, use the date the individual applied for an SSN, or the individual's date of birth, preceded by *"999"* as the individual's SSN. For example, an individual applied for an SSN on October 13, 2006, enter "*999*101306" as the individual's SSN. *In ADAPT, use "APP" as the first 3 digits and the individual's DOB or date of SSN application as the final 6 digits.*

E. Legal Presence (Effective January 1, 2006)

Effective January 1, 2006, Section 63.2-503.1 of the Code of Virginia requires most applicants for or recipients of public assistance who are age 19 or older to provide proof of citizenship or legal presence in the U.S. Applicants or recipients age 19 or older for whom medical assistance is requested must prove their citizenship or legal presence.

Individuals who, on June 30, 1997, were Medicaid-eligible and were residing in long-term care facilities or participating in home and community-based waivers, and who continue to maintain that status (eligible for Medicaid and reside in long-term care facilities or participate in home and community-based waivers) are exempt from this requirement.

Non-citizens applying for Medicaid payment for emergency services are not subject to the legal presence requirement. An individual who is applying on behalf of another and is not requesting assistance for himself is not subject to the legal presence requirement.

2. Documents That Demonstrate Legal Presence

An applicant may demonstrate legal presence by presenting one of the following documents:

- valid evidence of U.S. citizenship;
- valid evidence of legal permanent resident status;
- valid evidence of conditional resident alien status;
- a valid SSN verified by SSA;
- a U.S. non-immigrant visa;
- a pending or approved application for legal asylum;
- a refugee or temporary protected status document; or
- a pending application for an adjustment of residence status.

3. Failure to Provide Proof of Legal Presence

An applicant who cannot provide documentation that he is a citizen or legally present at the time of application must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the U.S. in order to meet the requirement for proof of legal presence for either:

- a period of 90 days or until it is determined that he is not legally present in the U.S., whichever is earlier; or

- indefinitely if the applicant provides a copy of a completed application for a birth certificate that has been filed and is pending and being actively pursued in accordance with federal or state law. Such extension shall terminate upon the applicant's receipt of a birth certificate or determination that a birth certificate does not exist because the applicant is not a U.S. citizen.

The affidavit form is on the intranet at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi.

NOTE: The individual's address on the affidavit form must be the individual's **residence** address, not the mailing address.

4. Relationship to Other Medicaid Requirements

Providing proof of legal presence or submitting a signed affidavit meets the legal presence eligibility requirement. To be eligible for Medicaid, however, the individual must meet all other state and federal Medicaid eligibility requirements. Submission of the affidavit without proof of application for an SSN as required by M0130.200 D. does **NOT** meet the SSN requirement.

F. Third Party Liability (TPL)

Applicants must be asked to provide information about any health insurance they may have. The eligibility worker must enter that information into the Medicaid Management Information System (MMIS) TPL file. Verification of health insurance information is not required.

In the event the client is eligible for benefits to be used exclusively for the payment of medical expenses (i.e. an insurance settlement), but there is no TPL code for that benefit, the worker must email the information to the DMAS TPL Unit at TPLUnit@dmas.virginia.gov, or send the information to:

DMAS Third Party Liability Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

G. Health Insurance Premium Payment (HIPP) Program

The HIPP program is a cost-savings program for individuals enrolled in Medicaid which may reimburse some or all of the employee portion of the employer group health insurance premium. Eligibility for HIPP is determined by the HIPP Unit at DMAS. Participation in HIPP is voluntary.

The local DSS agency must give each applicant or enrollee who reports that he or someone in his family is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan must be given a HIPP Fact Sheet, which provides a brief description of the program and the contact information for the HIPP Unit at DMAS. The HIPP Fact Sheet is available on-line at: http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi. *Enrollees and other members of the public may contact the HIPP Unit for additional information at hippcustomerservice@dmas.virginia.gov.*

If the health insurance policy holder lives outside of the home, a HIPP Consent Form must be completed by both the policy holder and the parent/authorized representative so the DMAS HIPP Unit can process the HIPP application. If the form is required, the DMAS HIPP Unit will send it to the applicant for completion.

H. Verification of Financial Eligibility Requirements

The eligibility worker must verify the following financial eligibility requirements:

- the value of all countable, non-excluded resources;
- all earned and unearned income; and
- asset transfer information for individuals in need of long-term care services, including the date of transfer, asset value, and compensation received.

Social Security and/or Supplemental Security Income must be verified through SSA. The State Data Exchange (SDX) system should only be used as an alternate method when the SVES or SOLQ-I is not available.

Searches of online information systems, including but not limited to the State Online Query-Internet (SOLQ-I) and the State Verification Exchange System (SVES) are permitted **only** for applicants and family members whose income and/or resource information is required to determine eligibility for the applicant or patient pay for an enrollee. This includes spouses of applicants and parents of child applicants.

Chapters M05 through M11 include specific instructions for the verification of resources and income. Subchapter M1450 includes instructions for verifying the transfer of assets.

M0130.300 Eligibility Determination Process

A. Evaluation of Eligibility Requirements

The eligibility determination process consists of an evaluation of an individual's situation that compares each of the individual's circumstances to an established standard or definition. The applicant must be informed of all known factors that affect eligibility.

The evaluation of eligibility requirements must be documented in writing for cases not processed in the ADAPT system. The Evaluation of Eligibility

(form #032-03-823) may be used. The form is available online at http://www.localagency.dss.state.va.us/divisions/bp/me/forms/general.cgi. Agency-created evaluation forms are also acceptable as long as all information needed to determine eligibility is documented on the evaluation form. Because ADAPT has a built-in verification log and evaluation record, a written evaluation is not used for cases processed in ADAPT.

Eligibility decisions are made following a prescribed sequence:

- The applicant must meet all non-financial requirements, including a covered group.
- If applicable to the covered group, resource limits must be met.
- The income limits appropriate to the covered group must be met.

Subchapter M0210 contains the Medicaid *non-financial requirements.*

B. Hierarchy of Covered Group

An applicant must be evaluated for eligibility in all potential covered groups and enrolled in the group that is the most beneficial to the applicant. First, evaluate under covered groups offering full coverage and if the applicant is not eligible, evaluate under groups offering *limited* coverage. Further specific instructions regarding the determination of covered group are contained in chapter M03.

C. Applicant's Choice of Covered Group

An individual who meets more than one covered group may choose the covered group under which he wishes his eligibility determined. Appropriate policy used is based on that individual's choice. If the choice is not clear on the application/redetermination form, the individual must state his covered group choice in writing. If the applicant does not make a choice, enroll him in the covered group that is the most beneficial.

D. Application Disposition

1. General Principle

Each application must be disposed of by a finding of eligibility or ineligibility as supported by the facts in the case record, unless the application is withdrawn or terminated (see M0130.400).

If an applicant dies during the application process, his eligibility can only be established for the period during which he was alive.

2. Entitlement and Enrollment

a. Entitlement

Entitlement to medical assistance is based on the application month. However, entitlement cannot begin prior to an individual's date of birth, and cannot continue after an individual's date of death. See section M1510.100 for detailed entitlement policy and examples.

b. Enrollment

Medicaid enrollees must be enrolled in the Medicaid Management Information System (MMIS). The Medicaid Eligibility Manual contains enrollment instructions based on the former MMIS. Some terminology and procedures used in the current MMIS differ from those used with the former MMIS. When following enrollment instructions in this manual, please note the following changes:

- The program designation (PD) is now known as aid category (AC). The AC is now the former PD prefaced by the digit "0." (e.g. AC 051).

- Coverage types are no longer used to enroll limited periods of coverage. Coverage is determined by begin and end dates.

- The former cancel reasons are now prefaced by the digit "0" (e.g. cancel reason 007).

When enrolling an individual in the MMIS, the appropriate aid category (AC) for the applicant's covered group must be used. Enrollment procedures

and a list of ACs are found in the MMIS Users' Guide for DSS, that can be accessed from the DSS local agency intranet at: http://localagency.dss.virginia.gov/divisions/bp/me/vammis_documents.cgi.

3. Notification to Applicant

The Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs (NOA), form #032-03-008 (available at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi) must be used to notify the applicant when:

- the application has been approved, including the effective date(s) of his Medicaid coverage;

- the retroactive Medicaid coverage was approved, including the effective dates;

- the application has been denied, including the specific reason(s) for denial cited from policy;

- retroactive Medicaid coverage was denied, including the specific reason(s) for denial cited from policy;

- there is a reason for delay in processing his application;

- a request for re-evaluation of an application in spenddown status has been completed; and

- a child has been approved or denied (including the specific reason for denial cited from policy) for FAMIS (see M21).

A copy of the notice must also be mailed to the individual who has applied on behalf of the applicant.

E. Notification for Retroactive Entitlement

There are instances when an applicant is not eligible for ongoing eligibility but is eligible for retroactive benefits or a change in the applicant's situation during the application process results in the applicant being eligible for only a limited period of time. Only one NOA is sent to the applicant covering both actions. Statements of the exact dates of eligibility, the date of ineligibility, and the reason(s) for ineligibility must be included on this notice.

M0130.400 Applications Denied Under Special Circumstances

A. General Principle

When an application is withdrawn or the applicant cannot be located, the application is denied. The reason for the denial must be recorded in the case record, and a Notice of Action on Medicaid must be sent to the applicant's last known address.

B. Withdrawal

An applicant may withdraw his application at any time. The request *can* be *verbal or* written. An applicant may voluntarily withdraw only his application for retroactive coverage by signing a statement *or by a verbal statement* specifically indicating the wish to withdraw the retroactive coverage part of the application.

A written withdrawal request must be placed in the case record. A verbal request for withdrawal can be accepted only from the applicant or case head, or his authorized representative. A verbal request must be documented in the case record with the date and time the withdrawal request was received, the name of the person who made the withdrawal request, and the signature and title of the agency staff person who took the call.

When the applicant withdraws an application, the eligibility worker must send a Notice of Action on Medicaid *to the applicant*.

C. Inability to Locate

The agency must send a letter to the last known address informing the applicant of the agency's attempt to locate him and asking that he contact the office. For applicants who are documented as homeless, maintain all correspondence at the local agency. If the applicant does not respond within 45 days of the date of application, deny the application.

D. Duplicate Applications

Applications received requesting Medicaid and/or FAMIS for individuals who already have an application recorded or who are currently active will be denied due to duplication of request. A Notice of Action on Medicaid will be sent to the applicant when a duplicate application is denied.

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M0210.000 GENERAL RULES & PROCEDURES

M0210.001 PRINCIPLES OF MEDICAID ELIGIBILITY DETERMINATION

A. Introduction

Medicaid is an assistance program which pays medical service providers for services rendered to eligible needy individuals. An individual's need for medical care, the state of his health, or his coverage by private health insurance, have no effect on his Medicaid eligibility.

The eligibility determination consists of an evaluation of an individual's situation which compares each of the individual's circumstances to an established standard or definition. The evaluation provides a structured decision-making process. An individual must be evaluated for eligibility in all covered groups for which he meets the definition, and the applicant/enrollee shall be informed of all known factors that affect eligibility.

B. Eligibility Requirements

Although all the requirements that follow may not be applicable in a particular individual's situation, they must be looked at and evaluated.

1. Nonfinancial Eligibility Requirements

The Medicaid nonfinancial eligibility requirements are:

a. Legal presence in the U.S., effective January 1, 2006 (M0210.150).
b. Citizenship/alien status (M0220).
c. Virginia residency (M0230).
d. Social Security number (SSN) provision/application requirements (M0240).
e. Assignment of rights to medical benefits and pursuit of support from the absent parent requirements (M0250).
f. Application for other benefits (M0270).
g. Institutional status requirements (M0280).
h. Covered group requirements (M03).

2. Financial Eligibility Requirements

The Medicaid financial eligibility requirements are:

a. Asset transfer for individuals who need long-term care (subchapter M1450).

b. Resources within resource limit appropriate to the individual's covered group. (Chapter M06 for F&C covered groups; Chapter S11 for ABD covered groups).

c. Income within income limit appropriate to the individual's covered group. (Chapter M07 for F&C covered groups; Chapter S08 for ABD covered groups).

3. Example

EXAMPLE: On January 5, 2006, Mr. H applies for Medicaid. He is in a nursing facility in Virginia, and has been there since July 5, 2005. When evaluating his application, the worker finds that he:

- is a U.S. citizen,
- is currently a Virginia resident residing in a medical institution in Virginia,
- provided his SSN,
- refused to provide third party liability and medical support information,
- has applied for all benefits to which he is entitled,
- meets the institutional status requirements,
- is age 67 years and meets a covered group requirement.

He currently has $5,000 in the bank. His income is $600 per month Social Security (SS). Since he refused to provide third party liability and medical support information, he does not meet the assignment of right requirements and his application must be denied. He is also informed of the resource limit and that he is ineligible for Medicaid because his resources exceed the limit.

M0210.100 INELIGIBLE PERSONS

A. Introduction

The individuals listed in this section are not eligible for Medicaid. However, their income and resources may be considered in determining the eligibility of others in the household who have applied for Medicaid.

B. Certain Recipients of General Relief (GR)

A recipient of General Relief (GR) maintenance who does not meet a Medicaid covered group is not eligible for Medicaid.

An applicant for Medicaid and Supplemental Security Income (SSI) who receives GR from the interim assistance component may become eligible for Medicaid following the establishment of SSI eligibility. Eligibility for an SSI payment is effective the month **following** the SSI application month. When the Medicaid application is dated in the same month as the SSI application, Medicaid eligibility can be effective the month of application if the applicant meets all Medicaid eligibility requirements and another covered group requirement in the application month.

C. Essential Spouse of an ABD Individual

An essential spouse of an aged, blind, or disabled person who does not himself/herself meet a covered group is not eligible for Medicaid.

D. Individual Who Refuses to Assign Rights

An individual, who refuses to assign rights to third-party payments or support for himself or anyone for whom he can legally assign rights, is not eligible for Medicaid. Failure to assign rights for another person will not affect the eligibility of that other person.

E. Individual Who Refuses to Pursue Support From an Absent Parent

An individual, other than a medically indigent pregnant woman, applying for Medicaid for herself and on behalf of a child who refuses to cooperate in the pursuit of support from an absent parent, is not eligible for Medicaid. Eligibility could exist if the individual meets a covered group and the individual chooses not to apply for the child.

F. Individual Found Guilty of Medicaid Fraud

An individual found guilty by a court of Medicaid fraud is not eligible for Medicaid. Ineligibility will last for a period of 12 months beginning with the month of conviction.

G. Individual Who Has Transferred *Assets*

An individual who transferred *assets*:

- to become or remain eligible for Medicaid,
- who did not receive adequate compensation, and
- who did not meet one of the asset transfer exceptions

is ineligible for Medicaid payment for long-term care services for a specified period of time unless adequate compensation is received before the time period is over. See Chapter M1450 for asset transfer policy.

H. Individual Who Refuses to Supply or Apply For an SSN

Any individual, except a child under age 1 born to a Medicaid-eligible mother or an illegal alien, who does not apply for an SSN account number or who fails or refuses to furnish all SSNs to the Department of Social Services is not eligible for Medicaid.

M0210.150 LEGAL PRESENCE

A. Legal Presence (Effective January 1, 2006)

Effective January 1, 2006, Section 63.2-503.1 of the Code of Virginia requires most applicants for or recipients of public assistance who are age 19 or older to provide proof of citizenship or legal presence in the U.S. Applicants or recipients age 19 or older for whom medical assistance is requested must prove their citizenship or legal presence. Individuals who, on June 30, 1997, were Medicaid eligible and were residing in long-term care facilities or participating in home and community-based waivers, and who continue to maintain that status (eligible for Medicaid and reside in long-term care facilities or participate in home and community-based waivers) are **exempt** from this requirement. **Non-citizens applying for Medicaid payment for emergency services are not subject to the legal presence requirement.**

An individual who is applying on behalf of another and is not requesting assistance for himself is not subject to the legal presence requirement.

B. Documents That Demonstrate Legal Presence

An applicant may demonstrate legal presence by presenting one of the following documents:

- valid evidence of U.S. citizenship;
- valid evidence of legal permanent resident status;
- valid evidence of conditional resident alien status;
- a valid SSN verified by the Social Security Administration (SSA);
- a U.S. non-immigrant visa;
- a Resident Alien Card, form I-551, showing lawful permanent residence (green card);
- a pending or approved application for legal asylum;

- a refugee or temporary protected status document; or
- a pending application for an adjustment of residence status.

C. Failure to Provide Proof of Legal Presence

At the time of application, an applicant who cannot provide documentation that he is a citizen or legally present must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the United States in order to meet the requirement for proof of legal presence for either:

- a period of 90 days or until it is determined that he is not legally present in the U.S., whichever is earlier; or

- indefinitely if the applicant provides a copy of a completed application for a birth certificate within the United States or its territories that has been filed and is pending. The affidavit's validity shall terminate upon the applicant's receipt of a birth certificate or determination that a birth certificate does not exist because the applicant is not a citizen of the United States.

The Affidavit Of United States Citizenship Or Legal Presence In The United States is available at:
http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi

NOTE: The individual's address on the affidavit form must be the individual's **residence** address, not the mailing address.

D. Relationship to Other Medicaid Requirements

Providing proof of legal presence or submitting a signed affidavit meets the legal presence eligibility requirement. To be eligible for Medicaid, however, the individual must meet all other state and federal Medicaid eligibility requirements. Submission of the affidavit without proof of application for an SSN as required by M0130.200.D does **NOT** meet the SSN requirement.

M0210.200 COVERED GROUPS

A. Introduction

An individual who meets the nonfinancial eligibility requirements must also meet the definition for a Medicaid covered group. Covered groups include individuals who are age 65 or older, blind, disabled, under age 19, pregnant women, and the parent(s) or caretaker-relative of a dependent child. Medicaid financial eligibility requirements vary depending upon the covered group for which eligibility is being determined.

See chapter M03 for the covered groups' definitions, policy and procedures.

CHAPTER MO2
NONFINANCIAL ELIGIBILITY REQUIREMENTS
SUBCHAPTER 20

CITIZENSHIP & ALIEN REQUIREMENTS

M0220 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	Table of Contents pages 2, 3, 7, 8, 14d, 18-22a, 23 Appendix 5, page 3
TN #95	3/1/11	Table of Contents pages 3, 3a, 4-6a, 14a-14c, 17, 19, 20 pages 22a, 23, 24 Appendices 1-2a removed. Appendix 3 and Appendices 5-8 reordered and renumbered.
TN #94	9/1/10	pages 3-3b, 7-9, 14a-14d, 18, 21, 22a, 23 Appendix 1 Appendix 3, page 3
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TN #93	1/1/10	Table of Contents pages 7-8, 14a, 14c-14d, 15-20, 22a Appendix 1 Appendix 3, page 3 Appendix 4, pages 1 and 2 Appendix 6, page 2
TN #92	5/22/09	Table of Contents pages 1-6a Appendix 8 (18 pages) pages 4a-4t were removed and not replaced.
TN #91	5/15/09	page 7 pages 14a, 14b page 18 page 20 Appendix 3, page 3

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M0220.000 CITIZENSHIP & ALIEN REQUIREMENTS

M0220.001 GENERAL PRINCIPLES

A. Introduction

This subchapter explains in detail how to determine if an individual is a citizen or alien eligible for full Medicaid benefits (referred to as "full benefit aliens") or emergency services only (referred to as "emergency services aliens"). The federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) made major changes to the Medicaid eligibility of non-citizens of the United States. These changes eliminated the "permanently residing under color of law" (PRUCOL) category of aliens. The Medicaid benefits for which an alien is eligible are based upon whether or not the alien is a "qualified" alien as well as the alien's date of entry into the United States.

With some exceptions, the Deficit Reduction Act of 2005 (DRA) required applicants for Medicaid and Medicaid recipients to verify their United States citizenship and identity to be able to qualify for Medicaid benefits. The citizenship and identity *(C&I)* verification requirements became effective July 1, 2006. The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA) allows additional exemptions from the *C&I* verification requirements *and provides states with the option to verify C&I through the use of an electronic data match with the Social Security Administration (SSA).* It also requires states to enroll otherwise eligible individuals prior to providing *C&I* verification, and grant them a "reasonable opportunity" period after enrollment to provide documentation, if necessary.

The policy and procedures for determining whether an individual is a citizen or a "full-benefit" or "emergency services" alien are contained in the following sections:

M0220.100 Citizenship & Naturalization;
M0220.200 Alien Immigration Status
M0220.300 Full Benefit Aliens
M0220.400 Emergency Services Aliens
M0220.500 Aliens Eligibility Requirements
M0220.600 Full Benefit Aliens Entitlement & Enrollment
M0220.700 Emergency Services Aliens Entitlement & Enrollment

B. Declaration of Citizenship/Alien Status

The Immigration Reform and Control Act (IRCA) requires as a condition of eligibility that the adult applicant who is head of the household (with exceptions below) declare in writing under penalty of perjury whether or not the individual(s) for whom he is applying is a citizen or national of the United States, and if not, that the individual is a lawfully admitted alien. For children under 18 years of age, the declaration is made by an adult family member. The declaration statement is on the application form.

EXCEPTION: An individual who is an "unqualified" alien (as defined in section M0220.410) does NOT complete the declaration.

Individuals who are required to sign the declaration and who fail or refuse to sign are NOT eligible for any Medicaid services.

M0220.100 CITIZENSHIP AND NATURALIZATION

A. Introduction

A citizen or naturalized citizen of the United States meets the citizenship requirement for Medicaid eligibility, and is eligible for all Medicaid services if he meets all other Medicaid eligibility requirements.

B. Citizenship Determination

1. Individual Born in the United States

An individual born in the United States, any of its territories (Guam, Puerto Rico, United States Virgin Islands, or Northern Mariana Islands), American Samoa, or Swain's Island is a United States citizen.

A child born in the United States to non-citizen parents who are in the United States as employees of a foreign country's government may not meet the United States citizen requirement. When a child born in the United States to non-citizen parents is a United States citizen by birth, the child may not meet the Virginia residency requirements in M0230.201 because of the parents' temporary stay in the United States.

2. Individual Born Outside the U.S.

a. Individual Born to or Adopted by U.S. Citizen Parents

A child or individual born outside the United States to U.S. citizen parents (the mother, if the child was born out-of-wedlock) automatically becomes a citizen by birth. A child under age 18 years who is a lawful permanent resident, who is currently residing permanently in the U.S. in the legal and physical custody of a U.S. citizen parent, and who meets the requirements applicable to adopted children under immigration law automatically becomes a citizen when there is a final adoption of the child, and does not have to apply for citizenship.

b. Individual Born to Naturalized Parents

A child born outside the United States to alien parents automatically becomes a citizen after birth, if his parents (the mother, if the child was born out-of-wedlock) are naturalized before he becomes 16 years of age.

c. Naturalized Individual

A child or individual born outside the U.S. and not automatically a citizen as in a) or b) above must have been naturalized to be considered a citizen.

C. Verification

1. Requirements

The DRA requires that satisfactory documentation of citizenship and identity must be obtained for all Medicaid enrollees who claim to be U.S. citizens. Medicaid enrollees who claim U.S. citizenship must have a declaration of citizenship AND documentary evidence of citizenship and identity in their case records.

2. Exceptions to Verification Requirements

The following groups of individuals are NOT required to provide verification of C&I. Document in the case record why an individual is exempt from verifying C&I:

a. All foster care children and IV-E Adoption Assistance children;

b. Individuals born to mothers who were eligible for Medicaid in any state on the date of the individuals' birth;

c. Individuals entitled to or enrolled in Medicare, individuals receiving Social Security benefits on the basis of a disability and SSI recipients currently entitled to SSI payments. Former SSI recipients are not included in the exemption. The local department of social services (LDSS) must have verification from the Social Security Administration (such as a SVES response) of an individual's Medicare enrollment, benefits entitlement or current SSI recipient status.

When an individual loses an exception status and his C&I has not previously been verified, the individual must be given a reasonable opportunity to provide C&I.

NOTE: A parent or caretaker who is applying for a child, but who is NOT applying for Medicaid for himself, is NOT required to verify his or her C&I.

3. Verification Required One Time

Once verification of C&I has been provided, it is not necessary to obtain verification again. Documentary evidence may be accepted without requiring the individual to appear in person. C&I documentation must be stored in the case record.

4. Enroll Under Good Faith Effort

If an individual meets all other Medicaid eligibility requirements and declares that he is a citizen, he is to be enrolled under a good faith effort. **Do not request verification of C&I from the applicant, and do not delay or deny application processing for proof of C&I.**

If the applicant meets all other Medicaid eligibility requirements:

- Approve the application and enroll the applicant in Medicaid, *AND*
- Specify on the Notice of Action that the individual may have to provide documentation of C&I if it cannot be obtained by other means, *OR*
- Include the Reasonable Opportunity Insert, available on SPARK at: http://spark.dss.virginia.gov/divisions/bp/me/citizenship/index.cgi, with the Notice of Action.

Do NOT verify citizenship using the Birth Record Verification System (BRVS) unless it is known that the SSA data match is not successful. The BRVS should be used only when (1) citizenship cannot be verified by SSA and (2) the individual was born in Virginia and requests assistance with obtaining birth record verification.

The individual remains eligible for Medicaid while the agency attempts to verify C&I through the data matching process described in M0220.100 D below, or if necessary, requests verification from the individual. The same good faith effort requirements apply should an individual lose his exemption from providing C&I verification.

D. Procedures for Documenting C&I

CHIPRA allows the option for verification of C&I for individuals newly enrolled in Medicaid or Family Access to Medical Insurance Security Plan (FAMIS) using a data match with SSA to confirm the consistency of a declaration of citizenship with SSA records in lieu of presentation of original documentation. This option, implemented in March 2010, allows for a monthly exchange of data between

the Medicaid Management Information System (MMIS) and SSA for the documentation of C&I for individuals enrolled in the Medicaid and FAMIS programs. In order for this process to be used to verify citizenship and identity, the individual's SSN must be verified by SSA (see M0240).

1. MMIS Data Matches SSA

If the information in the MMIS matches the information contained in the SSA files, the MMIS will be updated to reflect the verification of C&I. No further action is needed on the part of the eligibility worker, and the enrollee will not be required to provide any additional documentation, if the SSA match code in MMIS shows that SSA verified the individual's C&I.

2. MMIS Data Does Not Match SSA

If the information in the MMIS does not match the information in the SSA files, a discrepancy report will be generated monthly listing the inconsistent information. Eligibility staff is expected to review the report to see if the report lists any enrollees who were rejected because SSA could not verify the enrollee's citizenship and identity.

a. SSA Cannot Verify C&I

If the SSA data match result does not verify the individual's C&I, eligibility workers must review the information in the MMIS or ADAPT to determine if a typographical or other clerical error occurred. If it is determined that the discrepancy was the result of an error, steps must be taken to correct the information in the MMIS or ADAPT so that SSA can verify C&I when a new data match with SSA occurs in the future.

If the inconsistency is not the result of a typographical or other clerical error, the individual must be given a reasonable opportunity period of 90 days to either resolve the issue with SSA or provide verification of C&I. The eligibility worker must send a written notification to the enrollee that informs the enrollee of the discrepancy and gives him 90 calendar days from the date of the notice to either resolve the discrepancy with the SSA and to provide written verification of the correction, OR provide acceptable documentation of C&I to the LDSS.

The notice must specify the date of the 90th day, and must state that, if the requested information is not provided by the 90th day, the individual's Medicaid coverage will be canceled. Include with the notice the "Proof of U.S. Citizenship and Identity for Medicaid" document available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/citizenship/index.cgi#forms. Acceptable forms of documentation for C &I are also included in Appendix *1* to this subchapter.

b. Individual Does Not Provide Verification in 90 Days

If the individual does not provide the information necessary to meet the C&I documentation requirements by the 90th day, his coverage must be canceled. Send an advance notice, and cancel coverage at the end of the month in which the 90th day occurs.

c. Discrepancy Resolved With SSA Within 90 Days

If written verification is received that corrects the SSA discrepancy within the 90 days, update the MMIS accordingly so that the enrollee's information will be *included in a future data match for C&I verification. The individual continues to remain enrolled pending the results of the subsequent data match.*

If this subsequent data match with SSA results in verified C&I, MMIS will automatically enter code "CV" in the Cit Lvl and Identity fields in the individual's MMIS record. No further match will be done with the SSA files for C&I verification.

d. Verification of C&I Provided Within 90 Days

If the individual provides acceptable verification of his C&I within the 90 days, update the appropriate demographic fields in MMIS (and ADAPT, if the case is in ADAPT) with the appropriate codes. No further match will be done with the SSA files for C&I verification.

3. Subsequent Applications

If the individual who lost coverage for failure to provide C&I documentation files a subsequent application, a new reasonable opportunity period is not granted. The individual must provide acceptable documentation of C&I prior to approval of the re-application.

M0220.200 ALIEN IMMIGRATION STATUS

A. Introduction

An alien's immigration status is used to determine whether the alien meets the definition of a "full benefit" alien. All aliens who meet the state residency, covered group and all other nonfinancial eligibility requirements (except SSN for illegal aliens), and who meet all financial eligibility requirements are eligible for Medicaid coverage of emergency services. "Full benefit" aliens may be eligible for all Medicaid covered services. "Emergency services" aliens may be eligible for emergency services only.

B. Procedure

An alien's immigration status must be verified. Use the procedures in sections M0220.201 and 202 below to verify immigration status. After the alien's immigration status is verified, use the policy and procedures in section M0220.300 to determine if the alien is a full benefit alien. If the alien is a full benefit alien and is eligible for Medicaid, use the policy and procedures in section M0220.600 to enroll the alien in Medicaid.

If the alien is an emergency services alien who is eligible for Medicaid, use the policy and procedures in section M0220.700 to enroll an eligible emergency services alien in Medicaid for emergency services only.

C. Changes in Immigration Status

If a "full benefit" alien who was admitted to the U.S with immigration status in one of the "seven-year" alien groups listed in M0220.313.A becomes a Lawful Permanent Resident, he is considered to have full benefit status for the purposes of Medicaid eligibility for the first seven years of residency in the U.S.

M0220.201 IMMIGRATION STATUS VERIFICATION

A. Verification Procedures

An alien's immigration status is verified by the official document issued by the *United States Citizenship and Immigration Services* (USCIS) and a comparison with the Systematic Alien Verification for Entitlements (SAVE) system. The EW must see the original document or a photocopy. Submission of just an alien number is NOT sufficient verification.

If the alien has an alien number but no USCIS document, or has no alien number and no USCIS document, use the **secondary verification** SAVE procedure in M0220.202 below if the alien provides verification of his or her identity.

NOTE: If the alien claims to be an illegal alien, do not use the verification procedures in this section or the SAVE procedures. Go to section M0220.400 below to determine the illegal alien's eligibility.

B. Documents That Verify Status

Verify lawful permanent resident status by a Resident Alien Card or Permanent Resident Card (Form I-551), or for recent arrivals a temporary I-551 stamp in a foreign passport or on Form I-94.

Verify lawful admission by a Resident Alien Card (issued from August 1989 until December 1997) or Permanent Resident Card (Form I-551); a Re-entry Permit; or a Form I-688B with a provision of law section 274A.12(A)(1).

Afghan and Iraqi immigrants admitted to the U.S. under a Special Immigrant Visa will have either (1) a Form I-551 or (2) a passport or I-94 form indicating categories SI1, SI2, SI3, QQ1, SQ2, or SQ3 and bearing the Department of Homeland Security stamp or notation.

Form I-151 (Alien Registration Receipt Card – the old "green card"), Form AR-3 and AR-3a are earlier versions of the Resident Alien Card (Form I-551). An alien with one of the older cards who does not have an I-551should be referred to USCIS to obtain the application forms for the I-551. The forms may be ordered by calling 1-800-375-5283. When an I-151 is presented, refer the alien to USCIS, but accept the document for further verification (see M0220.201.E below).

C. Letters that Verify Status

The USCIS and the Office of Refugee Resettlement (ORR) issue letters that are used in lieu of or in conjunction with USCIS forms to identify alien status. If the letter is the only document provided, it is necessary to verify the status of the alien. For USCIS letters, contact the USCIS *at 1-800-375-5283* for assistance in identifying the alien's status. For ORR letters, contact the toll-free ORR Trafficking Verification Line at 866-401-5510 (see Appendix *2* of this subchapter). Do not verify ORR letters via the SAVE system.

D. Local USCIS Office Documents

Some USCIS offices have developed their own stamps. Therefore, it is possible that a locally produced stamp or legend will be on an USCIS form. If there is any question as to the veracity or status of the document, contact USCIS.

E. Expired or Absent Documentation

If an applicant presents an expired USCIS document or is unable to present any document showing his immigration status, refer the individual to the USCIS district office to obtain evidence of status **unless** he provides an alien registration number.

If the applicant provides an alien registration number with supporting verification of his identity, use the SAVE procedures in M0220.202 below to verify immigration status.

If an applicant presents an expired I-551 or I-151, follow procedures for initiating a primary verification. If the alien presents any expired document other than an expired I-551 or I-151, follow procedures for initiating a secondary verification.

If the alien does not provide verification of his identity, his immigration status cannot be determined, and he must be considered an unqualified alien.

M0220.202 SYSTEMATIC ALIEN VERIFICATION FOR ENTITLEMENTS (SAVE)

A. SAVE

Aliens must submit documentation of immigration status before eligibility for the full package of Medicaid benefits can be determined. If the documentation provided appears valid and meets requirements, eligibility is determined based on the documentation provided AND a comparison of the documentation provided with immigration records maintained by the USCIS.

The comparison is made by using the SAVE system established by Section 121 of the Immigration Reform and Control Act of 1986 (IRCA).

1. Primary Verification

Primary verification is the automated method of accessing the USCIS data bank. SAVE regulations require that automated access be attempted prior to initiating secondary verification. There are some specific instances, however, when the agency will forego the primary verification method and initiate secondary verification (see **Secondary Verification**).

SAVE is accessed by the Alien Registration Number. SAVE is accessed directly by the local agency. The alien registration number begins with an "A" and should be displayed on the alien's USCIS document(s).

Information obtained through SAVE should be compared with the original USCIS document. If discrepancies are noted, the secondary verification process must be initiated. No negative action may be taken on the basis of the automated verification only.

A primary verification document must be **initiated prior to case approval.** The primary verification document must be filed in the case record.

2. Secondary Verification

Secondary verification is required in the following situations:

a. The alien has an alien number but no USCIS document, or the alien has no alien number and no USCIS document.

b. Primary verification generates the message "Institute Secondary Verification" or "No File Found."

c. Discrepancies are revealed when comparing primary verification to the original immigration document.

d. Immigration documents have no Alien Registration Number (A-Number).

e. Documents contain an A-Number in the A60 000 000 or A80 000 000 series.

f. The document presented is an USCIS Fee Receipt.

g. The document presented is Form I-181 or I-94 in a foreign passport that is endorsed "Processed for I-551, Temporary Evidence of Lawful Permanent Residence," and the I-181 or I-94 is more than one year old.

When secondary verification is required, the agency must complete the top portion of a Document Verification Request (Form G-845) or initiate an on-line request for a secondary verification through SAVE. The G-845 is *available at* http://www.uscis.gov. *Click on "Forms."*

B. Document Verification Request (Form G-845)

If the alien has filed an USCIS application for or received a change in status, the application for or change in status in itself is not sufficient basis for determining immigration status. Likewise, any document which raises a question of whether USCIS contemplates enforcing departure is not sufficient basis for determining the alien's status. In such situations, verify the alien's status with USCIS using the Document Verification Request (Form G-845). For an alien who entered the U.S. before 8-22-96 and whose status is adjusted to a qualified status after he entered the U.S. use the Form G-845 Supplement to request the period of continuous presence in the U.S. The G-845 Supplement (S) is *available at* http://www.uscis.gov. *Click on "Forms."*

Form G-845 should be completed as fully as possible by the submitting agency. It is essential that the form contain enough information to identify the alien.

A separate form must be completed for each alien. Completely legible copies (front and back) of the alien immigration documents must be stapled to the upper left corner of Form G-845. Copies of other documents used to make the initial alien status determination such as marriage records or court documents must also be attached.

Once the requirement to obtain secondary verification is determined, the agency must initiate the request within ten work days. *The USCIS mailing address is subject to frequent changes. Obtain the current mailing address from the SAVE web site at http://www.uscis.gov. Click on "Direct Filing Addresses for Form G-845."*

A photocopy of the completed G-845 form must be filed in the record as evidence that the form has been forwarded to USCIS.

The USCIS maintains a record of arrivals and departures from the United States for most legal entrants, and LDSS can obtain the required information from their USCIS office. The USCIS does not maintain an arrival and departure record for Canadian and Mexican border crossers. For these immigrants, as well as immigrants whose status was adjusted and whose original date of entry cannot be verified by USCIS, LDSS will need to verify continuance presence by requiring the immigrant to provide documentation showing proof of continuous presence.

Acceptable documentation includes:

- letter from employer
- school or medical records
- series of pay stubs
- shelter expense receipts, such as utility bills

in the immigrant's name that verify continuous presence for the period of time in question.

C. Agency Action

When the primary verification response requires the eligibility worker to initiate a secondary verification from USCIS, do not delay, deny, reduce or terminate the individual's eligibility for Medicaid **on the basis of alien status**. If the applicant meets all other Medicaid eligibility requirements, approve the application and enroll the applicant in Medicaid. Upon receipt of the G-845 or response to the on-line query, compare the information with the case record. Timely notice must be given to the individual when Medicaid benefits are denied or reduced.

Note: When a secondary verification is requested for an alien with an expired I-551, the G-845 or response to the on-line SAVE query should indicate that the person continues to have lawful permanent resident status. When a secondary verification is requested for an alien with an expired I-151, the G-845 or response to the on-line SAVE query will indicate that the documentation is expired; however, do not delay, deny, reduce or terminate an individual's eligibility for Medicaid on the basis of an expired I-151.

Once information has been obtained through SAVE, aliens with a permanent status are no longer subject to the SAVE process. Aliens with a temporary or conditional status are subject to SAVE at the time of application and when the temporary or conditional status expires.

M0220.300 FULL BENEFIT ALIENS

A. Policy

A "full benefit" alien is

- an alien who receives SSI (M0220.305);
- an American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (INA) apply, or a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)) (M0220.306);
- a "qualified" alien (defined in M0220.310 below) who entered the U.S. before 8-22-96;
- a qualified alien refugee; asylee; deportee; Amerasian; Cuban or Haitian entrant; victim of a severe form of trafficking; or a qualified Afghan or Iraqi immigrant admitted to the U.S. on a Special Immigrant Visa; who entered the U.S. on or after 8-22-96, but only for the first **7** years of residence in the U.S. (M0220.313 C);
- a qualified lawful permanent resident who entered the U.S. on or after 8-22-96 who has at least 40 qualifying quarters of work, but only **AFTER** 5 years of residence in the U.S. (M0220.313 B);
- a qualified alien who meets the veteran or active duty military requirements in M0220.311 below; or
- a *lawfully residing non-citizen* child under age 19 who meets the requirements in M0220.314 below.

A full benefit alien is eligible for full Medicaid benefits if he/she meets all other Medicaid eligibility requirements.

Aliens who are not "full benefit" aliens are "emergency services" aliens and may be eligible for emergency Medicaid services only if they meet all other Medicaid eligibility requirements. See section M0220.400 for emergency services aliens.

B. Procedure

1. Step 1

First, determine if the alien receives SSI. Section M0220.305 describes this group of aliens who receive SSI.

If the alien does NOT receive SSI, go to Step 2.

If the alien receives SSI, go to Step 6.

2. Step 2

Second, determine if the alien is an American Indian born in Canada or a member of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)). Section M0220.306 describes this group of aliens.

If NO, go to Step 3. If YES, go to Step 6.

3. Step 3 Third, determine if the alien is a "qualified" alien eligible for full benefits (a full benefit qualified alien).

- Section M0220.310 defines "qualified" aliens.
- Section M0220.311 defines qualified veteran or active duty military aliens.
- Section M0220.312 describes qualified aliens who entered the U.S. before 8-22-96.
- Section M0220.313 describes qualified aliens who entered the U.S. on or after 8-22-96.

If the alien is NOT a qualified alien eligible for full benefits, go to step 4.

If the alien is a qualified alien eligible for full benefits, go to step 6.

4. Step 4 Fourth, determine if the alien is a *lawfully residing non-citizen* child under age 19. Section M0220.314 defines a legal immigrant child under age 19.

If the alien is NOT a *lawfully residing non-citizen* under age 19, go to Step 5.

If the alien is a *lawfully residing non-citizen* child under age 19, go to Step 6.

5. Step 5 The alien is an "**emergency services**" alien. Go to Section M0220.400 which defines emergency services aliens, then to M0220.500 which contains the eligibility requirements applicable to all aliens, then to M0220.700 which contains the entitlement and enrollment policy and procedures for emergency services aliens.

6. Step 6 Use Section M0220.500, which contains the Medicaid eligibility requirements applicable to all aliens, to determine the alien's Medicaid eligibility. Then use Section M0220.600, which contains the entitlement and enrollment procedures for **full benefit** aliens, to enroll an eligible full benefit alien.

M0220.305 ALIENS RECEIVING SSI

A. Policy An SSI recipient meets the Medicaid full benefit alien status requirements. Some SSI recipients who are aliens would have lost SSI and Medicaid eligibility. The Balanced Budget Act of 1997 restored SSI eligibility for certain groups of aliens:

- a legal alien who was receiving SSI on August 22, 1996, may continue to receive SSI if he/she meets all other SSI eligibility requirements.

- an alien who was blind or disabled on August 22, 1996, and who is residing legally in the U.S. may receive SSI in the future if he/she meets all other SSI eligibility requirements.

- a legal alien who is receiving SSI for months after July 1996 on the basis of an SSI application filed before January 1, 1979, is exempted from the SSI legal alien requirements, and is eligible for SSI if he/she meets all other SSI eligibility requirements

B. *SSI Extension for Elderly and Disabled Refugees Act*

The SSI Extension for Elderly and Disabled Refugees Act (P.L. 110-328), enacted on September 30, 2008, allows elderly or disabled aliens subject to the seven-year time limit for receiving SSI to receive up to two additional years of SSI benefits. Although the Social Security Administration makes the determination of eligibility for the SSI extension, the categories of seven-year aliens to which the SSI extension may apply are listed in M0220.313 A.1 through A.4.

Individuals receiving SSI benefits on the basis of the SSI extension also meet the alien status requirement for full-benefit Medicaid eligibility.

***C.* Procedure**

Verify the alien's SSI current payment status on the SDX or through SVES. If the alien currently receives SSI, and/or received SSI during the period for which Medicaid coverage is requested, the alien meets the alien status requirements for Medicaid with no further development.

Determine the alien SSI recipient's Medicaid eligibility using the policy and procedures for full benefit aliens in section M0220.600 below.

M0220.306 CERTAIN AMERICAN INDIANS

A. Policy

An alien who is

- an American Indian born in Canada to whom the provisions of section 289 of the Immigration and Nationality Act (INA) apply, or
- a member of an Indian tribe (as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)),

meets the Medicaid full benefit alien status requirements.

B. Procedure

Verify the status of an American Indian born in Canada from *USCIS* documents that the individual presents, or via the SAVE system.

Verify the status of a member of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e) from official documents that the individual presents.

M0220.310 QUALIFIED ALIENS DEFINED

A. Qualified Aliens Defined

A qualified alien is an alien who, at the time he applies for, receives or attempts to receive Medicaid is:

1. Lawful Permanent Resident

an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act.

2. Refugee

an alien who is admitted to the U.S. under the Immigration and Nationality Act as a **refugee under section 207 of the INA**, or an alien

who is admitted to the U.S. as **an Amerasian immigrant** pursuant to section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act 1988 (as contained in section 101(e) of Public Law 100-202 and amended by the 9th proviso under MIGRATION AND REFUGEE ASSISTANCE in title II of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1989, Public Law 100-461, as amended).

The refugee will have a Form I-94 identifying him/her as a refugee under section 207 of the INA. The Amerasian immigrant will have an I-94 coded AM1, AM2, or AM3, or an I-551 coded AM6, AM7, or AM8.

3. Conditional Entrant — an alien who is granted conditional entry pursuant to section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980.

Aliens admitted to the United States as conditional entrants pursuant to 203(a)(7) of the Immigration and Nationality Act (INA) (8 USC 1153(a)(7)) have an *USCIS* Form I-94 bearing the stamped legend "Refugee - Conditional Entry" and a citation of the INA section.

NOTE: Section 203(a)(7) of the INA was made obsolete by the Refugee Act of 1980 (P.L.96-212) and replaced by section 207 of the INA effective April 1, 1980.

4. Asylee — an alien who is granted asylum under section 208 of the Immigration and Nationality Act. Aliens granted asylum will have a Form I-94 and a letter.

5. Parolee — an alien who is paroled into the U.S. under section 212(d)(5) of the Immigration and Nationality Act for a period of at least 1 year. Aliens in this group will have a Form I-94 indicating that the bearer has been paroled pursuant to section 212(d)(5) of the INA.

6. Deportee--Deportation Withheld — an alien whose deportation is being withheld under section 243(h) of the INA (as in effect immediately before the effective date of section 307 of division C of Public Law 104-208) or section 241(b)(3) of the INA (as amended by section 305(a)of division C of Public Law 104-208) . These aliens will have an order from an immigration judge showing that deportation has been withheld under section 243(h) or section 241(b)(3) of the INA and/or a Form I-94.

7. Cuban or Haitian Entrant — an alien who is a Cuban and Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980. A Cuban or Haitian Entrant is a person from Cuba or Haiti who

- has been granted parole by *USCIS* for humanitarian or public interest reasons, unless a final order of deportation or exclusion has been issued;
- has an application for asylum pending with *USCIS*, unless a final order of deportation or exclusion has been issued;

- is subject to *USCIS* exclusion or deportation proceedings, unless a final order of deportation or exclusion has been issued.

a. Humanitarian, Public Interest, Application for Asylum

To meet the humanitarian, public interest or application for asylum status, the Cuban or Haitian entrant must be from Cuba or Haiti and must have an I-94 with one or more of the following notations:

- humanitarian parole;
- public interest parole;
- section 212(d)(5);
- parole; or
- Form I-589 filed.

Contact *USCIS* if there is reason to believe that a final order of exclusion or deportation has been issued.

b. Subject to Exclusion or Deportation

To be subject to exclusion or deportation proceedings, the Cuban or Haitian entrant must be from Cuba or Haiti and must have letters or notices which indicate ongoing exclusion or deportation proceedings that apply to the individual. Contact *USCIS* if there is reason to believe that a final order of exclusion or deportation has been issued.

8. Battered Alien

an alien, and/or an alien parent of battered children and/or an alien child of a battered parent who is battered or subjected to extreme cruelty while in the U.S. who meets the following requirements:

a. the perpetrator is a spouse, parent or other household member of the spouse or parent's family who was residing in the home at the time of the incident but is no longer in the home. The alien must not now be residing in the same household as the individual responsible for the battery or extreme cruelty, and

- the alien was battered or subjected to extreme cruelty while in the U.S. by a spouse or a parent, or by a member of the spouse or parent's family residing in the same household as the alien, and the spouse or parent consented to or acquiesced in such battery or cruelty;

- the alien's child was battered or subjected to extreme cruelty while in the U.S. by a spouse or a parent of the alien (without the active participation of the alien in the battery or cruelty), or by a member of the spouse or parent's family residing in the same household as the alien, and the spouse or parent consented or acquiesced to such battery or cruelty and the alien did not actively participate in such battery or cruelty; or

- the alien child resides in the same household as a parent who has been battered or subjected to extreme cruelty while in the U.S. by that parent's spouse, or by a member of the spouse's family residing in the same household as the parent and the spouse consented or acquiesced to such battery or cruelty.

b. the agency providing benefits determines (according to the guidelines to be issued by the U.S. Attorney General) that there is a substantial connection between the battery or cruelty and the need for benefits; and

c. the alien has a petition approved by or pending with *USCIS* for one of the following:

- status as an immediate relative (spouse or child) of a U.S. citizen;
- classification changed to immigrant;
- status as the spouse or child of a lawful permanent resident alien (LPR); or
- suspension of deportation and adjustment to LPR status based on battery or extreme cruelty by a spouse or parent who is a U.S. citizen or LPR alien.

9. Afghan or Iraqi Special Immigrant *an alien who is lawfully admitted into the U.S. on a Special Immigrant Visa (SIV) for permanent residency. Aliens in this group include the principal SIV holder, his spouse, and his children under age 21 living in the home. Afghan and Iraqi Special Immigrants will have either (1) a Form I-551 or (2) a passport or I-94 form indicating categories SI1, SI2, SI3, QQ1, SQ2, or SQ3 and bearing the Department of Homeland Security stamp or notation.*

M0220.311 VETERAN & ACTIVE DUTY MILITARY ALIENS

A. Veterans or Active Duty Military Aliens

An alien lawfully residing in the state (not here illegally) is always eligible for full Medicaid benefits (if he/she meets all other Medicaid eligibility requirements) **regardless of the date of entry into the U. S.**, if he or she meets one of the following conditions:

1. he/she is a qualified alien and is a veteran discharged honorably not on account of alienage, and who fulfills the minimum active-duty service requirements of section 5303A(d) of title 38, United States Code;

2. he/she is a qualified alien and is on active duty (other than active duty for training) in the Armed Forces of the United States (not in the Armed Forces Reserves),

3. he/she is the

   a) spouse or the unmarried dependent child of a living (not deceased) qualified alien who meets the conditions of 1. or 2. above, or

b) the unremarried surviving spouse of an individual described in 1. or 2. above who is deceased, if the spouse was married to the veteran

- before the expiration of fifteen years after the termination of the period of service in which the injury or disease causing the death of the veteran was incurred or aggravated; or
- for one year or more; or
- for any period of time if a child was born of the marriage or was born to them before the marriage.

A divorced person is not a spouse.

A "dependent child" for this section's purposes is one whom the Veterans Administration (VA) has determined to meet the VA definition of "dependent child." According to the VA, a dependent child is an unmarried child under age 18, an unmarried child between ages 18 and 23 who is attending a VA-approved school, or a "helpless" child who became disabled before attaining age 18.

B. Verification

Acceptable verification of honorable discharge or active duty status include the following documents:

1. Discharge Status

For discharge status, an original or notarized copy of the veteran's discharge papers (DD 214) issued by the branch of service in which the alien was a member verifies whether he/she was honorably discharged for a reason other than alien status.

Other documentation which is acceptable under the Department of Defense (DOD) or VA guidelines can be substituted for the DD 214 form.

A self declaration under penalty of perjury may be accepted pending receipt of acceptable documentation.

2. Active Duty Status

For active duty military status, an original or notarized copy of the alien's current orders showing the individual is on full-time duty in the U.S. Army, Navy, Air Force, Marine Corps, or Coast Guard (full-time National Guard duty is NOT active military status), or a military identification card (DD Form 2 (active)) verifies whether the alien is in active duty military status.

Other documentation which is acceptable under the Department of Defense (DOD) or VA guidelines can be substituted for the current orders or military ID card.

A self declaration under penalty of perjury may be accepted pending receipt of acceptable documentation.

C. Services Available To Eligibles

A qualified alien who meets the veteran or active duty military requirements above and who meets all other Medicaid eligibility requirements is eligible for the full package of Medicaid covered services available to the alien's covered group.

D. Entitlement & Enrollment of Eligibles

The Medicaid entitlement policy and enrollment procedures for eligible veteran/active duty military aliens are found in section M0220.600 below.

M0220.312 QUALIFIED ALIENS WHO ENTERED U.S. BEFORE 8-22-96

A. Qualified Aliens--Entered U.S. Before 8-22-96

Qualified aliens (as defined in M0220.310 above) who were living in the U.S. prior to 8-22-96 and who meet all other Medicaid eligibility requirements are eligible for the full package of Medicaid benefits available to the covered group they meet.

1. Full Benefit Qualified Aliens

These "full benefit" qualified aliens who entered the U.S. before 8-22-96 are:

- Lawful Permanent Residents,
- Refugees under section 207, and Amerasian immigrants,
- Conditional Entrants under section 203(a)(7),
- Asylees under section 208,
- Parolees under section 212(d)(5),
- Deportees whose deportation is withheld under section 243(h) or 241(b)(3),
- Cuban or Haitian Entrants, and
- Battered aliens, alien parents of battered children, and/or alien children of battered parents.

NOTE: If the qualified alien is a veteran or in active duty military status, or is the spouse or the unmarried dependent child of a qualified alien who meets the conditions in M0220.311 above, the alien is a full benefit alien.

2. Adjusted Status

When an alien entered the U.S. before 8-22-96 with an unqualified alien status and the alien's status is adjusted to a qualified status after the alien entered the U.S., the alien's qualified status is considered to be effective back to the date he/she entered the U.S. if:

- the alien was physically present in the U.S. before 8-22-96, and
- the alien remained physically present in the U.S. from the date of entry to the status adjustment date.

The date of entry will be the first day of the verified period of continuous presence in the U.S. (see M0220.202).

B. Services Available To Eligibles A qualified alien who entered the U.S. before 8-22-96 and who meets all other Medicaid eligibility requirements is eligible for the full package of Medicaid covered services available to the alien's covered group.

C. Entitlement & Enrollment of Eligibles The Medicaid entitlement policy and enrollment procedures for eligible qualified aliens who entered the U.S. before 8-22-96 are found in section M0220.600 below.

M0220.313 QUALIFIED ALIENS WHO ENTERED U.S. ON OR AFTER 8-22-96

A. First 7 Years of Residence in U.S. During the first seven years of residence in the U.S., six (6)groups of qualified aliens (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 are eligible for the full package of Medicaid benefits available to the covered group they meet (if they meet all other Medicaid eligibility requirements), *even if their status is adjusted later to LPR.*. These *6* groups of qualified aliens who entered the U.S. on or after 8-22-96 are:

1. Refugees Refugees under section 207 and Amerasian immigrants are full benefit aliens for 7 years from the date of entry into the U.S. Once 7 years have passed from the date the refugee entered the U.S., the refugee becomes an "emergency services" alien.

2. Asylees Asylees under section 208 are full benefit aliens for 7 years from the date asylum in the U.S. is granted. Once 7 years have passed from the date the alien is granted asylum in the U.S., the asylee becomes an "emergency services" alien.

3. Deportees Deportees whose deportation is withheld under section 243(h) or section 241(b)(3) are full benefit aliens for 7 years from the date withholding is granted. After 7 years have passed from the date the withholding was granted, the deportee becomes an "emergency services" alien.

NOTE: If the qualified alien is a veteran or in active duty military status, or is the spouse or the unmarried dependent child of a qualified alien who meets the conditions in M0220.313 above, the alien is a full benefit alien.

4. Cuban or Haitian Entrants Cuban and Haitian entrants as defined in section 501(e) of the Refugee Education Assistance Act of 1980 are full benefit aliens for 7 years from the date they enter the U.S. After 7 years have passed from the date they entered the U.S., a Cuban or Haitian entrant becomes an "emergency services" alien.

5. Victims of a Severe Form of Trafficking Victims of a severe form of trafficking as defined by the Trafficking Victims Protection Act of 2000, P.L. 106-386 are full benefit aliens for 7 years **from the date they are certified or determined eligible** by the Office of Refugee Resettlement (ORR). Victims of a severe form of trafficking are identified by either a letter of certification (for adults) or a letter of eligibility (for children

under age 18 years) issued by the ORR (see Appendix 5 of this subchapter). **The date of certification/eligibility specified in the letter is the date of entry for a victim of a severe form of trafficking.** After 7 years have passed from the certification/eligibility date, a victim of a severe form of trafficking becomes an "emergency services" alien unless his status is adjusted.

6. Afghan or Iraqi Immigrant Admitted to the U.S. on a Special Immigrant Visa

The Department of Defense Appropriations Act of 2010, enacted on December 19, 2009, provides that Iraqi and Afghan Special Immigrants are eligible for Medicaid benefits to the same extent and for the same time period as refugees. The legislation supersedes prior legislative authority that limited Special Immigrants to benefits for an 8-month time period. Provided that all other eligibility requirements are met, Iraqi and Afghan Special Immigrants are eligible for Medicaid benefits for the first seven years after entry into the United States (U.S.).

7. After 7 Years Residence in U.S.

After seven years of residence in the U.S., the qualified refugee, Amerasian, asylee, deportee, Cuban or Haitian entrant, victim of a severe form of trafficking, or Afghan or Iraqi Special Immigrant (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

B. AFTER 5 Years of Residence in U.S.

After five years of residence in the U.S., one group of qualified aliens (as defined in M0220.310 above) who entered the U.S. **on or after 8-22-96** is eligible for the full package of Medicaid benefits available to the covered group they meet (if they meet all other Medicaid eligibility requirements). This group of qualified aliens who entered the U.S. on or after 8-22-96 is the **LPR who has at least 40 qualifying quarters of work.**

1. LPR

When an LPR entered the U.S. on or after 8-22-96, the LPR is an **"emergency services" alien during the first 5 years** the LPR is in the U.S., regardless of work quarters.

Note: If the LPR had prior *immigration* status *in one of the "seven-year" alien groups listed in M0220.313.A,* he *is* considered to have *"seven-year"* status for the purposes of Medicaid eligibility *for the first seven years of residency in the U.S.* To determine former status of a LPR, check the coding on the I-551 for codes RE-6, RE-7, RE-8, or RE-9. *Contact the USCIS at 1-800-375-5283 for assistance in identifying the former status for other seven year aliens.*

AFTER 5 years have passed from the date of entry into the U.S., LPRs who have at least 40 qualifying quarters of work are "full benefit" aliens. LPRs who DO NOT have at least 40 qualifying quarters of work remain emergency services aliens after 5 years have passed from the date of entry into the U.S.

2. Qualifying Quarter

- A qualifying quarter of work means a quarter of coverage as defined under Title II of the Social Security Act which is worked by the alien and/or
- all the qualifying quarters worked by the spouse of such alien during their marriage and the alien remains married to such spouse or such spouse is deceased, and all of the qualifying quarters worked by a parent of such alien while the alien was under age 18 years.

See Appendix *3* to this subchapter for procedures for verifying quarters of coverage under Title II of the Social Security Act.

Any quarter of coverage, beginning after December 31, 1996, in which the alien, spouse or parent of the alien applicant received any federal means-tested public benefit (such as SSI, TANF, Supplemental Nutrition Assistance Program (SNAP-formerly Food Stamps) and Medicaid) **cannot** be credited to the alien for purposes of meeting the 40 quarter requirement.

C. Services Available To Eligibles

1. Refugee, Amerasian, Asylee, Deportee, Cuban or Haitian Entrant, Victim of a Severe Form of Trafficking; Afghan or Iraqi Special Immigrant

The following immigrants:

- qualified refugee,
- Amerasian,
- asylee,
- deportee,
- Cuban or Haitian entrant,
- victim of a severe form of trafficking, or
- Afghan or Iraqi Special Immigrant (as defined in M0220.310 above),

who entered the U.S. on or after 8-22-96 and who meets all other Medicaid eligibility requirements is eligible for the full package of Medicaid covered services available to the alien's covered group during the first 7 years of residence in the U.S. After 7 years of residence in the U.S., the refugee, Amerasian, asylee, deportee, Cuban or Haitian entrant, victim of a severe form of trafficking, or Afghan or Iraqi Special Immigrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and is eligible for emergency services only.

2. LPR With 40 Work Quarters

After five years of residence in the U.S., an LPR with 40 or more qualifying quarters of work who entered the U.S. on or after 8-22-96 is eligible for the **full package of Medicaid benefits** available to the covered group he/she meets if he/she meets all other Medicaid eligibility requirements.

D. Entitlement & Enrollment of Eligibles

The Medicaid entitlement policy and enrollment procedures for full benefit qualified aliens who entered the U.S. on or after 8-22-96 are found in section M0220.600 below.

The Medicaid entitlement policy and enrollment procedures for emergency services qualified aliens who entered the U.S. on or after 8-22-96 are found in section M0220.700 below.

M0220.314 *LAWFULLY RESIDING NON-CITIZEN* CHILDREN UNDER AGE 19

A. Policy

Section 214 of CHIPRA of 2009 gives states the option to provide Medicaid coverage to certain individuals who are lawfully residing in the United States and are otherwise eligible for assistance. Virginia has elected to cover children under the age of 19 who are lawfully residing in the U.S.

Children who are in one of the *lawfully residing non-citizen* children alien groups must have their immigration status verified at the time of the initial eligibility determination and at each annual renewal of eligibility to ensure that the children are lawfully residing in the U.S. and that their immigration status has not changed.

B. Eligible Alien Groups

Non-citizen children under 19 who are *lawfully residing* immigrants meet one of the following alien groups:

1. Lawful Permanent Resident

an alien who is lawfully admitted for permanent residence under the Immigration and Nationality Act.

2. Refugees

an alien who is admitted to the U.S. under the Immigration and Nationality Act as a refugee under any section of the INA. The refugee will have a Form I-94 identifying him/her as a refugee under the INA.

3. Conditional Entrant

an alien who is granted conditional entry pursuant to section 203(a)(7) of the Immigration and Nationality Act as in effect prior to April 1, 1980. Aliens admitted to the United States as conditional entrants pursuant to 203(a)(7) of the Immigration and Nationality Act (INA) (8 USC 1153(a)(7)) have an USCIS Form I-94 bearing the stamped legend "Refugee - Conditional Entry" and a citation of the INA section.

NOTE: section 203(a)(7) of the INA was made obsolete by the Refugee Act of 1980 (P.L.96-212) and replaced by section 207 of the INA effective April 1, 1980

4. Parolee

parolees are:

aliens paroled into the United States, including Cuban/Haitian entrants, pursuant to section 212(d)(5) of the INA (8 USC 1182(d)(5)); or

admitted to the United States for similar reasons as a refugee, i.e., humanitarian. However, this group, unlike refugee status, does not grant legal residence status. Parole status allows the alien temporary status until an USCIS determination of his/her admissibility has been made, at which time another status may be granted.

Aliens in this group will have a Form I-94 either indicating that the bearer has been paroled pursuant to section 212(d)(5) of the INA or stamped "Cuban/Haitian Entrant (Status Pending) Reviewable [date]" "Employment authorized until [date]." Possession of a properly annotated Form I-94 constitutes evidence of permanent residence in the U.S. under color of law, regardless of the date the Form I-94 is annotated.

5. Deportation Withheld

an alien with "deportation withheld" status is

- *an alien granted a stay of deportation by court order, statute or regulation, or by individual determination of USCIS pursuant to section 245 of the INA (8 USC 1253 (a)) or USCIS Operations Instruction 245.3 whose departure USCIS does not contemplate enforcing, or*

- *an alien who is in deportation proceedings but deportation has been withheld because of conditions similar to those leading to a granting of refugee status, i.e., fear of persecution.*

Aliens in this group have been found to be deportable, but USCIS may defer deportation for a specific period of time due to humanitarian reasons. These aliens will have an order from an immigration judge showing that deportation has been withheld under section 245(h) of the INA (8 USC 1253(h)) and/or a Form I-94.

6. Immediate Relative Petition

aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition, who are entitled to voluntary departure (under 8 CFR 242.5(a)(2)(vi)) and whose departure USCIS does not contemplate enforcing. An immediate relative for USCIS purposes is: husband, wife, father, mother, or unmarried child under age 21.

a. Aliens in this group are the immediate relatives of an American citizen or a lawful permanent resident and have had filed on their behalf a Form I-130 petition for issuance of an immigration visa. If this petition has been approved, a visa will be prepared, which will allow the alien to remain in the United States permanently.

b. Aliens in this group will have a Form I-94 and/ or I-210 Letter. These documents will indicate that the alien is to depart on a specified date (usually 3 months from date of issue), however, USCIS expects the alien's visa to be available within this time. If it is not, extensions will be granted until the visa is ready. Also indicated on these documents is the authorization for employment.

7. Status Adjustment Applicants

aliens who have filed applications for adjustment of status pursuant to section 245 INA (8 USC 1255) that USCIS has accepted as "properly filed" (within the meaning of 8 CFR 242.5(a) or (b)) or has granted, and whose departure the USCIS does not contemplate enforcing.

a. Aliens in this group have filed for lawful permanent resident status.

b. Aliens in this group will have a Form 1-181 or their passports will be stamped with either of the following: "adjustment application" or "employment authorized during status as adjustment applicant."

8. Deferred Action Status *Aliens granted deferred action status pursuant to USCIS operating instructions.*

a. Aliens in this group are similar to those under an order of supervision except there have been no formal deportation proceedings initiated.

b. Aliens in this group will have a Form I-210 or a letter indicating that the alien's departure has been deferred.

9. Deportation Suspended *Aliens granted suspension of deportation pursuant to section 244 of the INA (8 USC 1254) whose departure the USCIS does not contemplate enforcing.*

a. Aliens in this group have been found deportable, have met a period of continuous residence and have filed an application for USCIS to suspend deportation in an effort to be granted lawful permanent resident status.

b. If the suspension is granted, the alien must wait through two full sessions of the Congress. If the Congress does not take action on the application, USCIS will grant the alien lawful permanent residence.

c. These aliens will have a letter/order from the immigration judge and a Form I-94 with employment authorized for 1 year. After lawful permanent residence is granted, the alien will have a Form I-551, or I-151.

10. Compact of Free Association States *Aliens who are citizens of a Compact of Free Association State (Federated States of Micronesia, Republic of the Marshall Islands and the Republic of Palau) who have been admitted to the U.S. as a non-immigrant and are permitted by the Department of Homeland Security to reside permanently or indefinitely in the United States.*

11 Other Eligible Groups

a. Aliens described in 8 CFR 103.12(a)(4) who do not have a permanent residence in the country of their nationality and are in statuses that permit them to remain in the U.S. for an indefinite period of time pending adjustment of their status. This includes:

1. aliens currently in temporary resident status as an Amnesty beneficiary pursuant to section 210 or 245A of the Immigration and Nationality Act (INA);

2. aliens currently under a Temporary Protected Status pursuant to section 244 of the INA;

3. aliens classified as a Family Unit beneficiary pursuant to section 301 of Public Law 101-649 as well as pursuant to section 1504 of Public Law 106-554;

4. aliens currently under a Deferred Enforced Departure pursuant to a decision made by the President; and

5. alien children whose parent is a U.S. citizen, whose visa petition has been approved and who has a pending application for adjustment of status.

M0220.400 EMERGENCY SERVICES ALIENS

A. Policy

Any alien who does NOT meet the requirements for full benefits as described in section M0220.300 through 314 above is an "emergency services" alien and is eligible for emergency Medicaid services only, if he or she meets all of the Medicaid nonfinancial and financial eligibility requirements.

B. Procedure

Section M0220.410 describes the qualified aliens who entered the U.S. on or after 8-22-96 who are emergency services aliens.

Section M0220.411 defines "unqualified" aliens.

Section M0220.500 contains the Medicaid eligibility requirements applicable to full benefit and emergency services aliens.

Section M0220.700 contains the entitlement and enrollment procedures for emergency services aliens.

M0220.410 EMERGENCY-SERVICES-ONLY QUALIFIED ALIENS WHO ENTERED U.S. ON OR AFTER 8-22-96

A. First 5 Years of Residence in U.S.

During the first five years of residence in the U.S., four groups of qualified aliens (as defined in M0220.310 above) who entered the U.S. on or after 8-22-96 are eligible for **emergency Medicaid services only** provided they meet all other Medicaid eligibility requirements.

1. LPRs

An LPR who enters the U.S. on or after 8-22-96 is an "emergency services" alien during the first 5 years the LPR is in the U.S., regardless of work quarters.

Note: If the LPR had prior *immigration* status *in one of the "seven-year" alien groups listed in M0220.313.A,* he *is* considered to have *"seven year"* status for the purposes of Medicaid eligibility *for the first seven years of residency in the U.S.* To determine former status of a LPR, check the coding on the I-551 for codes RE-6, RE-7, RE-8, or RE-9. *Contact the USCIS at 1-800-375-5283 for assistance in identifying the former status for other seven year aliens.*

2. Conditional Entrants

A qualified Conditional Entrant who enters the U.S. on or after 8-22-96 is an "emergency services" alien.

3. Parolees

A qualified parolee who enters the U.S. on or after 8-22-96 is an "emergency services" alien.

4. Battered Aliens

A qualified battered alien who enters the U.S. on or after 8-22-96 is an "emergency services" alien.

B. AFTER 5 Years of Residence in U.S.

AFTER 5 years have passed from the date of entry into the U.S., the following groups of aliens who entered on or after 8-22-96 are eligible for emergency services only:

1. Lawful Permanent Residents Without 40 Work Quarters

Lawful Permanent Residents who DO NOT have at least 40 qualifying quarters of work remain emergency services aliens after residing in the U.S. for 5 years. Lawful Permanent Residents who have at least 40 qualifying quarters of work become full benefit aliens after 5 years of residing in the U.S.

2. Conditional Entrants

A qualified Conditional Entrant who enters the U.S. on or after 8-22-96 is an "emergency services" alien.

3. Parolees

A qualified parolee who enters the U.S. on or after 8-22-96 is an "emergency services" alien.

4. Battered Aliens

A qualified battered alien who enters the U.S. on or after 8-22-96 is an "emergency services" alien.

C. AFTER 7 Years of Residence in U.S.

1. Refugees

After 7 years of residence in the U.S., a refugee or Amerasian immigrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

2. Asylees

After 7 years have passed since asylum was granted, an asylee who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

3. Deportees

After 7 years have passed since deportation was withheld, a deportee who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

4. Cuban or Haitian Entrants

After 7 years of residence in the U.S., a Cuban or Haitian Entrant who entered the U.S. on or after 8-22-96 is no longer eligible for full Medicaid benefits and becomes an "emergency services" alien.

5. Afghan and Iraqi Special Immigrants

Medicaid coverage for Afghan and Iraqi Special Immigrants who are eligible in a Medicaid covered group cannot begin earlier than December 26, 2007. After 7 years of residence in the U.S., Afghan and Iraqi Special Immigrants are no longer eligible for full Medicaid benefits and become "emergency services" aliens.

After the applicable limited time period expires, individuals become "emergency services" aliens unless the requirements in M0220.313 B or M0220.314 are met.

***D.* Services Available To Eligibles**

An emergency services alien who meets all Medicaid eligibility requirements is eligible for Medicaid coverage of emergency services only.

***E.* Entitlement & Enrollment of Eligibles**

The Medicaid entitlement policy and enrollment procedures for emergency services aliens are found in section M0220.700 below.

F. Certain Pregnant Qualified Aliens

If a pregnant woman is ineligible for full-benefit Medicaid because the she does not meet the alien status requirements for full-benefit Medicaid, the woman is to be enrolled in FAMIS MOMS as long as she (1) meets the FAMIS MOMS alien

status requirements and all other FAMIS MOMS non-financial eligibility requirements and (2) has income less than or equal to 200% FPL. See M2220.100 for additional information.

The table below lists the differences between the qualified alien status policies for full Medicaid coverage and FAMIS MOMS coverage for individuals who entered the U.S. on or after August 22, 1996:

Qualified Alien Group	***Meets Medicaid alien status requirement for full coverage***	***Meets FAMIS MOMS alien status requirement (see M2220.100)***
veterans or active military	*yes, with no time limit*	*yes, with no time limit*
refugees; asylees; deportation withheld; Cuban/Haitian entrants; victims of a severe form of trafficking; and Iraqi and Afghan Special Immigrants	*yes, for first 7 years U.S. only*	*yes, with no time limit*
lawful permanent residents (LPRs),	*yes, only after 5 years in U.S. and with 40 qualifying work quarters*	*yes, only after 5 years in U.S., no work requirement*
conditional entrants; aliens paroled in the U.S.; and battered aliens, alien parents of battered children, alien children of battered parents	*No*	*yes, only after 5 years in U.S.*

M0220.411 UNQUALIFIED ALIENS

A. Unqualified Aliens

Aliens who do not meet the qualified alien definition M0220.310 above and who are **NOT** *lawfully residing non-citizen* children under age 19 (M0220.314 above) are "unqualified" aliens and are eligible for emergency services only if they meet all other Medicaid eligibility requirements. Unqualified aliens include illegal and non-immigrant aliens.

B. Illegal aliens

Illegal aliens were never legally admitted to the U.S. or were legally admitted for a limited period of time and did not leave when that period expired. If an alien remains in the U.S. after his visa expires, he becomes an illegal alien.

C. Non-immigrant Aliens

Aliens who are lawfully admitted to the U.S. for a temporary or limited period of time, and the limited period has **not** expired, are non-immigrant aliens. Non-immigrants, such as visitors, tourists, some workers, and diplomats, are not eligible for Medicaid because of the temporary nature of their admission status (they do not meet the state residency requirement). Non-immigrants have the following types of USCIS documentation:

- Form I-94 Arrival-Departure Record,
- Form I-185 Canadian Border Crossing Card,
- Form I-186 Mexican Border Crossing Card,
- Form SW-434 Mexican Border Visitor's Permit,
- Form I-95A Crewman's Landing Permit.

Note: If the alien remains in the U.S. after the limited time period (visa) is over, he becomes an illegal alien.

Non-immigrants include:

1. **Visitors** visitors for business or pleasure, including exchange visitors;

2. **Foreign Government Representative** foreign government representatives on official business and their families and servants;

3. **Travel Status** aliens in travel status while traveling directly through the U.S.;

4. **Crewmen** Crewmen on shore leave;

5. **Treaty Traders** treaty traders and investors and their families;

3. **Travel Status** aliens in travel status while traveling directly through the U.S.;

6. **Foreign Students** foreign students;

7. **International Organization** international organization representatives and personnel, and their families and servants;

8. **Temporary Workers** temporary workers including some agricultural contract workers;

9. **Foreign Press** members of foreign press, radio, film, or other information media and their families.

M0220.500 ALIENS ELIGIBILITY REQUIREMENTS

A. Policy An alien must meet all other Medicaid eligibility requirements to be eligible for any Medicaid services. The eligibility requirements are:

1. **Residency** the Virginia residency requirements (M0230);

Aliens who are visitors (non-immigrants) usually do not meet the Virginia state residency requirements because their visas will expire on a definite date. Ask the non-immigrant alien "Where do you intend to go after your visa expires?" If the visitor states in writing that he/she "intends to reside in Virginia permanently or indefinitely after his visa expires," then the alien has stated his intent to reside in Virginia permanently or indefinitely and can meet the Virginia state residence eligibility requirement for Medicaid.

If an individual who signed a statement indicating that he does not intend to remain subsequently changes his mind, eligibility cannot begin prior to the date of the original statement.

2. **Social Security Number (SSN)** the SSN provision/application requirements (M0240);

NOTE: An alien eligible only for Medicaid payment of emergency services does not have to apply for or provide an SSN. This includes emergency-services-only aliens as defined in M0220.410 and unqualified aliens as defined in M0220. 411.

3. Assignment of Rights and Pursuit of Support from Absent Parents — the assignment of rights to medical benefits requirements (M0250);

4. Application for Other Benefits — the requirements regarding application for other benefits (M0270);

5. Institutional Status — the institutional status requirements (M0280);

6. Covered Group — the covered group requirements (chapter M03);

7 Financial Eligibility — the asset transfer requirements (see subchapter M1450) apply.

Resources must be within the resource limit appropriate to the individual's covered group. (Chapter M06 for F&C covered groups; Chapter S11 for ABD covered groups).

Income must be within the income limit appropriate to the individual's covered group. (Chapter M07 for F&C covered groups; Chapter S08 for ABD covered groups). Spenddown provisions apply to these individuals. All medical expenses count toward meeting the spenddown, but once an entitlement date is determined after the individual meets the spenddown, only emergency services rendered on or after the entitlement date and which are within the period of coverage on the Emergency Medical Certification form are covered for emergency services aliens.

B. Emergency Services Certification--Not Applicable to Full Benefit Aliens

Certification that the service provided was an emergency service is an additional eligibility requirement for emergency services aliens (not applicable to full benefit aliens). LDSS can certify emergency services coverage for pregnancy-related labor and delivery services for limited, specified periods of time. DMAS must certify emergency services coverage for all other requests and determine the period of coverage.

1. LDSS Certification for Pregnancy-Related Labor and Delivery Services

LDSS can certify emergency services payment for pregnancy-related labor and delivery services, including inpatient hospitalizations that did not exceed:

- 3 days for a vaginal delivery, or
- 5 days for a cesarean delivery.

To determine the length of stay, count the day of admission, but not the day of discharge. If the length of stay exceeded 3 days for a vaginal delivery or 5 days for a cesarean delivery, DMAS must approve the coverage following the procedures in M0220.500 B.2 below. Note that the enrollment period for the emergency service(s) includes the day of discharge even though it is not counted to determine the length of stay (see M0220.700).

For LDSS certifications, verification of the labor and delivery services must be obtained from the physician or hospital and include the following information:

- patient name, address and date of birth,
- facility name and address where the delivery took place
- type of delivery (vaginal or cesarean), and
- inpatient hospital admission and discharge dates.

The verification must be documented in the record.

NOTE: A child born to an emergency-services-only alien mother who was eligible for Medicaid on the date of the child's birth is entitled to Medicaid as a newborn child (see M320.301).

2. DMAS Certification for Emergency Services Required

When DMAS certification for emergency services is required, *send a written request for the evidence of emergency treatment listed below to the applicant or authorized representative. Request that the applicant/authorized representative provide the following information from the hospital or treating physician, as applicable to the emergency service provided, **for each period of service**:*

- *On the Emergency Medical Certification Form, **specify the exact dates of service requested.** Ask for a phone number where the person can be reached .*
- *emergency room record, admission (admit) orders, history and physical, MD notes. discharge summary, operative notes;*
- *operative consent form;*
- *pre operative evaluation;*
- *labor and delivery notes, if pregnancy related; and*
- *dates of service – admission date/discharge date.*

If the applicant/authorized representative is unlikely to be able to obtain the above information without assistance (e.g. due to a language barrier), obtain a signed release of information. If necessary, use the release to request evidence of emergency treatment from the hospital and/or treating physician

If the hospital or treating physician is *unsure of* the information *that* is needed, refer the hospital's staff, physician or physician's staff to the Virginia Medicaid Hospital Provider Manual, Chapter VI "Documentation Guidelines."

Using the Emergency Medical Certification, form #032-03-628 (see M0220, Appendix 4) as a cover letter, send the medical evidence to:

Division of Program Operations
Department of Medical Assistance Services (DMAS)
600 E. Broad Street, Suite 1300
Richmond, VA 23219

for a determination of medical emergency and the duration of the emergency services certification period.

If more than one period of service is requested, the records must be separated, and a separate certification form must be attached for each period of service.

If a request is received with one certification form and the records contain multiple dates of service, and/or DMAS is unable to make a determination with the medical records received, the entire request will be returned to the eligibility worker with a note specifying the information needed.

Do not include application forms for disability, FAMIS, etc. These forms contain protected health information that is not needed for the determination of medical necessity.

Do **not** take action to approve or enroll an emergency services alien until you receive the completed Emergency Medical Certification form back from DMAS. If approved, DMAS will provide the certification for Medicaid payment for emergency services and coverage begin and end dates.

M0220.600 FULL BENEFIT ALIENS ENTITLEMENT & ENROLLMENT

A. Policy

An alien who is determined eligible for full Medicaid benefits and who meets all Medicaid eligibility requirements (including covered group requirements) is eligible for all Medicaid-covered services available to the recipient's covered group.

B. Application & Entitlement

1. Application Processing

The eligibility worker must take the application and develop it in the same manner as any other individual's application. All eligibility requirements, including covered group requirements must be met.

2. Entitlement

If the applicant is found eligible for Medicaid, ongoing eligibility may exist unless the recipient is on a spenddown.

3. Spenddown

Spenddown provisions apply to medically needy individuals who have excess income.

4. Notice

Appropriate notice must be sent to the applicant of the status of his application and of his Medicaid eligibility.

C. Enrollment Procedures

Once a full benefit alien is found eligible for Medicaid, he must be enrolled on the Medicaid computer (MMIS) using the following data:

1. Country

In this field, Country, enter the code of the alien's country of origin.

2. Cit Status

In this field, Citizenship Status, enter the MMIS Citizenship code that applies to the alien. Below, next to the MMIS code, is the corresponding Alien Code from the Alien Code Chart in Appendix *5* to this subchapter. Eligible alien codes are:

R = refugee (Alien Chart codes F1, F2, G1, G2); also used for Afghan and Iraqi Special Immigrants (Alien Chart Code Z1).
E = entrant (Alien Chart code D1).
P = full benefit qualified aliens (Alien Chart codes A1, A2, A3, B1, B3, C1, E1, H1, H2, I1, J1, J2).
I = legal immigrant children under age 19 only (Alien Chart codes Y1, Y2, Y3)

3. Entry Date THIS FIELD MUST BE ENTERED. Enter the date on which the alien entered the U.S., except for asylees and deportees. For asylees, enter the date asylum was granted. For deportees, enter the date deportation withholding was granted.

4. Appl Dt In this field, Application Date, enter the date of the alien's Medicaid application upon which the eligibility coverage period is based.

5. Coverage Begin Date In this field, Coverage Begin Date, enter the date the alien's Medicaid entitlement begins.

6. Coverage End Date Enter data in this field only if eligibility is a closed period of eligibility in the past. Enter the date the alien's Medicaid entitlement ended.

7. AC Enter the AC code applicable to the alien's covered group.

M0220.700 EMERGENCY SERVICES ALIENS ENTITLEMENT & ENROLLMENT

A. Policy Unqualified aliens, and qualified aliens eligible for emergency services only are eligible for Medicaid coverage of emergency medical care only. This care must be provided in a hospital emergency room or as an inpatient in a hospital.

B. Entitlement-Enrollment Period If the applicant is found eligible and is certified for emergency services, eligibility exists only for the period of coverage certified by the LDSS or DMAS staff on the Emergency Medical Certification form, # 032-03-628 (M0220, Appendix 4).

Once an eligibility period is established, additional requests for coverage of emergency services within 6 months will not require a new Medicaid application. However, each request for Medicaid coverage of an emergency service or treatment requires a new, separate certification and a review of the alien's income and resources and any change in situation that the alien reports.

An emergency services alien must file a new Medicaid application after the 6-month eligibility period is over if the individual receives an emergency service and wants Medicaid coverage for that service.

C. Enrollment Procedures Once an emergency services alien is found eligible for coverage of emergency services, the individual must be enrolled in MMIS using the following data:

1. Country In this field, Country of Origin, enter the code of the alien's country of origin.

2. Cit Status In this field, Citizenship Status code, enter :

A = Emergency services alien (Alien Chart codes B2, C2, C3, D2, D3, E2, E3, F3, G3, H3, I2, I3, codes J3 through V3, Z2) other than dialysis patient.

D = Emergency services alien who receives dialysis.

V = Visitor, non-immigrant alien (Alien Chart codes W1, W2, W3).

The Alien Codes Chart is found in Appendix *5* to this subchapter.

NOTE: Foreign visitors are not usually eligible for Medicaid because usually they do not meet the Medicaid Virginia state residency requirement.

3. **Entry date** — **THIS FIELD MUST BE ENTERED.** Enter the date on which the alien entered the U.S., except for asylees and deportees. For asylees, enter the date asylum was granted. For deportees, enter the date deportation withholding was granted.

4. **App Dt** — In this field, application date, enter the date of the alien's Medicaid application upon which the eligibility coverage period is based.

5. **Covered Dates Begin** — In this field, coverage begin date, enter the begin date of the emergency service(s).

6. **Covered Dates End** — In this field, coverage end date, enter the date when the alien's emergency service(s) ends. When the emergency service(s) received was related to labor and delivery, the end date includes the day of discharge even though it is not counted to determine the length of stay for certification purposes.

7. **AC** — Enter the code applicable to the alien's covered group.

D. Notices

Appropriate notice must be sent to the applicant of the status of his application and the duration of his eligibility.

*The USCIS requires that all benefit applicants who are denied benefits based **solely or in part** on the SAVE response be provided with adequate written notice of the denial as well as the information necessary to contact USCIS, so that the individual may correct his records in a timely manner, if necessary. The fact sheet, "Information for Applicants: Verification of Immigration Status and How to Correct Your Record with USCIS" (Form # 032-03-0427-00) must be included with the Notice of Action when benefits are denied, **including the approval of emergency-services-only Medicaid coverage**, and with the Advance Notice of Proposed Action when benefits are subsequently cancelled based on the results of a SAVE inquiry. The fact sheet is available on PARK at http://www.localagency.dss.state.va.us/divisions/dgs/warehouse.cgi.*

A Medicaid card will not be generated for an individual enrolled as an emergency services alien.

The agency must contact the provider(s) and supply the eligibility dates and Medicaid number for billing purposes by sending a copy of the completed referral form #032-03-628, Emergency Medical Certification, to the provider(s).

A Medicaid card will not be generated for an enrolled *emergency services* alien.

The agency must contact the provider(s) and supply the eligibility dates and Medicaid number for billing purposes by sending a copy of the completed referral form #032-03-628 Emergency Medical Certification to the provider(s).

Citizenship & Identity Procedures and Documentation Charts

Use the following procedures when citizenship and identity verification is required to determine the individual's continued eligibility.

A. Documents Establishing U.S. Citizenship and Identity

1. Citizenship Document

To establish U.S. citizenship, the document must show:

- a U.S. place of birth, or
- that the person is a U.S. citizen.

NOTE: Children born in the U.S. to foreign sovereigns or diplomatic officers are **not** U.S. citizens.

NOTE: A state driver's license issued by any state or territory, including Virginia, does NOT prove citizenship. It will satisfy requirements for proof of **identity** if the license has either a photograph of the individual or other identifying information about the individual such as name, age, sex, race, height, weight or eye color.

2. Identity Document

To establish identity, a document must show evidence that provides identifying information that relates to the person named on the document.

3. Acceptable Documents

All documents must be either originals or copies certified by the issuing agency. Photocopies of original documents, including notarized copies, **are not** acceptable. The original must be viewed by the agency or other authorized staff and a copy made of the original; the copy must have written on it the date the original was seen and the name and title of the individual who saw the original. See item C.3., below, for details regarding which staff are authorized.

Exceptions:

a. A copy of a **Virginia birth certificate** that is in the existing LDSS agency record, or is presented by an individual as verification, is acceptable temporarily while the LDSS agency is waiting for verification of the Virginia birth record from the Birth Record Verification System (BRVS). The agency may approve or renew coverage if the individual meets **all** other eligibility requirements. The agency must obtain verification of the Virginia birth record from BRVS, and a copy of the BRVS Birth Record Verification Results screen for the individual must be placed in the record when received. BRVS is accessed on SPARK. The procedures for using BRVS are in the BRVS User Guide, available in BRVS.

b. *Puerto Rico invalidated all birth certificates issued prior to July 1, 2010 and reissued the birth certificates. For individuals born in Puerto Rico **who are applying for Medicaid for the first time**, only a birth certificate issued on or after July 1, 2010 may be accepted from the individual. Should an individual born in Puerto Rico be unable to present a birth certificate issued on or after July 1, 2010, contact your Regional Medical Assistance Specialist, who will refer the case to DMAS. DMAS will obtain official birth verification on behalf of the local DSS. If the person is reapplying and the agency has a birth certificate issued prior to July 1, 2010 on record, no additional verification is required.*

Acceptance of a photocopied birth certificate does **not** apply to individuals born outside of Virginia or for documentation of an individual's identity.

4. Levels of Acceptable Documents

The tables in section D, below, list acceptable evidence of U.S. citizenship and identity in the order of their reliability level. Level tables 1-4 address citizenship; Level table 1 and Chart 5 address identity.

If an individual presents documents from Level 1, no other information is required. If an individual presents documents from Levels 2-4, then an identity document from Chart 5 must also be presented. Level tables 1-4 establish the hierarchy of reliability of citizenship documents.

The following instructions specify when a document of lesser reliability may be accepted by the agency. An asterisk by the document in the charts means that the document is listed in the law, section 6036 of DRA 2005 (public law No. 109-171).

See the Level 2 section for documents that prove citizenship by collective naturalization.

See M0220, Appendix *6* for information about the documents, the document issuer, and contact information for each document.

5. How to Verify Citizenship and Identity

First, ask the individual if he has a Level 1 document listed – U.S. Passport, Certificate of Naturalization or a Certificate of Citizenship. If the individual presents the original of one of these documents, he has verified his citizenship and identity.

6. How to Verify Citizenship

If the individual does not have one of the Level 1 documents, ask if he has one of the Level 2 documents to prove citizenship. If the individual presents the original of one of the documents in Level 2, he has verified his citizenship, but not his identity. He must present a document from Chart 5 to verify his identity.

If the individual does not have one of the Level 2 documents, ask if he has one of the Level 3 documents to prove citizenship. If the individual presents the original of one of the documents in Level 3, he has verified his citizenship, but not his identity. He must present a document from Chart 5 to verify his identity.

If the individual does not have one of the Level 3 documents, ask if he has one of the Level 4 documents to prove citizenship, which includes a written affidavit. If the individual presents the original of one of the documents in Level 4, he has verified his citizenship, but not his identity. He must present a document from Chart 5 to verify his identity.

If the individual does not present one of the Level 4 documents to verify citizenship, he is not eligible for Medicaid because he has failed to provide documentary evidence of citizenship. **However, see section C that follows before cancelling Medicaid because of failure to verify citizenship.**

NOTE: Naturalized citizens are limited to the documents in Level 1, Level 2 and the citizenship affidavit in Level 5 because they were not born in the United States. They should not have the documents listed in Levels 3 and 4, and they should not have any of the Level 5 documents except for the affidavit.

7. How to Verify Identity

If the individual presents the original of one of the documents in Levels 2, 3, or 4, he has verified his citizenship, but not his identity. He must present a document from Chart 5 to verify his identity.

a. Children Under Age 16

A written affidavit for a child under age 16 may be used to verify the child's identity **if an affidavit was not used to prove the child's citizenship** and the identity affidavit language is not on the application, ADAPT Statement of Facts (SOF) or renewal form submitted by the individual. The Affidavit of Identity for Medicaid Applicants and Recipients Under Age 16 is on the intranet at: http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0282-02-eng.pdf.

The Health Insurance for Children and Pregnant Women application form, form number 032-03-0401, has been updated to include the identity affidavit language. The application form is available on the intranet at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/famis.cgi. The Families& Children Medicaid and FAMIS Plus Renewal form contains the identity affidavit language. The form is available on the intranet at: http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi.

b. Individuals Age 16 or Older

An affidavit of identity cannot be used for an individual age 16 or older, except when the individual resides in an institution. This form is available on SPARK at: http://spark.dss.virginia.gov/divisions/bp/me/citizenship/forms.cgi. If the applicant is age 16 or older, the agency must assist the applicant in obtaining an identity document. If the individual does not present one of the documents in Chart 5 to verify identity, he is not eligible for Medicaid because he has failed to provide documentary evidence of identity. **See section E below before denying or cancelling Medicaid because of failure to verify identity.**

B. Hierarchy of Documentation

The agency's contact with the client about citizenship documents must follow the hierarchy of documentation. If the client does not have a Level 1, Level 2 or Level 3 citizenship document, the client must tell the agency why he or she cannot obtain these documents. The agency must write in the case record why the client cannot get Level 1, 2 or 3 document in order to explain why a Level 4 document was used (Level 4 includes the affidavits of citizenship).

NOTE: Applicants or recipients born outside the United States must submit a document listed under Level 1 - **primary evidence** of United States citizenship.

There is no hierarchy for the documentation of identity. For children under age 16, an affidavit of identity signed by the parent is acceptable whether or not other forms of identification may exist (see B.5 below).

1. LEVEL 1 – Primary Documents to Establish Both United States Citizenship and Identity

Level 1 primary evidence of citizenship and identity is documentary evidence of the highest reliability that conclusively establishes that the person is a United States citizen. Obtain primary evidence of citizenship and identity before using secondary evidence. Accept any of the documents listed in the Level 1 table as primary evidence of both United States citizenship and identity if the document meets the listed criteria and there is nothing indicating the person is not a United States citizen (e.g., lost United States citizenship).

NOTE: Persons born in American Samoa (including Swain's Island) are generally United States non-citizen nationals. References in this guidance to "citizens" should be read as references to non-citizen nationals.

NOTE: References to documents issued by the Department of Homeland Security (DHS) include documents issued by its predecessor, the Immigration and Naturalization Services (INS). On March 1, 2003, the former INS became part of DHS, and its naturalization function was assumed by United States Citizenship and Immigration Services (USCIS) within DHS. However, even documents issued after this date may bear INS legends.

Applicants or recipients born outside the United States who were not citizens at birth must submit a document listed under primary evidence of United States citizenship.

LEVEL 1 – Primary Documents	Explanation – Level 1
* United States Passport	The Department of State issues this. A United States passport does not have to be currently valid to be accepted as evidence of United States citizenship, as long as it was originally issued without limitation. Note: Spouses and children were sometimes included on one passport through 1980. United States passports issued after 1980 show only one person. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented. Exceptions: *(1)* Do not accept any passport as evidence of United States citizenship when it was issued with a limitation; *(2) do not accept an expired passport issued to a person born in Puerto Rico as evidence of citizenship.* However, such passports may be used as proof of identity *only*.
* Certificate of Naturalization (N-550 or N-570)	Department of Homeland Security issues this document for naturalization. NOTE: A Certificate of Naturalization may not have a number on it. Form numbers N-550 and N-570 are no longer used. DHS now uses form number N-565. The application form for naturalization is now N-400.
* Certificate of Citizenship (N-560 or N-561)	Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.

2. LEVEL 2 - Secondary Documents to Establish United States Citizenship

Level 2 secondary evidence of citizenship is documentary evidence of satisfactory reliability that is used when primary evidence of citizenship is not available. Available evidence is evidence that exists and can be obtained within the application processing time frame (see section M0130.100). **A second document establishing identity MUST also be presented (see Chart 5, Evidence of Identity)**.

Accept any of the documents listed in the Level 2 table as secondary evidence of United States citizenship if the document meets the listed criteria and there is nothing indicating the person is not a United States citizen (e.g., lost United States citizenship).

NOTE: Applicants or recipients born outside the United States must submit a document listed under **primary evidence** of United States citizenship.

LEVEL 2 – Secondary Documents	**Explanation – Level 2**
A United States public birth record	A United States public birth record showing birth in: • one of the 50 United States; • District of Columbia; • Puerto Rico (if born on or after January 13, 1941 *AND document was issued on or after July 1, 2010 or official verification is obtained by DMAS*); • Guam (on or after April 10, 1899). • Virgin Islands of the United States (on or after January 17, 1917); • American Samoa; • Swain's Island; or • Northern Mariana Islands (after November 4, 1986 (NMI local time). The birth record document may be recorded by the State, Commonwealth, Territory or local jurisdiction. It must have been recorded before the person was 5 years of age. A delayed birth record document that is recorded after 5 years of age is considered fourth level evidence of citizenship. Plastic birth certificate cards issued by the Virginia Department of Health are valid birth certificates. A copy of the card is to be placed in the case record, with a note that the original card was viewed. Other states may have issued similar plastic birth certificate cards. If an individual presents a plastic birth certificate card from another state, verify with that state's office of vital records that such cards are issued by the state.
	NOTE: Individuals born to foreign diplomats residing in one of the states, the District of Columbia, Puerto Rico, Guam or the Virgin Islands are not citizens of the United States.
Collective Naturalization	If the document shows the individual was born in Puerto Rico, the Virgin Islands of the United States, or the Northern Mariana Islands before these areas became part of the United States, the individual may be a collectively naturalized citizen. Collective naturalization

LEVEL 2 – Secondary Documents	Explanation – Level 2
Collective Naturalization	occurred on the dates listed for each of the Territories. The following will establish United States citizenship for collectively naturalized citizens:
	• **a. Puerto Rico:** 1) Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the United States, a United States possession or Puerto Rico on January 13, 1941; or 2) Evidence that the applicant was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917 and that he or she did not take an oath of allegiance to Spain. **b. United States Virgin Islands:** 1) Evidence of birth in the United States Virgin Islands, and the applicant's statement of residence in the United States, a United States possession or the United States Virgin Islands on February 25, 1927; or
	2) The applicant's statement indicating residence in the United States Virgin Islands as a Danish citizen on January 17, 1917 and residence in the United States, a United States possession or the United States Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship; or 3) Evidence of birth in the United States Virgin Islands and the applicant's statement indicating residence in the United States, a United States possession or Territory or the Canal Zone on June 28, 1932. **c. Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):** 1) Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the United States, or a United States Territory or possession on November 3, 1986 (NMI local time) and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or 2) Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981 (NMI local time), voter registration prior to January 1, 1975 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time); or

LEVEL 2 – Secondary Documents	Explanation – Level 2
Collective Naturalization	3) Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986 (NMI local time). 4) NOTE: If a person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a United States citizen.
*Certification of Report of Birth (DS-1350)	The Department of State issues a DS-1350 to United States citizens in the United States who were born outside the United States and acquired United States citizenship at birth, based on the information shown on the FS-240. When the birth was recorded as a Consular Report of Birth (FS-240), certified copies of the Certification of Report of Birth Abroad (DS-1350) can be issued by the Department of State in Washington, D.C. The DS-1350 contains the same information as that on the current version of Consular Report of Birth FS-240. The DS-1350 is not issued outside the United States.
*Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240)	The Department of State consular office prepares and issues this. A Consular Report of Birth can be prepared only at an American consular office overseas while the child is under the age of 18. Children born outside the U.S. to U.S. military personnel usually have one of these.
*Certification of Birth Issued by the Department of State (Form FS-545 or DS-1350)	Before November 1, 1990, Department of State consulates also issued Form FS-545 along with the prior version of the FS-240. In 1990, U.S. consulates ceased to issue Form FS-545. Treat an FS-545 the same as the DS-1350.
U.S. Citizen Identification Card	(This form was issued as Form I-197 until the 1980s by INS. Although no longer issued, holders of this document may still use it consistent with the provisions of section 1903(x) of the Act. Note that section 1903(x) of the Act incorrectly refers to the same document as an I-97). INS issued the I-179 from 1960 until 1973. It revised the form and renumbered it as Form I-197. INS issued the I-197 from 1973 until April 7, 1983. INS issued Form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.
Northern Mariana Card (I-873)	Issued by the DHS to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 4, 1986). The former Immigration and Naturalization Service (INS) issued the I-873 to a collectively naturalized citizen of the U.S. who was born in the NMI before November 4, 1986. The card is no longer issued, but those previously issued are still valid.
American Indian Card (I-872)	(Issued by DNS to identify a member of the Texas Band of Kickapoos living near the U.S./Mexican border). DHS issues this card to identify a member of the Texas Band of Kickapoos living near the

LEVEL 2 – Secondary Documents	Explanation – Level 2
	U.S./Mexican border. A classification code "KIC" and a statement on the back denote U.S. citizenship.
Final adoption decree showing the child's name and a U.S. place of birth	The adoption decree must show the child's name and U.S. place of birth. In situations where an adoption is not finalized **and** the State in which the child was born will **not** release a birth certificate prior to final adoption, a statement from a State-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.
Evidence of civil service employment by the U.S. government	The document must show employment by the U.S. government **before June 1, 1976.**
Official Military record of service	The document must show a U.S. place of birth (for example a DD-214 or similar official document showing a U.S. place of birth).
Child Citizenship Act of 2000	Adopted or biological children born outside the U.S. may establish citizenship obtained automatically under section 320 of the Immigration and Nationality Act (8 U.S.C. § 1431), as amended by the Child Citizenship Act of 2000 (Pub. L. 106-395, enacted October 30, 2000). The agency must obtain documentary evidence that verifies that at any time on or after February 27, 2001, the following conditions have been met: • At least one parent of the child is a United States citizen by either birth or naturalization (as verified under the Medicaid eligibility requirements); • The child is under the age of 18; • The child is residing in the United States in the legal and physical custody of the U.S. citizen parent; • The child was admitted to the United States for lawful permanent residence (as verified under the requirements of 8 U.S.C. 1641 pertaining to verification of qualified alien status); and • If adopted, the child satisfies the requirements of section 101(b)(1) of the Immigration and Nationality Act (8 U.S.C. § 1101(b)(1) pertaining to international adoptions (admission for lawful permanent residence as IR-3 (child adopted outside the United States)), or as IR-4 (child coming to the United States to be adopted) with final adoption having subsequently occurred).

3. LEVEL 3 – Third Level Documents to Establish U.S. Citizenship

Level 3 third level evidence of U.S. citizenship is documentary evidence of satisfactory reliability that is used when neither primary nor secondary evidence of citizenship is available. Third level evidence may be used ONLY when the following conditions exist:

- primary evidence cannot be obtained within the State's reasonable opportunity period (see reasonable opportunity discussion below),

- secondary evidence does not exist or cannot be obtained, **and**
- the applicant or recipient alleges being born in the U.S.

In addition, a second document establishing identity MUST be presented as described in Chart 5, "Evidence of Identity."

Third level evidence is generally a non-government document established for a reason other than to establish U.S. citizenship and showing a U.S. place of birth. The place of birth on the non-government document and the application must agree. Accept any of the documents listed in the Level 3 table as third level evidence of U.S. citizenship if the document meets the listed criteria, the applicant alleges birth in the U.S., and there is nothing indicating the person is not a U.S. citizen (e.g., lost U.S. citizenship).

LEVEL 3 - Third Level Documents	**Explanation – Level 3**
Extract of hospital record on hospital letterhead established at the time of the person's birth that was created 5 years before application and indicates a U.S. place of birth	An extract of a hospital record on hospital letterhead that was established at the time of the person's birth, that was created at least 5 years before the initial Medicaid application date and that indicates a U.S. place of birth is acceptable. Do not accept a birth certificate "souvenir" issued by the hospital. NOTE: For children under 16, the document must have been created near the time of birth or 5 years before the date of application.
Life, health or other insurance record created at least 5 years before initial Medicaid application date and indicates a U.S. place of birth	Life, health or other insurance records may show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth and it was created at least 5 years before the initial Medicaid application date. NOTE: For children under 16, the document must have been created near the time of birth or 5 years before the date of application.
Religious record recorded in the U.S. showing a U.S. place of birth	Religious record recorded in the U.S. within 3 months of birth showing the birth occurred in the U.S. and showing either the date of the birth or the individual's age at the time the record was made. The record must be an official record recorded with the religious organization.
	CAUTION: In questionable cases (for example, where the child's religious record was recorded near a U.S. international border and the child may have been born outside the U.S.), the agency must verify the religious record and/or document that the individual's mother was in the U.S. at the time of the individual's birth.
Early school record showing a U.S. place of birth	The early school record showing a U.S. place of birth must be from a Head Start program, a pre-school, kindergarten or elementary school (early school records do NOT include report cards). The school record must show the name of the child, the date of admission to the school, the date of birth, a U.S. place of birth, **and the name(s) and place(s) of birth of the applicant's parents.**

4. LEVEL 4 - Fourth Level Documents

Level 4 fourth level evidence of citizenship is documentary evidence of the lowest reliability. Fourth level evidence should ONLY be used in the rarest of circumstances. This level of evidence is used ONLY when primary evidence is not available, both secondary and third level evidence do not exist or cannot be obtained within the State's reasonable opportunity period, and the applicant alleges a U.S. place of birth. In addition, a second document establishing identity MUST be presented as described in Chart 5, Evidence of Identity. Available evidence is evidence that can be obtained within the State's reasonable opportunity period as discussed below.

Fourth level evidence, as described in the Level 4 table below, consists of documents established for a reason other than to establish U.S. citizenship and showing a U.S. place of birth. The U.S. place of birth on the document and the application must agree. Accept any of the documents listed in the Level 4 table as fourth level evidence of U.S. citizenship if the document meets the listed criteria, the applicant alleges U.S. citizenship, and there is nothing indicating the person is not a U.S. citizen (e.g., lost U.S. citizenship). A second document establishing identity must be presented.

The written affidavit described in the Level 4 table may be used only when the State is unable to secure evidence of citizenship listed in any other Level.

LEVEL 4 - Fourth Level Documents	Explanation – Level 4
Federal or State census record showing U.S. citizenship or a U.S. place of birth (Generally for persons born 1900 through 1950).	The census record must also show the applicant's age. NOTE: Census records from 1900 through 1950 contain certain citizenship information. To secure this information the applicant, recipient or agency should complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested." Add that the purpose is for Medicaid eligibility. This form requires a fee.
One of the documents listed that was created at least 5 years before the application for Medicaid	The other document must be one of the following documents that shows a U.S. place of birth and was created at least 5 years before the application for Medicaid. (For children under 16 the document must have been created near the time of birth or 5 years before the date of application.) This document must be one of the following and must show a U.S. place of birth: • Seneca Indian tribal census record, • Bureau of Indian Affairs tribal census records of the Navaho Indians, • U.S. State Vital Statistics official notification of birth registration, • A delayed U.S. public birth record that is recorded more than 5 years after the person's birth,

LEVEL 4 - Fourth Level Documents	Explanation – Level 4
	• Statement signed by the physician or midwife who was in attendance at the time of birth, or • The Roll of Alaska Natives maintained by the Bureau of Indian Affairs.
Institutional admission papers created at least 5 years before the **initial** application date	Institutional admission papers from a nursing facility, skilled nursing care facility, a local, state or federal prison or other institution created at least 5 years before the **initial** application date that indicate a U.S. place of birth are acceptable. Admission papers generally show biographical information for the person including place of birth. The record can be used to establish U.S. citizenship when it shows a U.S. place of birth.
Medical (clinic, doctor, or hospital) record created at least 5 years before the initial application date and indicates a U.S. place of birth.	Medical records generally show biographical information for the person including place of birth; the record can be used to establish U.S. citizenship when it shows a U.S. place of birth and was created at least 5 years before the initial application date. NOTE: An immunization record is not considered a medical record for purposes of establishing U.S. citizenship. NOTE: For children under 16 the document must have been created near the time of birth or 5 years before the date of Medicaid application.
Written affidavit of citizenship	Affidavits should ONLY be used in rare circumstances. When the LDSS is unable to secure any other form of documentation of citizenship listed above within the allowed processing time frame, a written affidavit described below may be accepted for citizens born in the U.S. and for naturalized citizens. The individual must also provide documentation of identity. **NOTE: The Affidavit of Identity for Medicaid Applicants/Recipients Under Age 16 cannot be used when an affidavit of citizenship is used.** If the citizenship documentation requirement needs to be met through affidavits, the following rules apply: • There must be at least two affidavits by two individuals who are United States citizens, including naturalized citizens, who have personal knowledge of the event(s) establishing the applicant's or recipient's claim of citizenship. • At least one of the individuals making the affidavit cannot be related to the applicant/recipient. Neither of the two individuals can be the applicant/recipient. • **In order for the affidavits to be acceptable, the persons making the affidavits must be able to provide proof of their own citizenship and identity.** • If the individuals making the affidavits have information which explains why documentary evidence establishing the

LEVEL 4 - Fourth Level Documents	Explanation – Level 4
Written affidavit of citizenship	applicant's claim of citizenship does not exist or cannot be readily obtained, the affidavit **must** contain this information as well. • The agency must obtain a separate affidavit from the applicant/recipient or other knowledgeable individual (or guardian or representative) explaining why the evidence does not exist or cannot be readily obtained. • The affidavits must be signed under penalty of perjury by the persons making the affidavits. The Affidavit of Citizenship On Behalf Of Medicaid Applicants and Recipients, to be used by the two persons attesting to the applicant/recipient's citizenship, is available on the intranet at: http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0280-00-eng.doc. The Affidavit of Citizenship By Medicaid Applicants and Recipients, to be used by the applicant/recipient or his guardian or authorized representative, is available on the intranet at: http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0281-00-eng.doc

5. CHART 5 - Evidence of Identity

Section 1903 (x) of the Act provides that identity must be established. When Level 1 primary evidence of citizenship is not available, a document from the Level 2, Level 3 or Level 4 tables above may be presented if accompanied by an identity document from the following Chart 5 Identity Documents table. The identity documents do not have a hierarchy of reliability.

Exception to Identity Documentation: Do not accept a **voter's registration card** or **Canadian driver's license** [as listed in 8 CFR 274a.2 (b) (1) (v) (B) (1)].

CHART 5 – Identity Documents	Explanation – Chart 5
Driver's license	A driver's license issued by State or Territory either with a photograph of the individual, or other identifying information such as name, age, sex, race, height, weight or eye color, is acceptable.
School identification card	A school identification card with the name and photograph of the individual is acceptable. The school ID card must be an official ID card issued by the school; unofficial ID cards such as those provided as a courtesy with school photographs, are not acceptable.

CHART 5 – Identity Documents	Explanation – Chart 5
United States military card or draft record	United States military card or draft record is acceptable.
Identification card issued by the Federal, State, or local government	An identification card issued by the Federal, State, or local government with the same information included on driver's licenses is acceptable. At a minimum, the ID must have the individual's name, address and photo. For photo ID cards, the photo must have been affixed to the ID card by the government agency that issued it. ID cards issued by a government agency that just have a space for the individual to attach a photo are NOT acceptable.
Military dependent's ID card	A military dependent's identification card is acceptable.
Native American Tribal document	A Native American Tribal document is acceptable.
United States Coast Guard Merchant Mariner card	A United States Coast Guard Merchant Mariner card is acceptable.
Certificate of Degree of Indian Blood, or other United States American Indian/Alaska Native tribal document	A Certificate of Degree of Indian Blood, or other United States American Indian/Alaska Native tribal document with a photograph or other personal identifying information relating to the individual is acceptable. The other personal identifying information relating to the individual on the document must be information such as age, weight, height, race, sex, and eye color.
State Agency Computer Data	Identifying information from a Virginia state governmental data system can be used to provide identity verification for applicants and recipients. A copy of the screen(s) from a state data system that shows the individual's name, DOB, gender and SSN is acceptable documentation of the individual's identity if the agency establishes the true identity of the individual. **NOTE: The state computer data base can only be used for identity verification; it cannot be used for verifying citizenship.**
Three or more corroborating documents	The agency may accept three or more documents that together reasonably corroborate the identity of an individual provided such documents have **not** been used to establish the individual's citizenship and the individual submitted second or third tier evidence of citizenship. The agency must first ensure that no other evidence of identity is available to the individual prior to accepting such documents. The documents must at a minimum contain the individual's name, plus any additional information establishing the individual's identity. All three documents used must contain consistent identifying information.

CHART 5 – Identity Documents	Explanation – Chart 5
Three or more corroborating documents	Examples of these documents include employer identification cards, high school and college diplomas from accredited institutions (including general education and high school equivalency diplomas), marriage certificates, divorce decrees and property deeds/titles.
Death Certificate	An official death certificate can be used to verify the identity of a deceased Medicaid applicant. NOTE: a death certificate CANNOT be used to verify citizenship.
Special identity rules for children under age 16	For children under 16, when the application form does not contain the parent or caretaker's statement of identity for children under age 16, a clinic, doctor, hospital or school record may be accepted for purposes of establishing identity. School records may include nursery or child care records and report cards that contain the required information. The school, nursery or daycare record must contain the child's name, date of birth, place of birth and the parents' names. The form agencies should use to request the school, nursery or daycare record is posted on the intranet. The school record request form workers can give to a child's parent or caretaker to give to the school is posted to the intranet at: http://localagency.dss.virginia.gov/divisions/bp/me/citizenship/forms.cgi.
	a. Foster Care and Title IV-E Adoption Assistance Children All foster care children and Title IV-E Adoption Assistance children are excluded from the citizenship and identity verification requirements. Non-Title-IV-E Special Medical Needs children and non-Title-IV-E adoption assistance children must verify their citizenship and identity. **b. Written affidavit of identity** **For children under 16 only,** an affidavit of identity may be used when the application or renewal form does not contain the identity affidavit language. An affidavit is only acceptable if it is signed under penalty of perjury by a parent or caretaker stating the date and place of the birth of the child and **cannot be used if an affidavit for citizenship was provided for the child.** The Affidavit of Identity for Medicaid Applicants and Recipients Under Age 16 is available on the LDSS Intranet at: http://localagency.dss.virginia.gov/divisions/bp/files/me/citizenship/forms/032-03-0282-02-eng.pdf and may be sent to the parent or caretaker with the application or renewal form that does not contain the identity affidavit language when the agency is aware that a child under age 16 is in the home. The Application for Health Insurance for Children and Pregnant Women (FAMIS 1) and the Families& Children Medicaid and FAMIS Plus Renewal form contain an area for the parent or caretaker to attest

CHART 5 – Identity Documents	Explanation – Chart 5
Special identity rules for children under age 16	to the identity of a child under age 16. The forms are available on the intranet. A separate affidavit of identity is not necessary when the parent or caretaker has attested to identity on the application or renewal form. The affidavit of identity, or the attestation of identity on the original application form, remains valid when the child reaches age 16 or older, as long as the child remains continuously enrolled in Medicaid. If the child's enrollment is canceled and he reapplies after turning age 16, his identity must be verified.
Special rules for individuals in institutions	The agency may accept an identity affidavit signed under penalty of perjury by a director or administrator of a residential care facility (such as an assisted living facility or group home), nursing home or hospital on behalf of an institutionalized individual who is residing or is an inpatient in the facility. The affidavit is not required to be notarized. **The agency should first pursue other means of verifying identity prior to accepting an affidavit.** The Affidavit of Identity for Medicaid Applicants/Recipients Residing in an Institution form is available on the intranet at: http://localagency.dss.virginia.gov/divisions/bp/me/citizenship/forms.cgi.

C. Agency Actions

1. Documentation From Case Record and Individual

Documentation of citizenship and/or identity may be obtained from a number of different sources including the following:

- Existing LDSS agency records as long as the documentation conforms to Medicaid policy for citizenship and identity verification in M0220 of the Medicaid Eligibility Manual.

- Applicants and Recipients. All applicants and recipients, **except** SSI recipients, Medicare beneficiaries, SSDI beneficiaries, individuals born to Medicaid-eligible mothers, all foster care children and IV-E Adoption Assistance children, must provide documents that show proof of United States citizenship and proof of the person's identity. Contact information for obtaining the various acceptable documents is available on the VDSS local agency intranet and the DSS public website and may be given to individuals to facilitate their obtaining documentation.

- *DMAS, for individuals born in Puerto Rico who are unable to provide a birth certificate issued on or after July 1, 2010. Contact the Regional Medical Assistance Program Specialist for assistance.*

Original documents may be viewed by all eligibility, administrative, and services staff of the LDSS as long as the person viewing the document makes a copy of the document, notes that the original was viewed, and signs and dates the copy.

2. Authorized Representative

For individuals who have authorized representatives, such as the disabled or individuals who are institutionalized, initiate efforts to assist in securing documentation with the appropriate representative.

In those instances in which an authorized representative lives in another locality than the Medicaid enrollee and the authorized representative's LDSS is more convenient to them than the locality where the case is maintained, a LDSS may copy and verify an original document for an authorized representative. The LDSS is not to give the copy to the client's representative; the agency staff must send it to the LDSS that holds the Medicaid enrollee's case. In this way, the "chain of evidence" is not broken—it has always stayed within DSS.

A local DSS agency may accept the copy as verification providing another LDSS:

- saw the original document,
- made the copy of the original,
- wrote on the copy that the staff member saw the original document on (date), and
- signed and dated the copy.

3. Documents From Other Approved Organizations

Original citizenship and identity documents can be accepted from other organizations approved by DMAS when the original document is viewed, the authorized person makes a copy and affixes a statement to the copy that has the following information:

- the original document was viewed and copied by (name and title of the individual who viewed the documentation), signature of staff member who saw the original,
- the name of the entity with which the individual is affiliated, and
- the date the documentation was viewed and copied.

DMAS has approved documentation copies from the following:

- an established outreach organization,
- local health department,
- Department of Corrections personnel for prisoners leaving the correctional system,
- Federally Qualified Health Centers (FQHC),
- hospital discharge planners or social workers.

Two lists of approved organizations are posted on the local agency intranet site: "Project Connect and Independent Outreach Projects List" and "FQHC-Virginia Primary Care Association Membership Roster".

Hospital contractors, such as Chamberlin-Edmonds, are **not** considered authorized to view original documents.

4. DMAS FAMIS Plus Unit

Original documents can be viewed by local department of social services (LDSS) for applications handled by the Department of Medical Assistance Services (DMAS) FAMIS Plus Unit. As a service to clients, staff from any LDSS is to view an original document, make a copy, and note on the copy that the original was viewed, including the date and signature of the staff person. The LDSS are to send or fax the annotated copy to the DMAS FAMIS Plus

Unit. The DMAS FAMIS Plus Unit will accept the copy and place it in the record. This process will significantly reduce the likelihood of important and possibly irreplaceable documents being misplaced or destroyed.

5. Birth Certificate Viewed By Out-of-State Agency

Local agencies are to accept copies of out-of-state birth certificates if the copies have statements on or attached to them that say the original birth certificates were viewed by staff of the issuing state's Department of Social Services or Medicaid state agency, and the statements are signed and dated by the issuing state's staff who viewed the originals.

6. Individuals Who No Longer Meet Exception

When an individual loses the exception status, and his citizenship and identity has not been previously verified, it must be verified for him to remain eligible for Medicaid. If the individual's eligibility in another covered group must be determined (due to the loss of SSI benefits, for example), obtain the documentation of citizenship and identity at the time of the eligibility review. If the verification is not readily available, the individual must be allowed a reasonable opportunity to obtain the documentation. See M0220.100 A 3.

Verify the SSI recipient's or Medicare beneficiary's entitlement to benefits through SVES or SOLQ-I. A copy of the SVES or SOLQ-I printout must be placed in the case file.

7. Individual NOT Required to Submit Documents in Person

Individuals do not have to submit their citizenship and identity to the agency worker in person. They may mail-in the **original document** for the agency to copy and mail back to the individual, with the exception of a copy of a Virginia birth certificate which may be furnished rather than the original. The worker must write on the copy made for the case record that "the original document was viewed on (date) and the original was mailed back to the individual on (date)."

For individuals who need assistance securing a birth certificate, LDSS may request Virginia birth record verification via BRVS without receiving additional approval from the recipient beyond the recipient's original signature on the application for Medicaid. If the result of a BRVS request is "unverified," however, the individual is to be notified that documentation of citizenship is needed and allowed the reasonable opportunity period to secure the documentation (see M0220.100 A 3).

8. Special Populations Needing Assistance

The agency shall assist special populations who need additional assistance, such as the homeless, mentally impaired, or physically incapacitated individual who lacks someone who can act on his behalf, to provide necessary documentation.

For individuals born in Virginia who are mentally impaired or physically incapacitated and lack someone who can act on their behalf, the agency should initiate action to secure the documentation for these individuals using the BRVS to request Virginia birth verification. For individuals not born in another state, use the procedures described in the Procedures-Verifying Citizenship and Identity document posted on SPARK.

9. Failure to Provide Requested Verifications

Failure to provide satisfactory evidence of citizenship and identity, after being provided a reasonable opportunity to present such documentation, is to result in the termination of Medicaid.

A recipient who fails to cooperate with the agency in presenting documentary evidence of citizenship may be denied or terminated. Failure to cooperate consists of failure by a recipient or that individual's representative, after being notified, to take a required action within the reasonable opportunity time period.

10. Notification Requirements

Prior to the termination of benefits, the enrollee must be sent the Advance Notice of Proposed Action (Form 032-03-018) at least 10 calendar days (plus one day for mailing) prior to the effective date of the closure.

A Notice of Action and appeal rights must be sent to an individual whose application is denied because of failure to provide citizenship and/or identity verification.

11. Maintain Documents in Case Record

The agency must maintain copies of the documents used to verify citizenship and identity in the individual's case record or data base and must make the documents available for state and federal audits.

12. No Reporting Requirements

There are no monthly reporting requirements. However, the Medical Assistance Program Consultants may conduct reviews of cases where Medicaid eligibility was denied or terminated because of lack of citizenship and/or identity verification.

13. Refer Cases of Suspected Fraud to DMAS

If documents are determined to be inconsistent with pre-existing information, are counterfeit, or are altered, refer the individual to DMAS for investigation into potential fraud and abuse. See section M1700.200 for fraud referral procedures.

Sample Letters of Certification/Eligibility for Victims of a Severe Form of Trafficking

[Used For Adults]

HHS Tracking Number

(Address)

CERTIFICATION LETTER

Dear _____:

This letter confirms that you have been certified by the U.S. Department of Health and Human Services (HHS) pursuant to section 107 (b) of the Trafficking Victims Protection Act of 2000. Your certification date is _____. Certification does not confer immigration status.

With this certification, you are eligible for benefits and services under any Federal or State program or activity funded or administered by any Federal agency to the same extent as an individual who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act, provided you meet other eligibility criteria.

You should present this letter when you apply for benefits or services. Benefit-issuing agencies should call the trafficking verification line at (866) 401-5510 to verify the validity of this document and to inform HHS of the benefits for which you have applied.

Sincerely,

[Signed]
Director/Acting Director
Office of Refugee Resettlement

Sample Letters of Certification/Eligibility for Victims of a Severe Form of Trafficking

[Used For Children Under Age 18 Years]

HHS Tracking Number

(Address)

Dear _____:

This letter confirms that pursuant to section 107 (b) of the Trafficking Victims Protection Act of 2000, you are eligible for benefits and services under any Federal or State program or activity funded or administered by any Federal agency to the same extent as an individual who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act, provided you meet other eligibility criteria.

Your initial eligibility date is _____. This letter does not confer immigration status.

You should present this letter when you apply for benefits or services. Benefit-issuing agencies should call the trafficking verification line at (866) 401-5510 to verify the validity of this document and to inform HHS of the benefits for which you have applied.

Sincerely,

[Signed]
Director/Acting Director
Office of Refugee Resettlement

SSA Quarters of Coverage Verification Procedures for Lawful Permanent Residents

This appendix contains the process for determining the number of qualifying quarters (QQ) with which a lawful permanent resident (LPR) who entered the U.S. on or after 8-22-96 can be credited and is to be used in conjunction with the State Verification Exchange System (SVES) User Guide.

I. Procedures:

A. To determine the number of QQ available to a LPR applicant, ask the applicant the following questions:

1. How many years has the applicant, the applicant's spouse, or the applicant's parents (before the applicant turned 18) lived in this country?

2. How many years has the applicant, the applicant's spouse, or the applicant's parents (before the applicant turned 18) commuted to work in the U.S. from another country before coming to the U.S. to live, or worked abroad for a U.S. company, or worked in self-employment while a legal resident of the U.S.?

   (If the total number of years to both questions is less than 10 years, **STOP** because the applicant cannot meet the 40 QQ requirement.)

3. In how many of the years reported in the answer to question 1 did the applicant, the applicant's spouse, or the applicant's parent earn money through work?

B. To determine whether the applicant's earnings were sufficient to establish "quarters of coverage" in those years, refer to the income chart in section II .

   If the answer to question 3 is 10 years or more, verify from INS documents or other documents the date of entry into the country for the applicant, spouse and/or parent. If the dates are consistent with having 10 or more years of work, initiate a SVES inqiuiry.

C. Complete or obtain from the applicant a completed "Consent for Release of Information" (see page 4 of this appendix) with the full name, social security number and date of birth of each individual (self, spouse, or parent) whose work history is relevant. In addition, the applicant must provide a form signed by each such individual, except deceased persons, giving SSA permission to release information through SVES on that individual to the agency and/or the applicant. Retain the consent form in the case file to document the individual's consent. A consent form is valid for 12 months from the time of the signature.

D. Information received through SVES will not report earnings for the current year nor possibly the last year's earnings (i.e. the lag period). The SVES report will also not include employment that is not covered under Social Security (i.e. not requiring payment of FICA/Social Security tax). The applicant must provide verification of earnings through pay stubs, W-2 forms, tax records, employer records, or other documents, if quarters of the lag period or non-covered employment are needed to meet the 40-quarter minimum. Use the information contained in section II to determine QQ for lag periods and non-covered earnings.

If the alien believes the information from SSA is inaccurate or incomplete, beyond the current two-year lag period, advise the applicant to provide the verification to SSA to correct the inaccurate income records.

In evaluating the verification received directly from the applicant or through SVES, **exclude** any quarter, beginning January 1997, in which the person who earned the quarter received benefits from the TANF, SSI, or Medicaid, or SNAP Programs or the food assistance block grant program in Puerto Rico.

E. In situations when consent to release information through SVES cannot be obtained from a parent or spouse, other than death, request information about quarters of coverage directly from the Social Security Administration. Complete or obtain from the applicant a Request for Quarters of Coverage (QC) History Based on Relation form, SSA-513. The form specify the period(s) for which the verification is requested. Submit the completed from to:

Social Security Administration
P.O. Box 33015
Baltimore, Maryland 21290-3015

F. When the SSA is unable to determine if a quarter should be allowed, the SVES inquiry will show "Z" or "#" codes. If an applicant cannot meet the 40-quarter minimum without using a questionable quarter, SSA will investigate the questionable quarter(s) and will either confirm or deny the quarter. Use Form SSA-512, "Request to Resolve Questionable Quarters of Coverage (QC)," to resolve quarters before 1978. A copy of the SVES report must accompany the completed form. Submit Form SSA-512 to:

Social Security Administration
Office of Central Records Operations
P.O. Box 33015
Baltimore, Maryland 21290-3015

For questionable quarters for 1978 or later, the applicant must complete Form SSA-7008. "Request for Correction of Earnings." This form is available at local SSA offices. At the top of the form write "Welfare Reform." Submit the form and proof of earnings to:

Social Security Administration
Office of Central Records Operations
P.O. Box 30016
Baltimore, Maryland 21290-3016

II. Establishing Quarters:

Use the following information to (1) determine whether the applicant's earnings as reported in section I.A were sufficient to establish quarters of coverage and (2) to determine the number of QQ during lag periods and when the reported employment is not a covered earning for Social Security reporting purposes:

- A quarter is a period of 3 calendar months ending with March 31, June 30, September 30 and December 31 of any year.

- Social Security quarters of coverage are credits earned by working at a job or as a self-employed individual. A maximum of four credits or quarters can be earned each year.

- For 1978 and later, credits are based solely on the total yearly amount of earnings. The number of creditable QQ are obtained by dividing the total earned income by the increment amount for the year. All types of earnings follow this rule. The amount of earnings needed to earn a credit increases and is different for each year. The amount of earnings needed for each credit and the amount needed for a year in order to receive four credits are listed below.

Year	Quarter Minimum	Annual Minimum	Year	Quarter Minimum	Annual Minimum
1978	$250	$1000	1991	$540	$2160
1979	$260	$1040	1992	$570	$2280
1980	$290	$1160	1993	$590	$2360
1981	$310	$1240	1994	$620	$2480
1982	$340	$1360	1995	$630	$2520
1983	$370	$1480	1996	$640	$2560
1984	$390	$1560	1997	$670	$2680
1985	$410	$1640	1998	$700	$2800
1986	$440	$1760	1999	$740	$2960
1987	$460	$1840	2000	$780	$3120
1988	$470	$1880	2001	$830	$3320
1989	$500	$2000	2002	$870	$3480
1990	$520	$2080	2003	$890	$3560

- A current year quarter may be included in the 40-quarter computation. Use the current year amount as the divisor to determine the number of quarters available.

If you need to use quarters before 1978:

- A credit was earned for each calendar quarter in which an individual was paid $50 or more in wages (including agricultural wages for 1951-1955);

- Four credits were earned for each taxable year in which an individual's net earnings from self-employment were $400 or more; and/or

- A credit was earned for each $100 (limited to a total of 4) of agricultural wages paid during the year for years 1955-1977.

Social Security Administration OMB No. 0960-0567

Consent for Release of Information

TO: Social Security Administration

Name	Date of Birth	Social Security Number
_____	_____	_____

I authorize the Social Security Administration to release information or records about me to:

NAME	ADDRESS
_____	_____
_____	_____
_____	_____
_____	_____

I want this information released because:

_____
_____
_____
_____

(There may be a charge for releasing information.)

Please release the following information:

_____ Social Security Number
_____ Identifying information (includes date and place of birth, parents' names)
_____ Monthly Social Security benefit amount
_____ Monthly Supplemental Security Income payment amount
_____ Information about benefits/payments I received from _____ to _____
_____ Information about my Medicare claim/coverage from _____ to _____
(specify) _____
_____ Medical records
_____ Record(s) from my file (specify) _____
_____
_____ Other (specify) _____

I am the individual to whom the information/record applies or that person's parent (if minor) or legal guardian. I know that if I make any representation which I know is false to obtain information from Social Security records, I could be punished by a fine or imprisonment or both.

Signature: _____

(Show signatures, names and addresses of two people if signed by mark.)

Date: _____ Relationship: _____

SSA-3288

OMB NO: 0960-0575

Date of Request_____

REQUEST TO RESOLVE QUESTIONABLE QUARTERS OF COVERAGE (QC)

Complete the information below when the QC array contains either a (#) pound sign or code "Z" prior to 1978. Mail the form and a copy of the system's printout to the Social Security Administration, PO Box 17750, Baltimore, MD. 21235-0001.

Print
Name: _____ _____ _____
Last First MI

SSN_____-_____-_____ Date of Birth _____-_____-_____
MM DD YY

Request Years

19_____, 19_____, 19_____, 19_____, 19_____, 19_____,

19_____, 19_____, 19_____, 19_____, 19_____, 19_____,

20_____, 20_____, 20_____.

OR

19_____ thru 19_____, 19_____ thru 19_____, 19_____, thru 19_____,

20_____ thru 20_____.

State's Name & Address _____

_____

_____

Contact Person's Name _____
&
Telephone Number _____

The Paperwork Reduction Act of 1995 requires us to notify that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number.

SSA-512

Date of Request _________ QMB NO: 0960-0575

REQUEST FOR QUARTERS OF COVERAGE (QC) HISTORY BASED ON RELATIONSHIP

Complete the information below when requesting QC history for spouse(s) or parent (s) of a lawfully admitted non-citizen applicant. Mail the form to the Social Security Administration, PO Box 17750, Baltimore, MD 21235-0001.

Print Name: ________________________ ________________________ _________
Last First MI

SSN ________-________-________ Date of Birth ______-______-______
MM DD YY

Relationship to Applicant ________________________________

NOTE: COMPLETE THE YEAR COLUMN AND CIRCLE THE PERTINENT QUARTER (S) FOR THE YEAR. SSA WILL PROVIDE INFORMATION ONLY FOR YEARS AND QUARTERS YOU INDICATE.

YEAR	QC PATTERN 1ST Q	2nd Q	3RD Q	4TH Q	YEAR	QC PATTERN 1ST Q	2nd Q	3RD Q	4TH Q
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____	_____	_____
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_____	_____	_____	_____	_____	_____	_____	_____	_____	_____

State's Name & Address ____
____
____

Contact Person's Name & Telephone Number ____
____

FORM SSA-513 (9/97)

Commonwealth of Virginia
Department of Social Services

APPLICANT'S NAME:

_____

CASE NUMBER:

EMERGENCY MEDICAL CERTIFICATION

TO: DIVISION OF PROGRAM OPERATIONS
DEPT. OF MEDICAL ASSISTANCE SERVICES
600 EAST BROAD STREET, SUITE 1300
RICHMOND, VA 23219

I. REFERRAL SECTION

THE ABOVE-NAMED INDIVIDUAL HAS APPLIED FOR MEDICAID. A DETERMINATION OF EMERGENCY NEED AND DURATION IS NEEDED NO LATER THAN _____.
(DATE)

INDIVIDUAL'S STATUS: ☐ A ☐ B ☐ C
ATTACHED IS INFORMATION ON THE EMERGENCY MEDICAL TREATMENT.

SIGNED: _____WORKER #:_____*TELEPHONE #*_____DATE: _____

AGENCY NAME:_____

AGENCY ADDRESS:_____

II. CERTIFICATION SECTION

I HAVE REVIEWED THE MEDICAL EVIDENCE AND DETERMINED THAT THE MEDICAL CONDITION
☐ IS AN EMERGENCY ☐ IS NOT AN EMERGENCY

THE REASON FOR DETERMINATION, OR SPECIFICS OF COVERED SERVICES AND DURATION OF COVERAGE ARE DETAILED BELOW.

SIGNED:_____TITLE:_____*TELEPHONE #*_____DATE:_____

III. NOTIFICATION SECTION

TO: MEDICAID SERVICE PROVIDERS

☐ THE ABOVE-NAMED INDIVIDUAL HAS BEEN DETERMINED INELIGIBLE FOR MEDICAID BENEFITS.

REASON FOR DENIAL:_____

☐ THE ABOVE-NAMED INDIVIDUAL IS ELIGIBLE FOR MEDICAID TO COVER EMERGENCY SERVICES. ONLY SERVICES DIRECTLY RELATED TO THE EMERGENCY ARE COVERED FOR THE TIME PERIOD SPECIFIED BELOW. THIS FORM SERVES AS YOUR NOTIFICATION OF ELIGIBILITY IN LIEU OF A MEDICAID CARD. IF YOU HAVE ANY QUESTIONS, CALL THE PROVIDER HELPLINE AT 1-800-552-8627.

PERIOD OF COVERAGE: _____

MEDICAID NUMBER: _____

OTHER INSURANCE: _____

SIGNED: _____TITLE: _____DATE:_____

Appendix 4: EMERGENCY MEDICAL CERTIFICATION

FORM NUMBER - 032-03-628

PURPOSE

1. To request from the Department of Medical Assistance Services (DMAS) certification that the medical service received by an emergency services alien was an emergency.

2. To certify that the medical service was an emergency as defined by law and to provide the reason(s) for the decision and the duration of the emergency coverage.

3. To notify the medical service provider(s) that the emergency services alien is either ineligible or eligible for Medicaid, and for what coverage period, in lieu of generating a Medicaid card.

USE OF FORM - Completed for all emergency services alien applicants.

NUMBER AND DISTRIBUTION OF COPIES - Prepare original; make copy for agency record before sending original to DMAS. DMAS will complete Section II and return the "Local Agency" and "Emergency Service Provider" copies to the agency. After completing Section III, the agency will keep the "Local Agency" copy of the original in the eligibility case folder and send the "Emergency Service Provider" copy to the provider(s).

Forms must be retained for a period of three years following the current fiscal year if a federal audit has been made within that period and no audit questions have been raised. If such an audit has not been made within that time, the form must be retained until an audit has been made or until the end of five years following the current fiscal year, whichever is earlier. In all cases, if audit questions are raised, the form must be retained until the questions are resolved.

INSTRUCTIONS FOR PREPARATION OF FORM

SECTION I - REFERRAL SECTION -Enter the date which is 45 days or 90 days if applicant is applying as disabled) from the application date in the blank marked "(Date)". Check the individual's status; "A" for the Qualified Alien, "B" for the Unqualified Aliens and "C" for the Undocumented Alien. The worker must sign his/her own name and worker number, *telephone number*, the date the section was completed and the agency name and address.

SECTION II - CERTIFICATION SECTION - The authorized DMAS staff person completes this section, signs his/her name, title, *telephone number* and the date, keeps the copy marked "DMAS", and sends the original and provider copy back to the agency.

SECTION III - NOTIFICATION SECTION - The worker checks the appropriate box. If the applicant is ineligible, briefly state why. If the applicant is eligible, note the begin and end dates of coverage and the recipient's Medicaid I.D. number, and other health insurance. The worker must sign his/her own name, title, *telephone number* and the date this section was completed, which should also be the date this notice is sent to the emergency service provider. Send the carbon copy marked "Emergency Service Provider" to the provider(s) of emergency services received within the coverage period. This notice serves in place of a Medicaid card as verification of the applicant's Medicaid coverage. A separate "Notice of Action on Medicaid" form #032-03-008 is sent to the applicant and **no Medicaid card is generated.**

Line Item	MEDICAID ALIEN CODE CHART QUALIFIED ALIEN GROUPS	Arrived Before August 22, 1996	Arrived On or After August 22, 1996	
			1st 5 years	After 5 years
A	Qualified aliens who are Veterans or Active Military (includes spouses/dependent children); certain American Indians [Form DD 214-veteran]	Full Benefit A1	Full Benefit A2	Full Benefit A3
B	Permanent Resident Aliens (Aliens lawfully admitted for permanent residence) who have worked 40 qtrs., except Amerasians [I-151; AR-3a; I-551; I-327; I-688B-274a.12(a)(1)]	Full Benefit B1	Emergency Only B2	Full Benefit B3
C	Permanent Resident Aliens (Aliens lawfully admitted for permanent residence) who have NOT worked 40 qtrs., except Amerasians [I-327; I-151; AR-3a; I-551; I688B-274 a.12(a)(1)]	Full Benefit C1	Emergency Only C2	Emergency Only C3
			1st 7 years	After 7 years
D	Conditional entrants-aliens admitted pursuant to 8 U.S.C. 1153(a)(7), section 203(a)(7) of the INA [I-94]	Full Benefit D1	Emergency Only D2	Emergency Only D3
E	Aliens, other than Cuban or Haitian Entrants, paroled in the US pursuant to 8 U.S.C. 1182(d)(5) section 212(d)(5) of INA [I-94; I-688B – 274a(12)(c)(11)]	Full Benefit E1	Emergency Only E2	Emergency Only E3
F	Aliens granted asylum pursuant to section 208 of the INA [I-94; I-688B – 274a.12(a)(5)]	Full Benefit F1	Full Benefit F2	Emergency Only F3
G	Aliens admitted as refugees pursuant to section 207 of the INA, or as Cuban or Haitian Entrants as defined in section 501(e) of Refugee Education Assistance Act of 1980 {including those under section 212(d)(5)}, or Amerasians [I-551; I-94; I-688B]	Full Benefit G1	Full Benefit G2	Emergency Only G3
H	Aliens whose deportation has been withheld pursuant to Section 243(h) or 241(b)(3) of the INA [I-688B – 274a.12(a)(10); Immigration Judge's Order]	Full Benefit H1	Full Benefit H2	Emergency Only H3
I	Battered aliens, alien parents of battered children, alien children of battered parents [U.S. Attorney General]	Full Benefit I1	Emergency Only I2	Emergency Only I3
J	Victims of a Severe Form of Trafficking pursuant to the Trafficking Victims Protection Act of 2000, P.L. 106-386 [ORR Certification/eligibility Letter]	N/A J1	Full Benefit J2	Emergency Only J3

	UNQUALIFIED ALIEN GROUPS	Arrived Before 8-22-96	Arrived On or After 8-22-96	
K	Aliens residing in the US pursuant to an indefinite stay of deportation [I-94; Immigration Letter]	Emergency Only K1	Emergency Only K2	Emergency Only K3
L	Aliens residing in the US pursuant to an indefinite voluntary departure [I-94; Immigration Letter]	Emergency Only L1	Emergency Only L2	Emergency Only L3
M	Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition who are entitled to voluntary departure under 8 CFR 242.5(a)(2)(vi) and whose departure the INS does not contemplate enforcing [I-94; I-210]	Emergency Only M1	Emergency Only M2	Emergency Only M3
N	Aliens who have filed an application for adjustment of status pursuant to §245 INA that the INS has accepted as properly filed and whose departure the INS does not contemplate enforcing [I-181; Endorsed Passport]	Emergency Only N1	Emergency Only N2	Emergency Only N3
O	Aliens granted stay of deportation by court order, statute or regulation, or by individual determination of the INS whose departure the agency does not contemplate enforcing [I-94; Court Order; INS Letter]	Emergency Only O1	Emergency Only O2	Emergency Only O3
P	Aliens granted voluntary departure pursuant to section 242(b) of the INA whose departure the INS does not contemplate enforcing [I-94; I-210; I-688B – 247a.12(a)(11) or (13)]	Emergency Only P1	Emergency Only P2	Emergency Only P3
Q	Aliens granted deferred action status pursuant to INS Operations Instruction 103.1(a)(ii) prior to 6/15/84 or 242.1a22 issued 6/15/84 and later [I-210; INS Letter]	Emergency Only Q1	Emergency Only Q2	Emergency Only Q3
R	Aliens residing in the U.S. under orders of supervision [I-220B]	Emergency Only R1	Emergency Only R2	Emergency Only R3
S	Aliens who entered before January 1972 and have continuously resided in the U.S. since January 1972 [Case Record]	Emergency Only S1	Emergency Only S2	Emergency Only S3

	UNQUALIFIED ALIEN GROUPS **(cont.)**	**Arrived Before 8-22-96**	**Arrived On or After 8-22-96**	
T	Aliens granted suspension of deportation pursuant to Section 244 of the INA and whose deportation the USCIS does not contemplate enforcing [Immigration Judge Court Order]	Emergency Only T1	Emergency Only T2	Emergency Only T3
U	Any other aliens living in the US with the knowledge and permission of the USCIS whose departure the agency does not contemplate enforcing [USCIS Contact]	Emergency Only U1	Emergency Only U2	Emergency Only U3
V	Illegal aliens – aliens not lawfully admitted or whose lawful admission status has expired	Emergency Only V1	Emergency Only V2	Emergency Only V3
W	Visitors (non-immigrants): tourists, diplomas, foreign students, temp. workers, etc. [I-688B – 274a.12(b)(1)-(20); I-94; I-185: I-I186; SW-434; I-95A]	Emergency Only W1	Emergency Only W2	Emergency Only W3
	***LAWFULLY RESIDING NON-CITIZEN* CHILDREN UNDER AGE 19**			
Y	Non-citizen (alien) children under the age of 19 lawfully residing in the U.S. who meet the requirements in M0220.314.	**N/A**	Full Benefits	Full Benefits

	AFGHAN AND IRAQI SPECIAL IMMIGRANTS	**First 7 Years after Entry into U.S.**	**After 7 Years**
Z	Afghan and Iraqi Special Immigrants admitted on a Special Immigrant Visa (SIV), including the spouse and children under age 21 living in the home with the principal visa holder. [I-551 or passport/ I-94 indicating categories SI1, SI2, SI3, QQ1, SQ2, or SQ3 and bearing Department of Homeland Security stamp or notation]	Full Benefits Z1	Emergency Only Z2

Proof of U.S. Citizenship and Identity for Medicaid

Effective July 1, 2006, individuals who declare on a Medicaid application that they are United States citizens must provide proof of citizenship and identity. Individuals who are already enrolled in Medicaid must provide this documentation at the time of their next Medicaid renewal.

Some common documents that may be used to meet the citizenship and identity requirement are listed below. Representatives from your local department of social services can tell you what other documents may be acceptable. If you have difficulty obtaining one of the documents listed or have any questions, please discuss your situation with your eligibility worker. Whenever possible, we will allow additional time for you to obtain the necessary documentation.

The following documents are proof of both citizenship and identity; no additional documents are necessary to meet the Medicaid requirement to provide proof of citizenship and identity.

Document	Shows Proof Of	Issued By	Fee	For More Information, Contact
U.S. Passport (unexpired or expired)	Citizenship & Identity (if issued with limitation and expired, only shows proof of identity)	U.S. Department of State	Varies	(202) 647-4000 or www.state.gov
Certificate of Naturalization (N-550 or N-570)	Citizenship & Identity	U.S. Department of Homeland Security, Bureau of Citizenship and Immigration Services	Varies	1-800-375-5283 or www.uscis.gov
Certificate of Citizenship (N5-560 or N-561)—issued when a person was born outside U.S. to U.S. Citizen parent(s)	Citizenship & Identity	U.S. Department of Homeland Security, Bureau of Citizenship and Immigration Services	Varies	1-800-375-5283 or www.uscis.gov

The following documents may be used to prove citizenship only. You must also provide proof of identity.

Document	Shows Proof Of	Issued By	Fee	For More Information, Contact
U.S. Public Birth Record ("Birth Certificate")—must contain original embossed seal	Citizenship—(Must also provide proof of identity)	The state, commonwealth, territory or local jurisdiction	Va. Birth Cert. $12	For citizens born in Virginia: Department of Health, Division of Vital Records: (804) 662-6200 or www.vdh.virginia.gov (will also assist citizens born outside Virginia with finding contact information for their birth state)

Document	Shows Proof Of	Issued By	Fee	For More Information, Contact
Certification of Report of Birth (FS-240); Consular Report of Birth Abroad of a Citizen of the U.S.A. (FS-545), Certification of Birth Abroad (FS-545	Citizenship (Must also provide proof of identity)	U.S. Department of State	Varies	(202) 647-4000 or www.state.gov
American Indian Card (I-872)	Citizenship (Must also provide proof of identity)	U.S. Department of Homeland Security, Bureau of Citizenship and Immigration Services	Contact agency	1-800-375-5283 or www.uscis.gov
Final adoption decree (or statement from state-approved adoption agency if adoption is not finalized) —must show child's name and U.S. place of birth	Citizenship (Must also provide proof of identity)	The state in which the adoption was finalized	Possible copying fee	The court issuing the decree or the adoption agency that handled the adoption
Evidence of Civil Services Employment by the U.S. Government—must show employment by the U.S. government before June 1, 1976	Citizenship (Must also provide proof of identity)	U.S. Office of Personnel Management	Possible copying fee	1-888-767-6738 or www.opm.gov
Official Military Record of Service—must show a U.S. place of birth (e.g. DD-214)	Citizenship (Must also provide proof of identity)	National Archives Allow 6-8 weeks	None	1-866-272-6272 or www.vetrecs.archives.gov
Extract of hospital record on hospital letterhead (not a "birth certificate" issued by a hospital) — must have been established at the time of birth, created at least 5 years before initial application date for Medicaid, and indicate a U.S. place of birth	Citizenship (Must also provide proof of identity)	Hospital of birth	Possible copying fee	Hospital in which individual was born
Life or health or other Insurance Record—must have been created at least 5 years before the initial application date for Medicaid and show a U.S. place of birth	Citizenship (Must also provide proof of identity)	Insurance Company	Possible copying fee	Insurance company that issued the policy—contact information should be listed on the policy

Document	Shows Proof Of	Issued By	Fee	For More Information, Contact
A statement signed by the physician or midwife who was in attendance at the time of the birth—must have been created at least 5 years before the date of the initial Medicaid application and show a U.S. place of birth.	Citizenship (Must also provide proof of identity)	Physician or Midwife who delivered the individual	Possible copying fee	Physician or Midwife
Institutional admission papers from a nursing home or other institution or medical records—must have been created at least 5 years before the date of the initial Medicaid application and indicate a U.S. place of birth		Nursing home or other institution in which the individual resides or resided	Possible copying fee	Nursing home or other institution

The following documents may be used to prove identity when you provide proof of citizenship.

Document	Shows Proof Of	Issued By	Fee	For More Information, Contact
Certificate of Degree of Indian Blood; other U.S. American Indian/Alaska Native or Native American tribal document—must have a photograph of individual or other personal identifying information	Identity	U.S. Department of Interior, Bureau of Indian Affairs	Contact agency	(202) 208-3100 or www.doi.gov
Driver's license issued by a state or territory—must have a photograph of individual or other personal identifying information	Identity	State or Territory	$12 - $28	In Virginia, Division of Motor Vehicles: 1-866-368-5463 or www.dmv.virginia.gov
School identification (ID) card with photograph of individual	Identity	School	Contact agency	School or school district office
U.S. Military card or draft record; military dependent's ID card		Department of Veteran's Affairs	Contact agency	1-800-827-1000 or www.va.gov
Identification card issued by federal, state, or local government with the same information included on driver's licenses	Identity	Va. Division of Motor Vehicles issues non-driver ID cards	Va. ID $10	1-866-368-5463 or www.dmv.virginia.gov

CHAPTER M02
NONFINANCIAL ELIGIBILITY REQUIREMENTS
SUBCHAPTER 30

VIRGINIA RESIDENCY REQUIREMENTS

M0230 Changes

Changed With	Effective Date	Pages Changed
TN #95	3/3/11	pages 1, 2
TN #93	1/1/10	page 2

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M02 NONFINANCIAL ELIGIBILITY REQUIREMENTS

M0230.000 VIRGINIA RESIDENCY REQUIREMENTS

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M0230.000 VIRGINIA RESIDENCY REQUIREMENTS

M0230.001 POLICY PRINCIPLES

A. Policy

An individual must be a Virginia resident in order to be eligible for Medicaid, but is not required to have a fixed address. This subchapter, M0230, explains in detail how to determine if an individual is a Virginia resident.

An individual placed by a Virginia government agency in an institution is considered a Virginia resident for Medicaid purposes even when the institution is in another state (section M0230.203 below).

For all other individuals, Virginia residency is dependent on whether the individual is under age 21 years or is age 21 or older (sections M0230.201 and 202 below).

B. Retention of Residency

Residence is retained until abandoned. Temporary absence from Virginia with subsequent return to the state, or intent to return when the purposes of the absence have been accomplished, does not interrupt continuity of Virginia residence.

C. Non-immigrant Aliens

Aliens who are non-immigrants (visitors, temporary workers) usually do not meet the Virginia state residency requirements because their visas will expire on a definite date. Ask the non-immigrant alien "Where do you intend to live after your visa expires?" If the non-immigrant alien states in writing that he "intends to reside in Virginia permanently or indefinitely after his visa expires," then the non-immigrant alien has stated his intent to reside in Virginia permanently or indefinitely and can meet the Virginia residence eligibility requirement for Virginia Medicaid.

If an individual who signed a statement indicating that he does not intend to remain subsequently changes his mind, eligibility cannot begin prior to the date of the original statement.

D. Cross-Reference to Intra-State Transfer

Procedures for handling cases where individuals who are Virginia residents move from one Virginia locality to another are described in subchapter M1520.

E. No Fixed Address

The agency cannot deny Medicaid to an eligible Virginia resident just because the resident has no fixed address. A Virginia resident is not required to have a fixed address in order to receive Medicaid.

For an eligible Virginia resident who does not have a fixed address, use the local social services department's address for the Medicaid card and inform the resident that he must come to the social services department to receive his card until he obtains a fixed address.

F. Length of Residency

The agency may not deny Medicaid eligibility because an individual has not resided in Virginia for a specified period of time.

G. Residency in Virginia Prior to Admission to Institution

The agency may not deny Medicaid eligibility to an individual in an institution who meets the Virginia residency requirements previously identified in this subchapter, because the individual did not establish residence in Virginia before entering the institution.

H. Temporary Absence

The agency may not deny or terminate Medicaid eligibility because of that individual's temporary absence from Virginia if the individual intends to return to Virginia when the purpose of the absence has been accomplished, UNLESS another state has determined that the individual is a resident there for Medicaid purposes.

I. Disputed or Unclear Residency

If state residency is unclear or is in dispute, contact the regional specialist for help in resolution. When two or more states cannot resolve the residency, the state where the individual is physically located becomes the state of residence.

M0230.100 DEFINITION OF TERMS

A. Introduction

For purposes of this subchapter only, the terms in this section have the following meanings:

B. Institution

An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor is an **institution**.

For purposes of state placement of an individual, the term "institution" also includes foster care homes approved by the state and providing food, shelter and supportive services to one or more persons unrelated to the proprietor.

C. In An Institution

"In an institution" refers to an individual who is admitted to live in an institution and receives treatment or services provided there that are appropriate to his requirements.

D. Incapable of Indicating Intent

An individual is incapable of declaring his intent to reside in Virginia or any state if the individual:

- has an I.Q. of 49 or less or has a mental age of 7 or less, based on tests acceptable to the Virginia Department of Behavioral Health and Developmental Services (DBHDS);
- is judged legally incompetent; or
- is found incapable of declaring intent to reside in a specific state based on medical documentation obtained from a physician, psychologist, or other professional licensed by the State in the field of mental retardation.

E. Virginia Government Agency

A Virginia government agency is any state or local government agency, and any entity recognized by State law as being under contract with a Virginia state or local government agency.

M0230.200 RESIDENCY REQUIREMENTS

M0230.201 INDIVIDUALS UNDER AGE 21

A. Under Age 21 NOT In An Institution

1. Blind or Disabled

For any individual under age 21

- who is not residing in an institution (as defined above in M0230.100) AND
- whose Medicaid eligibility is based on blindness or disability,

the state of residence is the state in which the individual is living. If the individual lives in Virginia, he/she is a Virginia resident.

2. Other Individuals Under Age 21

An individual under age 21 who is **not** in an institution is considered a resident of Virginia if he/she:

a. is married or emancipated from his/her parents, is capable of indicating intent and is residing in Virginia with the intent to remain in Virginia permanently or for an indefinite period;

b. is presently living in Virginia on other than a temporary basis;

c. lives with a caretaker who entered Virginia as a result of a job commitment or a job search (whether or not currently employed) and is not receiving assistance from another state;

d. is a non-IV-E (state/local) foster care child whose custody is held by Virginia (see M230.204 C. and D.);

e. is a non-IV-E child adopted under an adoption assistance agreement with Virginia (see M230.204 C. and D.);

f. is a non-IV-E foster care child whose custody is held by a licensed, private foster care agency in Virginia, regardless of the state in which the child physically resides;

g. is under age 21 and is residing in another state for temporary period (for reasons such as medical care, education or training, vacation, (or visit) but is still in the custody of his/her parent(s) who reside in Virginia.

h. is living with a parent(s) who is a non-immigrant alien (admitted to the U.S. for a temporary or limited time) when the parent has declared his intent to reside in Virginia permanently or for an indefinite period of time, and no other information is contrary to the stated intent.

B. Under Age 21 In An Institution

If the individual was placed in the institution by a state government agent, go to section M0230.203 below.

An institutionalized individual (who was not placed in the institution by a state government) who is under age 21 and is not married or emancipated, is a resident of Virginia if:

1. the individual's parent or legal guardian was a Virginia resident at the time of the individual's institutional placement;

2. the individual's parent or legal guardian who applies for Medicaid is a Virginia resident and the individual is institutionalized in Virginia; or

3. the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia, and the party who files the Medicaid application resides in Virginia.

4. for an individual under 21, if a legal guardian has been appointed for the child and parental rights have been terminated, the guardian's state of residence is used instead of the parent's to determine residency.

C. Under Age 21, Custody or Adoption Agreement with Another State

When another state's child-placing agency has custody of a child who lives in Virginia with a foster family, the child is NOT a Virginia resident unless the child is eligible as a IV-E Foster Care child and receives a IV-E Foster Care maintenance payment.

1. IV-E Eligible Children

A Title IV-E Foster Care child who lives in Virginia and who receives a Title IV-E maintenance payment from another state meets the Virginia residency requirements for Medicaid.

A Title IV-E Adoption Assistance child who lives in Virginia and has a Title IV-E Adoption Assistance agreement in effect with another state's child-placing agency meets the Virginia residency requirements for Medicaid.

2. Non-IV-E Foster Care

A non-IV-E Foster Care child placed in Virginia from another state does NOT meet the Virginia residency requirements for Medicaid.

3. Non-IV-E Adoption Assistance and Adoptive Placement

A child who lives in Virginia with an adoptive family is considered to be living with a parent, regardless of whether a final order of adoption has been entered in court. When his adoptive parent is a Virginia resident, the child is a Virginia resident for Medicaid eligibility purposes. A Non-IV-E Adoption Assistance child whose adoption assistance agreement is signed by another state's child-placing agency is a Virginia resident when the child lives in Virginia with the adoptive parent(s).

M0230.202 INDIVIDUALS AGE 21 OR OLDER

A. Introduction

For an individual age 21 or older, the determination of state residency depends on

- whether or not the individual is in an institution, and
- whether or not the individual is capable of indicating his or her intent to reside in the state.

B. Age 21 Or Older NOT In An Institution

For any individual age 21 or older NOT residing in an institution, the state of residence is Virginia when:

- the individual is living in Virginia with the intention to remain in Virginia permanently or for an indefinite period;
- the individual is incapable of indicating intent and the individual is living in Virginia; or
- the individual is living in Virginia and entered the state with a job commitment or seeking employment (whether or not currently employed).

C. Age 21 Or Older In An Institution

If the individual was placed in the institution by a state government agent, go to section M0230.203 below.

1. Capable of Stating Intent

An individual in an institution who is age 21 or over and who is capable of declaring his intent to reside in Virginia, is a resident of Virginia if the individual is in an institution in Virginia with the intent to remain permanently or for an indefinite period.

2. Became Incapable Before Age 21

An individual in an institution who is age 21 or over and who became incapable of stating intent before age 21 is a Virginia resident if:

a. regardless of the physical location where the individual actually resides, Virginia is the individual's state of residence when the individual's legal guardian or parent who files the Medicaid application resides in Virginia;

b. the individual's parent or legal guardian was a Virginia resident at the time of the individual's institutional placement;

c. the individual's parent or legal guardian who applies for Medicaid resides in Virginia and the individual is institutionalized in Virginia; or

d. the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia and the party who files the Medicaid application resides in Virginia.

If a legal guardian has been appointed for the individual and parental rights have been terminated, the guardian's state of residence is used instead of the parent's to determine residency.

3. Became Incapable At or After Age 21

An individual in an institution who is age 21 or over and who became incapable of stating intent at or after age 21 is a Virginia resident if he or she is residing in Virginia and was not placed here by another state.

M0230.203 STATE PLACEMENT IN INSTITUTION

A. Policy

Any agency of the state, including an entity recognized under state law as being under contract with the state for such purposes, that arranges for an individual to be placed in an institution located in another state, is recognized as acting on behalf of the state in making the placement. The state arranging or actually making the placement is considered the individual's state of residence. When an individual is placed by state or local government in an institution in another state, the individual remains the responsibility of the placing state unless the state or local government agency in the other state assumes responsibility for the individual's care or Medicaid eligibility.

When an individual is placed by a Virginia government agency in an institution in another state, the individual remains the responsibility of Virginia unless

- a state or local government agency in the other state assumes responsibility for the individual's care or Medicaid eligibility,
- the individual is a child who receives a IV-E foster care or adoption assistance payment, or
- the individual is a child who receives **non-IV-E adoption assistance** and the state in which he is placed is a reciprocal state under the interstate compact, verified by the central office Deputy Compact Administrator, Adoption Unit, Division of Family Services, Virginia Department of Social Services (DSS).

B. State Placement

Placement by a state government agency is any action taken by the agency, beyond providing general information to the individual and *his* family, to arrange admission to an institution for the individual. The following actions do not constitute state placement:

- providing basic information to individuals about other states' Medicaid programs or about the availability of health care services and facilities in other states;
- assisting an individual, who is capable of declaring intent and who independently decides to move out-of-state, in locating an institution in another state.

1. Lack Of Facilities

When a placement is initiated by a state because the state lacks a sufficient number of appropriate facilities to provide services to its residents, the state making the placement is the individual's state of residence for Medicaid purposes.

2. Individual Leaves Facility

When a competent individual leaves the facility in which he was placed by a state, that individual's state of residence for Medicaid purposes is the state where the individual is physically located.

C. Individual Placed Out-of-State by Virginia Government

An individual can leave Virginia and retain Virginia residency if he is placed in an institution outside Virginia by a Virginia government agency. Out-of-state placement into a long-term care facility must be preauthorized by the Director of the Virginia Department of Medical Assistance Services for Virginia Medicaid to pay for the institutional care.

When a competent individual voluntarily leaves the facility in which Virginia placed him, he becomes a resident of the state where he is physically located.

M0230.204 CASH ASSISTANCE PROGRAM RECIPIENTS

A. Introduction

Certain individuals are considered residents of Virginia for Medicaid purposes if they live in Virginia and receive a cash assistance payment specified below in this section. Some recipients of cash assistance from a Virginia social services agency who do NOT reside in Virginia are considered residents of Virginia for Medicaid purposes, as specified below.

B. Auxiliary Grants Recipients

An individual receiving an Auxiliary Grants (AG) payment from a locality in Virginia is considered a Virginia resident.

An individual who receives a State Supplement of SSI payment from another state is considered a resident of the state making the State Supplement payment.

C. IV-E Payment Recipients

For an individual of any age who receives federal foster care or adoption assistance payments under Title IV-E of the Social Security Act, the state of residence for Medicaid eligibility is the state where the child lives.

D. Non-IV-E Foster Care *Payment* Recipients

The non IV-E (state/local) foster care payment recipient is a resident of the state that is making the non IV-E payment.

E. Non-IV-E Adoption Assistance Payment Recipients

The non IV-E (state/local) Adoption Assistance recipient is a resident of the state in which the child's adoptive parent(s) resides, regardless of whether a final order of adoption has been entered in court.

CHAPTER M02
NONFINANCIAL ELIGIBILITY REQUIREMENTS
SUBCHAPTER 40

SOCIAL SECURITY NUMBER REQUIREMENTS

M0240 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	pages 2-4
TN #94	9/1/10	pages 1-6
TN #93	1/1/10	pages 1-4
Update (UP) #1	7/1/09	pages 1, 2
TN #91	5/15/09	pages 1, 2

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M0240.000 SOCIAL SECURITY NUMBER REQUIREMENTS

M0240.001 GENERAL PRINCIPLES

A. Policy

1. Medicaid

To be eligible for Medicaid, an individual must provide his Social Security number (SSN) as well as the SSN of any person for whom Medicaid is requested, or must provide proof of application for an SSN, UNLESS the applicant

- is an alien who is eligible only for Medicaid payment of emergency services, as defined in subchapter M0220, or
- is a child under age one born to a Medicaid-eligible mother, as long as the mother would still be eligible for Medicaid had the pregnancy not ended and the mother and child continue to live together (see M0320.301 B. 2.).

An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

2. FAMIS & FAMIS MOMS

To be eligible for FAMIS or FAMIS MOMS, an individual is **not** required to provide or apply for an SSN.

B. Failure to Meet SSN Requirement

Any Medicaid family unit member for whom an application for an SSN has not been filed or for whom the SSN is not furnished **is not eligible** for Medicaid EXCEPT for:

1. Child Under Age 1

a child under age one born to a Medicaid-eligible mother; a newborn is deemed to have applied and been found eligible for Medicaid, whether or not the eligibility requirements, including SSN, have actually been met.

2. Emergency-Services-Only Alien

an alien eligible for Medicaid payment of emergency services only, as defined in M0220.410 and M0220.411; an emergency-services-only alien does not have to provide or apply for an SSN.

C. Relationship to Other Medicaid Requirements

An applicant who cannot provide documentation that he is a citizen or legally present at the time of application must sign an affidavit under oath attesting that he is a U.S. citizen or legally present in the U.S. in order to temporarily meet the requirement for proof of legal presence (see M0210.150). **Submission of the affidavit without proof of application for an SSN does NOT meet the SSN requirement.**

D. Verification

1. Name

The name entered in the official case record and computer enrollment systems for an applicant must match the applicant's name on his Social Security card or Social Security Administration (SSA) records verification. It is important to spell the name correctly so that when the Medicaid

Management Information System (MMIS) sends the enrollee information to SSA for the Medicare Buy-in or the citizenship and identity match, the enrollee can be matched to SSA records.

At the time of the initial Medicaid application, the State Verification Exchange System (SVES) must be used to verify the SSA record of the individual's name because SVES verifies the spelling, etc., of the individual's name in the SSA records. For subsequent reapplications, the State Online Query-Internet system (SOLQ-I) may be used.

1. SSN

The individual's SSN must be verified. The worker may use the SOLQ-I or SVES to verify an individual's SSN.

2. Verification Systems - SVES & SOLQ-I

SVES verifies the individual's SSN, name spelling, entitlement to SSA benefits and the amount of the benefit, entitlement to SSI and the amount, and entitlement to Medicare & the Medicare premium amounts. SVES tells the worker what is wrong with the name, if the name is incorrectly spelled.

The SOLQ-I verifies the individual's SSN, entitlement to SSA benefits and the amount of the benefit, entitlement to SSI and the amount, and entitlement to Medicare & the Medicare premium amounts. SOLQ-I does not verify the individual's name according to the SSA records.

Workers may use either the SOLQ-I or SVES to verify the individual's SSN and entitlement to Social Security benefits and Medicare. However, to verify the SSA record of the individual's name at the initial application, SVES must be used.

E. Procedure

Section M0240.100 below explains in detail how to determine if an individual meets the SSN requirements when the individual or child does not have an SSN.

M0240.100 APPLICATION FOR SSN

A. Policy

If an SSN has not been issued for the individual or the individual's child(ren), the applicant must cooperate in applying for a number with the local Social Security Administration Office (SSA). *Instruct the applicant to submit form SS-5, the Application for Social Security Number, to the SSA and to obtain a receipt from SSA verifying that the application was submitted. The SS-5 is available online at: http://www.socialsecurity.gov/ssnumber/ss5.htm.*

The applicant must provide the SSN to the local social services department as soon as it is received and the number must be verified and entered in the Medicaid Management Information System (MMIS).

1. Newborns

In the case of a newborn child, the applicant/recipient may satisfy this requirement by requesting that an SSN be applied for by hospital staff in conjunction with the filing of the birth record at the time of the child's birth. Form SSA-2853 will be given to the mother by hospital staff as verification of application for the child's SSN.

2. Failure to Apply for SSN Applicants who refuse to furnish an SSN or to show proof of application for a number are ineligible for Medicaid.

3. Retroactive Eligibility An individual who provides proof of application for an SSN after he applies for medical assistance, meets the application for SSN requirement in the three months retroactive to his medical assistance application.

B. Exceptions Any Medicaid family unit member for whom an SSN has not been applied is not eligible for Medicaid EXCEPT for:

1. Child Under Age 1 a child under age one born to a Medicaid-eligible mother, who meets the definition in M0320.301 of a newborn "deemed" eligible for Medicaid. A newborn is deemed to have applied and been found eligible for Medicaid, whether or not the eligibility requirements, including SSN, have actually been met. See M0320.301 for a newborn's eligibility as a child under age 1.

2. Emergency-Services-Only Alien an alien eligible for Medicaid payment of emergency services only, as defined in M0220.410 and M0220.411; an emergency-services-only alien does not have to apply for an SSN.

M0240.200 FOLLOW-UP REQUIREMENTS FOR SSN APPLICATION

A. Applicant Applied for SSN When an applicant who has applied for an SSN is determined eligible for medical assistance, he is enrolled with a pseudo-SSN. The worker must obtain the enrollee's SSN when it is assigned and enter it into the enrollee's records.

B. Follow-Up Procedures *The follow-up procedures below do not apply to individuals listed in M0240.100 B.*

1. Documentation If the applicant does not have an SSN, the agency must document in the record the date he applied for an SSN.

2. Entering Computer Systems When entering the individual in MMIS or MedPend, use the date the individual applied for an SSN, or the individual's date of birth, preceded by *"999"* as the individual's SSN. *In ADAPT, use "APP" as the first 3 digits and the individual's DOB or date of SSN application as the final 6 digits.*

For example, an individual applied for an SSN on October 13, 2006. Enter "*999*101306" as the individual's SSN *in MMIS and MedPend; in ADAPT, enter "APP101306."*

3. Follow-up

a. Follow-up in 90 Days

After enrollment of the eligible individual, the agency must follow-up within 90 days of the Social Security number application date or 120 days if application was made through hospital enumeration:

b. Check for Receipt of SSN

Check the MMIS and ADAPT records for the enrollee's SSN. If the SSN still has "*999*" *or "APP"* as the first 3 digits, contact the enrollee to obtain the enrollee's SSN verbally or by mail.

c. Verify SSN

Verify the SSN by a computer system inquiry of the SSA records.

d. Enter Verified SSN in Systems

Enter the enrollee's SSN in MMIS, and in ADAPT if the enrollee is in ADAPT. If the enrollee is in an active Medicaid case in ADAPT, and his pseudo SSN is not changed to a valid SSN at renewal, ADAPT will determine him ineligible for Medicaid.

4. Renewal Action

If the enrollee's SSN has not been assigned by the 90-day follow-up, the worker must follow-up no later than the enrollee's annual renewal, by checking the systems for the enrollee's SSN and by contacting the enrollee if necessary.

a. Check for Receipt of SSN

Before or at renewal, the SSN must be entered into MMIS and ADAPT. Check the MMIS and ADAPT records for the enrollee's SSN. If the SSN has "*999*" *or "APP"* as the first 3 digits, contact the enrollee to obtain the enrollee's SSN verbally or by mail, or on the renewal form if a renewal form is required.

b. Verify SSN

Verify the SSN by a computer system inquiry of the SSA records.

c. Enter Verified SSN in Systems

Enter the enrollee's SSN in MMIS, and in ADAPT if the enrollee is in ADAPT. If the enrollee is in an active Medicaid case in ADAPT, and his pseudo SSN is not changed to a valid SSN at renewal, ADAPT will determine him ineligible for Medicaid.

d. SSN Not Provided by Renewal Deadline

The worker must assist the enrollee in obtaining the applied-for SSN. The worker will ask the enrollee for the assigned SSN at the first renewal, and give a deadline date for the enrollee to provide the SSN.

If the enrollee does not provide the SSN by the deadline, the worker will ask the enrollee why it was not provided to the worker:

- Did the enrollee ever receive the SSN from SSA?
- If not, why not?

If the problem is an SSA administrative problem, such as a backlog of SSN applications causing the delay in issuing an SSN to the enrollee, the enrollee continues to meet the Medicaid SSN eligibility requirement. The worker will assist the enrollee with obtaining the SSN and will periodically check with the computer systems and the enrollee.

If the problem is **not** an SSA administrative problem, the worker must cancel Medicaid coverage for the enrollee whose SSN is not provided.

M0240.300 SSN Verification Requirements

A. SSN Provided By Individual

The individual's SSN must be verified. When the individual provides his SSN, the worker may use the SOLQ-I or SVES to verify the individual's SSN. The individual is not eligible for Medicaid and cannot be enrolled in MMIS if his SSN is not verified.

B. Procedures

1. Enter Verified SSN in Systems

Enter the eligible enrollee's verified SSN in MMIS, and in ADAPT if the enrollee's Medicaid eligibility is determined in ADAPT.

2. SSN and Citizenship Update Report

When an individual's SSN is entered into MMIS, the SSN and identifying data is transmitted on the 21st of the month to SSA for SSN verification. If SSA does not verify the individual's SSN, the individual will be listed on the SSN and Citizenship Update Report (RS-O-485A) that is posted on SPARK, Medicaid Management Reports.

3. Review Report Each Month

Eligibility staff is expected to review the report to see if the report lists any enrollees who were rejected because their SSN, name or date of birth did not match the information in the SSA records. If an enrolled individual is listed on the report with an "SSN Status" that is not verified, the worker must attempt to resolve the discrepancy.

4. Resolving Unverified SSN Discrepancies

a. Data Entry Error Caused Discrepancy

If it is determined that the discrepancy was the result of an error made while entering the SSN in the system, steps must be taken to correct the information in the MMIS and/or ADAPT so that a new data match with SSA can occur in the next month.

b. Discrepancy Not Caused by Data Entry Error

If the discrepancy is not the result of a typographical or other data entry error, the individual must be given a period of 10 days to resolve the issue or provide written verification from SSA of the individual's correct SSN. The eligibility worker must send a written notification to the enrollee that informs the enrollee of the SSN discrepancy and gives him 10 calendar days from the date of the notice to either resolve the discrepancy with the SSN or to provide

written verification of his correct SSN to the worker. The notice must inform the individual that if he does not verify his SSN by the deadline, his Medicaid coverage will be canceled.

c. Individual Provides SSN Verification

If verification of the SSN is received within the 10 days, update the MMIS (and ADAPT if appropriate) accordingly so that the enrollee's information will be included in a future data match.

d. SSN Verification Not Provided

If verification of the SSN is NOT received within the 10 days, send the individual an advanced notice of proposed cancellation and cancel the individual's coverage in MMIS.

CHAPTER M02
NONFINANCIAL ELIGIBILITY REQUIREMENTS
SUBCHAPTER 50

ASSIGNMENT OF RIGHTS *AND PURSUIT OF SUPPORT FROM THE ABSENT PARENT REQUIREMENTS*

M0250 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/01/11	Page 3
TN #94	09/01/2010	Pages 3-5

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M0250.000 ASSIGNMENT OF RIGHTS AND PURSUIT OF SUPPORT FROM THE ABSENT PARENT REQUIREMENTS

M0250.001 GENERAL PRINCIPLES

A. Introduction

The assignment of rights to medical support and the pursuit of support from absent parent(s) are Medicaid nonfinancial requirements that must be met as a condition of Medicaid eligibility.

B. Policy and Procedures

The policy and procedures for the local agency to follow in determining if an individual has met the Medicaid assignment of rights and pursuit of support from absent legally responsible relatives are contained in the following sections:

- M0250.100 Assignment of Rights.
- M0250.200 Procedures for the Assignment of Rights.
- M0250.300 Pursuit of *Medical* Support From the Absent Parent.

M0250.100 *ASSIGNMENT OF RIGHTS*

A. *Assignment of Rights* Policy

To be eligible for Medicaid, a Medicaid applicant or recipient must:

- assign his rights to medical support and payment for medical care from any third party to the Department of Medical Assistance Services (DMAS) *if he is applying for himself*;
- assign the rights of any other individual for whom he applies and can make an assignment of rights to support and third party payments;
- cooperate with the agency in identifying (to the extent he is able) potentially liable insurers and other third parties who may be liable to pay for the individual's, and any other individual for whom he *applies and* can assign rights *for* care and medical services.

B. Individual Unable To Assign Rights

If the individual is unable to his assign rights, a spouse, legally appointed guardian or conservator, attorney-in-fact (person who has the individual's power-of-attorney), or the authorized representative can make such an assignment. If the individual is a child, the parent, legal custodian, authorized representative, or the adult relative with whom the child lives and who signed the application can assign rights.

If the person who has the authority to assign the applicant's/recipient's rights refuses to assign the rights, the person who has the authority to assign the rights will be ineligible for Medicaid. However, the applicant/recipient will meet the assignment of rights requirement and can be eligible for Medicaid if he meets all other eligibility requirements.

M0250.200 PROCEDURES FOR ASSIGNMENT OF RIGHTS

A. Forms

The assignment of rights information is contained on the following application forms used for Medicaid:

- Application For Benefits (form #032-03-824),
- Application/Redetermination For Medical Assistance For SSI Recipients (form #032-03-091),
- An Application for Children's Health Insurance in Virginia (form FAMIS – 1),
- Medicaid Application For Medically Indigent Pregnant Women (form #032-03-040), and
- the ADAPT Statement of Facts.

By signing the application for Medicaid, the individual assigns his/her own rights and the rights of anyone for whom the individual has applied and can assign rights.

B. Refusal To Assign Rights Or Cooperate

An individual who is able to assign rights but who refuses or fails to meet the assignment of rights requirements in this subchapter is not eligible for Medicaid. Deny or cancel Medicaid coverage to an individual who:

- refuses to assign his own rights *if he applies for himself,*
- *refuses to assign the rights* of any other applicant for whom he can make an assignment, or
- refuses to cooperate in identifying and providing liable third party information, unless cooperation has been waived for good cause.

C. Cooperation – *Assignment of Rights*

Cooperation in assisting the agency in securing medical support and payments includes requiring the individual to:

- provide identifying information about liable third parties, such as the liable person's insurance company and policy number, the medical services covered by the insurance policy, etc.;
- appear as a witness at a court or other proceeding;
- provide information, or attest to lack of information, under penalty of perjury;
- pay to the agency any medical care funds received that are covered by the assignment of rights; and

- take any other reasonable steps to assist the state in pursuing any liable third party.

Should DMAS or the local agency request information from the individual, including information about third party liability, or otherwise require cooperation with the pursuit of medical support and/or third party liability as outlined in M0250.200 C. above, the individual must cooperate with the pursuit of medical support in order for the individual's eligibility to continue.

1. Waiver of Cooperation

A waiver of the cooperation requirement in identifying and providing liable third party information is allowed if the agency finds that cooperation is against the best interests of the individual, or other person for whom he/she can assign rights, because the agency anticipates that cooperation will result in reprisal against or cause physical or emotional harm to the individual or other person.

2. Documentation

Document the case record with the reason(s) the individual refuses to cooperate in identifying and providing liable third party information and the reason(s) the agency finds that cooperation is against the best interests of the individual or other person for whom he/she can assign rights.

M0250.300 PURSUIT OF MEDICAL SUPPORT FROM THE ABSENT PARENT

A. Policy

To be eligible for Medicaid, an individual applicant or recipient must cooperate with the agency in obtaining medical support and payments from, or derived from, the absent parent(s) of a child for whom the individual is applying, unless the individual establishes good cause for not cooperating. The individual's non-cooperation does NOT affect the individual's *Plan First eligibility, nor the individual's* child(ren)'s Medicaid eligibility.

A pregnant woman is not required to cooperate with DCSE when requesting assistance for herself and her child(ren) born out of wedlock. If she is or was married, she is required to cooperate in pursuing medical support for her legitimate child(ren) from the legitimate child(ren)'s absent father.

A married pregnant woman who meets the medical assistance support requirement **cannot be denied** medical assistance for failure to cooperate in pursuing support even when ineligible for another program because of failure to cooperate with pursuit of support.

B. Definition of Cooperation

1. Application

By signing the application for Medicaid, the individual meets the eligibility requirement to cooperate in pursuing support from the absent parent(s) of the child for whom the individual is applying. No further action by the applicant is required at the time of application**.**

The individual is not required to contact DCSE about pursuing support from the absent parent. If the individual chooses to request DCSE services, the individual's continued cooperation with DCSE **is required** for the individual to remain eligible for Medicaid.

2. Ongoing

After the individual's application has been approved, if *DCSE*, DMAS or the local agency requests information from the individual about the absent parent, or otherwise requires the individual's cooperation with the pursuit of medical support from the absent parent, the individual must cooperate in order for the individual's eligibility to continue.

Medicaid enrollees who were approved for Medicaid before January 1, 2007, and who were referred to DCSE, must continue to cooperate with DCSE in the pursuit of medical support from the absent parent to remain eligible for Medicaid.

C. Local DSS Agency Responsibility

1. Applicants

Explain and offer the Division of Child Support Enforcement (DCSE) services to all Medicaid applicants who apply for Medicaid for themselves and/or on behalf of children who have an absent parent. A child's parent is not considered absent if the absence is due to death, single parent adoption, artificial insemination, or termination of parental rights.

Give the applicant the DCSE Fact Sheet available on the intranet at: http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi.

2. Enrollees

If the local agency or DMAS requires from the enrollee information related to medical support from the absent parent, such as the policy number of the health insurance policy the absent parent has that covers the child, and the enrollee refuses to give it to the requesting agency but does not have good cause for refusing, the enrollee is no longer eligible for Medicaid because of failure to cooperate in pursuing medical support and third party liability. The child(ren) remain eligible for Medicaid.

a. Enrollees who were approved before January 1, 2007

For a Medicaid enrollee who was approved for Medicaid before January 1, 2007, and was referred to DCSE, the local agency must take action when notified by DCSE that the enrollee is not cooperating in the pursuit of medical support from the absent parent. The child(ren)'s eligibility for Medicaid is NOT affected.

b. Enrollees who applied on or after January 1, 2007

If the enrollee who applied for Medicaid on/after January 1, 2007, chooses to apply for DCSE services and DCSE opens a case for the applicant, the enrollee must cooperate with DCSE in the pursuit of medical support from

the absent parent, unless there is good cause for not cooperating. If the agency is notified by DCSE that the enrollee is not cooperating, the agency worker must take appropriate action on the enrollee's Medicaid coverage; the child(ren)'s eligibility for Medicaid is NOT affected.

If the recipient wants to claim good cause for not cooperating, contact a Medical Assistance Program Consultant for instructions.

D. DCSE

DCSE District Offices have the responsibility of pursuing support from absent legally responsible parent(s), establishing paternity when the alleged father is absent from the home, and notifying the local DSS when the enrollee does not cooperate. This responsibility entails locating the parent(s), determining ability to support, collecting support from legally responsible parent(s), establishing medical support and/or health insurance covering the applicant child (ren), and court action to secure support from the absent legally responsible parent.

The booklet, "Child Support and You", form #032-01-945, gives an overview of DCSE services and the addresses for the district offices.

CHAPTER M02
NONFINANCIAL ELIGIBILITY REQUIREMENTS
SUBCHAPTER 60

RESERVED

NOTE: Policy references to M0260 that are still in effect have been moved to subchapter M0250.

CHAPTER M02
NONFINANCIAL ELIGIBILITY REQUIREMENTS
SUBCHAPTER 70

APPLICATION FOR OTHER BENEFITS

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M0270.000 APPLICATION FOR OTHER BENEFITS

M0270.100 GENERAL PRINCIPLE

A. Policy

Because Medicaid is a "last pay" medical assistance program, it is important that the individual and agency worker assess the other benefits for which an individual is eligible based on his or her own activities or based on indirect qualification through family circumstances.

As a condition of eligibility, an individual must take all necessary steps to apply for and obtain any annuities, pensions, retirement, and disability benefits to which he/she is entitled, unless he/she can show good cause for not doing so.

1. Steps to Pursue Other Benefits

An individual must take all appropriate steps to pursue eligibility for other benefits. This includes

- applying for the benefit, and
- providing the source of the other benefit with the necessary information to determine the individual's eligibility for the benefit.

2. Refusal To Apply

Refusal to apply for a benefit or refusal to accept a benefit to which the individual is entitled will result in the inability of a local agency to determine the individual's Medicaid eligibility.

In the case of a minor or an incapacitated individual, a parent or other responsible person must pursue benefits for which the minor or the incapacitated individual might be entitled. If such benefits are not pursued, eligibility must be denied.

A non-applicant parent or spouse cannot be required to apply for any benefit on their own behalf. A child's or spouse's Medicaid eligibility cannot be denied due to the failure of the non-applicant parent or spouse to apply for or accept a benefit for which the non-applicant parent or spouse might be entitled.

3. Good Cause For Not Applying

An individual meets this requirement for Medicaid, despite failure to apply for other benefits or take other steps necessary to obtain them, if the individual has good cause for not doing so. For example, good cause exists if:

- the individual is unable to apply for other benefits because of illness;
- it would be useless to apply because the individual had previously applied and the other benefit source turned him down for a reason(s) that has not changed;
- it would result in no additional benefit which would affect the individual's Medicaid eligibility or amount of Medicaid services.

B. Procedure

The types of benefits for which an individual must apply and/or accept are listed in section M0270.200 below.

The procedures to follow are in section M0270.300 below.

M0270.200 TYPES OF BENEFITS

A. Benefits Excluded From Requirement to Apply

An applicant is NOT required to apply for benefits or assistance that is based on the individual's need. An individual is not required to apply for cash assistance program benefits such as Supplemental Security Income (SSI) or Temporary Assistance For Needy Families (TANF).

Payments such as child support, alimony, accelerated life insurance, etc., are NOT benefits for which an individual must apply.

B. Types of Benefits For Which An Individual Must Apply

1. Benefit Characteristics

Benefits for which the individual must apply have the following characteristics in common:

- require an application or similar action;
- have conditions for eligibility;
- make payments on an ongoing or one-time basis.

2. Major Benefit Programs

Annuities, pensions, retirement and disability benefits to which an individual may be entitled and for which he must apply, if he appears to be entitled, include but are not limited to:

a. Veterans' Compensation and Pensions, including apportionment of augmented dependents' benefits;

b. Social Security Title II Benefits (OASDI - Old Age, Survivors & Disability Insurance)

c. Railroad Retirement Benefits

d. Unemployment Compensation

e. Worker's Compensation

f. Black Lung Benefits

g. Civil Service and Federal Employee Retirement System Benefits

h. Military Pensions

3. Other Benefits

Other benefits to which an individual may be entitled and for which he must apply, if he appears to be entitled, include but are not limited to:

a. private insurance company disability, income protection, etc., benefits when the individual has such a policy;

b. private pension plan benefits;

c. union benefits.

M0270.300 AGENCY PROCEDURES

A. Written Notice

The local agency Eligibility Worker (EW) must advise the individual in writing on a dated notice that the individual must apply for other benefits for which he or she is potentially eligible. The written notice must list the benefits for which the individual must apply.

B. Identify Potential Eligibility For Other Benefits

Obtain clues to an individual's possible eligibility for other benefits from:

- information obtained from the interview, including responses to leading questions on the application;
- the recipient's responses on a redetermination form and/or interview;
- inquiries received from another agency;
- agency knowledge of pension plans and benefits;
- third party reports;
- computer system inquiries.

C. Disability Referral Processing

Do not hold the *Disability Determination Services (DDS)* referral while waiting for the applicant to provide proof of his/her application for disability benefits; send it immediately to the *DDS.*

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NONFINANCIAL ELIGIBILITY REQUIREMENTS
SUBCHAPTER 80

INSTITUTIONAL STATUS REQUIREMENTS

M0280 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	page 1
TN #93	01/01/2010	page 13

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M0280.000 INSTITUTIONAL STATUS REQUIREMENTS

M0280.001 GENERAL PRINCIPLES

A. Introduction

To be eligible for Medicaid, an institutionalized individual must meet the institutional status requirement. An individual does not necessarily have to live in an institution to be considered an "inmate of a public institution." Inmates of public institutions are NOT eligible for Medicaid.

B. Procedure

This subchapter, M0280, contains the Medicaid institutional status policy, inmate of a public institution policy and procedures for determining whether an individual meets the Medicaid institutional status eligibility requirement.

Refer to M0520.001 for the policy and procedures for determining the assistance unit size for children in medical institutions or residential treatment facilities.

M0280.100 DEFINITION OF TERMS

A. Child Care Institution

A child care institution is a

- non-profit private child-care institution, or
- a public child care institution that accommodates no more than 25 children which has been licensed by the state in which it is located or has been approved by the agency of the state responsible for licensing or approval of institutions of this type, as meeting the standards established for licensing.

The term "child care institution" does NOT include detention facilities, forestry camps, training schools or any other facility operated primarily for the detention of children who are determined to be delinquent.

B. Facility for the Mentally Retarded

An “institution (facility) for the mentally retarded” (ICF-MR) is not an IMD. Therefore, an individual under age 65 who is in an *ICF-MR* meets the institutional status eligibility requirement, unless he is incarcerated, as defined below.

C. Institution

An institution is an establishment that furnishes (in single or multiple facilities) food, shelter and some treatment or services to four or more persons unrelated to the proprietor.

D. Institution for the Treatment of Mental Diseases (IMD)

An IMD is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, to persons with mental diseases. *A psychiatric residential treatment facility for children and adolescents is an IMD.* An *ICF-MR or other facility for individuals with intellectual disabilities* is NOT an IMD.

E. Medical Facility

A medical facility is an institution that:

- is organized to provide medical care, including nursing and convalescent care,

- has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,

- is authorized under state law to provide medical care, and

- is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

F. Public Institution (Facility)

A public institution is an institution (facility) that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control, and which is NOT a medical facility.

The following are NOT public facilities for this section's purposes:

- a medical facility, including a nursing facility;

- a publicly operated community residence (serves no more than 16 residents);

- a child care institution, for children who receive foster care payments under Title IV-E or AFDC foster care under Title IV-A, that accommodates no more than 25 children;

- an institution certified as an ICF-MR for individuals with mental retardation or related conditions.

G. Publicly Operated Community Residence

A publicly operated community residence is a public residential facility (institution) with 16 beds or less, that provides some services beyond food and shelter such as social services, help with personal living activities or training in socialization and life skills. Occasional medical or remedial care may also be provided.

Publicly operated community residences do NOT include the following facilities even though these facilities have 16 or less beds:

- residential facilities located on the grounds of, or adjacent to, any large (more than 16 beds) institution;

- correctional or holding facilities for individuals who are prisoners, who have been arrested or detained pending disposition of charges, or who are held under court order as material witnesses or juveniles;

- detention facilities, forestry camps, training schools or any other facility for children determined to be delinquent;

- educational or vocational training institutions that primarily provide an approved, accredited or recognized program to individuals residing there.

NOTE: An individual residing in a public educational or vocational training institution for purposes of securing education or vocational training is NOT an inmate of a public institution, and therefore may be eligible for Medicaid, even though the educational or training facility is not a publicly operated community residence.

H. Residential Institution An institution that does not meet the definition of a "medical facility."

M0280.200 INSTITUTIONAL STATUS RULE

A. Introduction Federal regulations in 42 CFR 435.1008 prohibit federal financial participation in Medicaid services provided to two groups of individuals in institutions; these individuals are NOT eligible for Medicaid:

1. individuals who are **inmates of a public institution**.

2. individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMD), unless they are under age 22 and are receiving inpatient psychiatric services. NOTE: an ICF-MR is not an IMD.

B. Procedures The policy and procedures for determining whether an individual is in an IMD are contained in subchapter M1430.

The policy and procedures for determining whether an individual is an inmate of a public institution are contained in the following sections:

- M0280.201 Individuals in Medical Facilities
- M0280.202 Individuals in Residential Facilities
- M0280.300 Inmate of A Public Institution
- M0280.301 Who Is NOT An Inmate of A Public Institution
- M0280.400 Procedures For Determining Institutional Status
- M0280.500 Individuals Moving To or From Public Institutions
- M0280.600 Departmental Responsibility.

M0280.201 INDIVIDUALS IN MEDICAL FACILITIES

A. Public or Private The public or private ownership or administration of a **medical** facility is irrelevant because a medical facility is not a public institution as defined in this subchapter.

B. *Incarcerated Individual Not Eligible* *To be eligible for Medicaid, an institutionalized individual in a medical facility must meet the institutional status requirement. A medical facility is NOT a public institution even if it is administered by a governmental unit.*

However, an individual who resides in a medical facility may be considered an inmate of a public institution because he is incarcerated, as defined in this subchapter. If a medical facility patient is incarcerated, he is an inmate of a public institution and is not eligible for Medicaid.

C. Individuals in IMDs

The following individuals in public or private IMDs are NOT eligible for Medicaid because they do not meet the institutional status requirement:

- *an individual who is age 22 or over, but under age 65;*
- *an individual who is under age 22 who is NOT receiving inpatient psychiatric services in the IMD.*

An individual is in an IMD from the date of admission to the IMD until discharge from the IMD.

1. Eligible Patient In An IMD

An individual is in an IMD when he/she is admitted to live there and receive treatment or services provided there that are appropriate to his/her requirements. A patient in an IMD is an individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or lessening of illness, disability, or pain.

An individual who is age 65 or older and who is a patient in a public or private IMD meets the institutional status requirement for Medicaid. An individual who is under age 22, who is a patient in a public or private IMD and who is receiving inpatient psychiatric services in the IMD meets the institutional status requirement for Medicaid.

2. Conditional Release From IMD

A patient in an IMD who is transferred or discharged to a medical facility that is not an IMD, including a patient under conditional release or convalescent leave from the IMD, meets the institutional status requirement and may be eligible for Medicaid.

B. Facility for the Mentally Retarded

A facility (institution) for the mentally retarded (ICF-MR) is not an IMD. Therefore, an individual under age 65 who is in a facility for the mentally retarded meets the institutional status eligibility requirement, unless he is incarcerated, as defined in this subchapter.

C. Residential Facilities With Certified Medical Beds

Some institutions have both medical and residential sections. Individuals in the residential section (or beds) are residents of a residential facility. If the resident receives Medicaid Community-based Care (CBC) waiver services, use Chapter M14 to determine the individual's eligibility. If the resident does not receive Medicaid CBC, he is not in long-term care; use the Medicaid eligibility requirements for non institutionalized individuals.

Individuals in the medical certified portion (or beds) of an institution are patients in a medical facility. Use Chapter M14 in determining their Medicaid eligibility.

D. *District Homes*

The District Homes are public institutions that serve more than 16 residents. A District Home may have a portion of the institution certified as a nursing facility. There are two District Homes in Virginia, one in Waynesboro and one in Manassas.

Patients in the certified nursing facility portion of the District Home meet the institutional status requirement, unless they are incarcerated or are juveniles in detention as defined in this subchapter.

Residents in the residential portions of the District Homes are inmates of a public institution and are not eligible for Medicaid because the residential portion is a public residential facility of more than 16 beds.

G. Cross Reference

If the individual has been, or is expected to be, in the medical facility or medical section of the facility for 30 or more consecutive days, the individual is receiving long-term care. *Chapter M14 contains additional eligibility policy for individuals in long-term care.*

M0280.202 INDIVIDUALS IN RESIDENTIAL FACILITIES

A. Institutions With Medical and Residential Sections

1. Some institutions have both medical and residential sections. An individual in the medical certified section (or beds) of the institution is a patient in a medical facility. If the individual has been, or is expected to be, in the medical facility for 30 or more consecutive days, the individual is receiving long-term care. Go to New Volume XIII Chapter M1400 to determine the individual's eligibility.

2. An individual in the residential portion (or beds) of the institution is a resident of a residential facility. Use this subchapter to determine the resident's institutional status.

B. Private Residence or Group Home

An individual who lives in a private residence in the community that is not an institution (it is an establishment that provides food, shelter and some services to three or less persons unrelated to the proprietor) is not living in an institution. **A group home that has three or less residents is not an institution.**

However, the individual may be an inmate of a public institution because he/she is considered incarcerated or a juvenile in detention, as described below. If the individual is considered incarcerated or a juvenile in detention, he/she is not eligible for Medicaid because he does not meet the institutional status eligibility requirement.

C. Private Residential Facility

A resident of any age in a private residential facility meets the institutional status requirement for Medicaid UNLESS the individual is incarcerated, as defined below.

D. Public Residential Facility

A resident of any age in a PUBLIC residential facility meets the institutional status requirement for Medicaid UNLESS:

1. the public residential facility has more than 16 beds, or

2. the individual is an inmate - an incarcerated adult or a juvenile in detention - as described in section M0280.300 below, and is not an individual listed in M0280.301 below.

M0280.300 INMATE OF A PUBLIC INSTITUTION

A. Policy

Inmates of public institutions fall into three groups:

- individuals living in ineligible public institutions;
- incarcerated individuals;
- juveniles in detention.

An individual is an inmate of a public institution from the date of admission to the public institution until discharge, or from the date of actual incarceration in a prison, county or city jail or juvenile detention facility until permanent release, bail, probation or parole.

An individual is considered incarcerated until permanent release, bail, probation or parole. For example, an individual released from jail due to a medical emergency who would otherwise be incarcerated but for the medical emergency is still considered incarcerated and is an inmate of a public institution. An individual released from jail under a court probation order due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

B. Public Residential Facility Residents

An individual who lives in a public residential facility that serves more than 16 residents is NOT eligible for Medicaid.

1. District or County Homes

The District Homes or County Homes are public residential facilities that serve more than 16 residents. A District or County home may have other portions of the institution certified as a nursing facility. There are two District Homes in Virginia, one in Waynesboro and one in Manassas. There is one county home - the Orange County Home.

Residents in the residential portions of the District or County Homes are inmates of a public institution and are not eligible for Medicaid because the residential portion is a public institution of more than 16 beds and does not meet the definition of a publicly operated community residence.

Patients in the certified nursing facility portion of the District or County Home are NOT inmates of a public institution because that portion is a medical facility. Patients in the nursing facility portion of the District or County Home meet the institutional status requirement and may be eligible for Medicaid.

2. Ineligible Public Residential Facilities

A public residential facility that does not meet the definition of a "publicly operated community residence" in section M0280.100 above, is an "ineligible public institution." Public residential institutions with more than 16 beds are ineligible public institutions. The following public institutions are ineligible public institutions even though these facilities have 16 or less beds:

- residential facilities located on the grounds of, or adjacent to, any large (more than 16 beds) institution;
- correctional or holding facilities for individuals who are prisoners, who have been arrested or detained pending disposition of charges, or who are held under court order as material witnesses or juveniles;
- detention facilities, forestry camps, training schools or any other facility for children determined to be delinquent.

C. Incarcerated Individuals

An incarcerated individual is an inmate of a public institution, even when he/she is in a medical facility. The key element is whether the incarcerated individual resided in a jail or prison immediately prior to admission to the medical facility. The following incarcerated individuals are inmates of a public institution:

1. Prison Inmate

An inmate in a prison is not eligible for Medicaid.

2. Jail Inmate

An inmate in a county or city jail is not eligible for Medicaid.

3. Prison or Jail Inmate

An inmate in a prison or jail prior to arraignment, conviction, or sentencing is not eligible for Medicaid. An inmate may be eligible if he/she is out on bail or released on his/her own recognizance.

An individual in prison or jail who transfers temporarily to a halfway house or residential treatment facility prior to a formal probation release order is still an inmate of a public institution and is not eligible for Medicaid.

4. Work Release

An individual who is incarcerated but can leave the prison, jail or work release center on work release or work furlough and must return to prison or jail at specific intervals is NOT eligible for Medicaid.

5. Released on Medical Emergency

An individual released from prison or jail due to a medical emergency who would otherwise be incarcerated but for the medical emergency is not eligible for Medicaid.

D. Juveniles in Detention

In determining whether a juvenile (individual under age 18 years) is incarcerated and an inmate of a public institution, the federal Medicaid regulations distinguish between the nature of the detention, pre- and post-disposition situations, and types of facilities.

1. Prior to Court Disposition

1) A juvenile who is in a detention center due to criminal activity is an inmate of a public institution. Incarceration in a detention center due to criminal activity makes the individual an inmate of a public institution. The length of stay in the detention center is irrelevant. A short incarceration in a detention facility is NOT temporary placement pending other arrangements.

A juvenile who has criminal charges pending (no court disposition has been made) who is ordered by the judge to go to a treatment facility, then come back to court for disposition when the treatment is completed, is an inmate of a public institution.

2) A juvenile who is in a detention center due to care, protection or in the best interest of the child is NOT an inmate of a public institution.

2. After Court Disposition

Juveniles who are on probation with a plan of release which includes residence in a detention center are inmates of a public institution. If they go to any of the secure juvenile correctional facilities, they are inmates of a public institution. *See Appendix 1 to this subchapter for a list of secure detention facilities in Virginia.*

If they go to a nonsecure group home, they are NOT inmates of a public institution because a nonsecure group home is not a detention center.

3. Type of Facility

The type of facility, whether it is residential or medical and whether it is public or private must be determined. A juvenile is not eligible if he/she is a resident of an ineligible public residential facility.

EXAMPLE #1: A juvenile is detained for criminal activity. He is placed on probation with specific conditions of release, including a stay of 30 days or longer at a detention facility. The facility is identified as a juvenile detention center, not a treatment center. Upon release from the detention center, he will be placed on probation and will live with his mother. Because of the nature of his custody (criminal activity) and the nature of the facility (a detention center is a public institution) he is not eligible for Medicaid during the period of incarceration. After he is released from the detention center and while he is on probation, he is NOT an inmate of a public institution and may be eligible for Medicaid.

4. Ineligible Juveniles in Detention

The following juveniles in detention are inmates of a public institution and are not eligible:

a. A minor in a juvenile detention center prior to disposition (judgement) due to criminal activity is not eligible for Medicaid.

b. A minor placed on probation by a juvenile court with specific conditions of release, including residence in a secure juvenile detention center is not eligible for Medicaid.

M0280.301 WHO IS NOT AN INMATE OF A PUBLIC INSTITUTION

A. *Who Is NOT An Inmate of a Public Institution*

An individual is NOT an inmate of a public institution if

- *he is in a public educational or vocational training institution for purposes of securing education or vocational training OR*
- *he is in a public institution for a temporary period pending other arrangements appropriate to his needs.*

B. Educational or Vocational Institution

An individual residing in a public educational or vocational training institution for purposes of securing education or vocational training is NOT an inmate of a public institution, and therefore may be eligible for Medicaid.

C. Temporary Stay

An individual residing in a public institution for a temporary period pending other arrangements appropriate to his needs is NOT an inmate of a public institution, and therefore may be eligible for Medicaid.

D. Admitted Under TDO

An individual over age 18 who was arrested or detained, but did not reside overnight in a prison or jail before being admitted to a public institution under a temporary detention order (TDO) is NOT an inmate of a public institution because he did not reside in the jail or prison immediately before admission to the treatment facility.

E. Arrested Then Admitted to Medical Facility

An individual who, after arrest but before booking, is escorted by police to a hospital for medical treatment and held under guard is NOT an inmate of a public institution and may be eligible for Medicaid. *He is not an inmate of a public institution because he did not reside in a jail, prison or secure detention facility immediately prior to admission to the medical facility.*

F. Inmate Out On Bail

An inmate in a prison or jail prior to arraignment, conviction, or sentencing is not eligible for Medicaid unless he/she is out on bail or released on his/her own recognizance.

G. Probation, Parole, or Conditional Release

An individual released from prison or jail on probation, parole, or release order with a condition of:

- home arrest
- community services
- outpatient treatment
- inpatient treatment

is not an inmate of a public institution and may be eligible for Medicaid.

An individual released from prison or jail under a court probation order due to a medical emergency is NOT an inmate of a public institution and may be eligible for Medicaid.

H. Juvenile in Detention Center Due to Care, Protection, Best Interest

A minor in a juvenile detention center prior to disposition (judgement) due to care, protection or the best interest of the child (e.g., Child Protective Services [CPS]), if there is a specific plan for that child that makes the detention center stay temporary, is NOT an inmate of a public institution and may be eligible for Medicaid.

This could include a juvenile awaiting placement but who is still physically present in the juvenile detention center.

I. Juvenile on Probation in Secure Treatment Center

A minor placed on probation by a juvenile court and placed in a secure treatment facility is NOT an inmate of a public institution and may be eligible for Medicaid.

J. Juvenile On Conditional Probation

A minor placed on probation by a juvenile court with, as a condition of probation, treatment in a psychiatric hospital or a residential treatment center, or treatment as an outpatient is NOT an inmate of a public institution and may be eligible for Medicaid

However, if the minor is NOT on probation but is ordered to the treatment facility, he remains an inmate of a public institution and is NOT eligible for Medicaid.

K. Juvenile On Probation in Secure Treatment Center

A minor placed on probation by a juvenile court and placed in a secure treatment facility may be eligible for Medicaid.

L. Juvenile On Conditional Probation

A minor placed on probation by a juvenile court with, as a condition of probation, treatment in a psychiatric hospital or a residential treatment center, or treatment as an outpatient may be eligible for Medicaid. However, if the juvenile is NOT on probation but is ordered to the treatment facility, he remains an inmate of a public institution and is not eligible for Medicaid.

M0280.400 PROCEDURES FOR DETERMINING INSTITUTIONAL STATUS

A. Procedures

In this order, determine:

B. Is the Individual In An Institution?

Ask: is the individual living in a home or establishment that provides food, shelter and some services to four or more persons unrelated to the proprietor?

1. If NO, the individual is not in a facility. Individual meets the institutional status eligibility requirement for Medicaid. STOP.

2. If YES, the individual is in a facility. Go to item C. below.

C. Is the Individual Incarcerated?

Is the individual incarcerated and an inmate of a public institution?
Ask the following questions:

Was he in a secure facility (jail, prison, secure detention) immediately before admission?

1. If NO, he is not an inmate of a public institution and meets institutional status requirement for Medicaid. STOP.

2. If YES, ask: is he a juvenile (under age 18)?

   a. NO: he is an inmate of a public institution and is NOT eligible for Medicaid. STOP.

   b. YES: Ask: Is this facility a secure treatment facility?

      1) NO: Ask: Was he in a juvenile detention center prior to admission due to criminal activity?

a) NO: he is not an inmate of a public institution and meets institutional status requirement for Medicaid. STOP.

b) YES: Ask: Was he placed on probation by a juvenile court with, as a condition of probation, treatment in a psychiatric hospital or a residential treatment center, or treatment as an outpatient?

(1) NO: he is an inmate of a public institution and is NOT eligible for Medicaid. STOP.

(2) YES: he is not an inmate of a public institution and may be eligible for Medicaid. *Go to D, below.*

2) YES: Ask: Is the secure treatment facility part of the criminal justice system?

a) NO: he is NOT an inmate of a public institution and may be eligible for Medicaid. *Go to D, below.*

b) YES: he is an inmate of a public institution and is NOT eligible for Medicaid. STOP.

D. ***Is the Facility Medical?***

Ask: is the institution, or portion of the institution, in which the individual resides a medical facility?

1. If NO, the facility is residential. Go to item F below.

2. If YES, the individual is in a medical facility. Go to item E, below.

E. ***Is the Medical Facility an IMD?***

Ask: is the medical facility an IMD?

1. NO: the individual is not in an IMD and meets institutional status requirement for Medicaid.

2. YES: Ask: is the individual age 65 or older?

a. NO: is the individual under age 22?

(1) NO: he is an ineligible IMD patient and is NOT eligible for Medicaid. STOP.

(2) YES: is he receiving inpatient psychiatric treatment in the IMD?

(a)NO: he is an ineligible IMD patient and is NOT eligible for Medicaid. STOP.

(b)YES: he is an eligible IMD patient and may be eligible for Medicaid. STOP.

b. YES: he is an eligible IMD patient and may be eligible for Medicaid. STOP.

F. Is the Individual in a Public *Residential* Institution?

Determine if the residential facility is a public institution as defined above. Ask: is the residential facility public?

1. *If NO, he is not an inmate of a public institution and meets institutional status requirement for Medicaid.*

2. *If YES, ask: how many beds does it have?*

   a. *If it has 16 beds or less, he is not an inmate of a public institution and meets institutional status requirement for Medicaid). STOP.*

   b. *If it has more than 16 beds, the individual DOES NOT meet the institutional status requirement and is not eligible for Medicaid. STOP.*

M0280.500 INDIVIDUALS MOVING TO OR FROM PUBLIC INSTITUTIONS

A. Moves To Public Institution

If a currently eligible recipient is incarcerated or enters an ineligible institution, he is no longer eligible for Medicaid. Outstanding bills for covered medical services incurred prior to his admission and during his Medicaid coverage period will be paid.

B. Moving From Public Institution

Although a person may not be eligible for Medicaid while living in a specified public institution or part thereof, he may apply for such assistance as a part of prerelease planning. If he is found eligible (except for institutional status), do not enroll until he leaves the institution to live elsewhere.

C. Resident Admitted to Medical Facility

A resident of an ineligible public institution, or an inmate of a public institution, who is admitted to a medical institution (general hospital or nursing facility) for inpatient care is NOT eligible for Medicaid during the period of care in the medical institution because his institutional status does not change when he is admitted to the medical facility. He is still considered an inmate of a public institution.

M0280.600 DEPARTMENTAL RESPONSIBILITY

A. *Department of Behavioral Health & Developmental Disabilities (DBHDS)* Patients

1. ABD Covered Groups

Medicaid eligibility of patients who are:

- in State-owned *Department Behavioral Health and Developmental Services (DBHDS)* institutions for the treatment of mental disease and mental retardation,
- not currently enrolled in Medicaid, and
- eligible in an Aged, Blind, or Disabled (ABD) covered group

is determined by the Medicaid Technician staff of the Division of Benefit Programs, Department of Social Services, who also carries responsibility for enrollment. (See subchapter M1550).

2. F&C *DBHDS* Patients

Local social services departments continue to carry responsibility for the determination of eligibility for Medicaid of a child eligible in a Families and Children's covered group who have been admitted to a *DBHDS* institution for treatment of the mentally retarded, and for the child's enrollment in Medicaid.

B. All Other Institutions

Local social services departments carry responsibility for the Medicaid eligibility determination and enrollment of individuals in institutions that are not operated by *DBHDS*. The local DSS agency in the Virginia locality where the individual last resided outside of an institution is the responsible DSS agency. If the individual resided outside of Virginia immediately before admission to the institution, the responsible local DSS is the DSS agency serving the locality where the institution is located.

When a local department carries responsibility for eligibility determination and enrollment of an individual living in an institution, the department is also responsible for:

- advising the institution of the individual's eligibility for Medicaid and enrollment in the program;
- submitting a DMAS-*225* form to the institution to indicate *the patient's eligibility and availability of* current patient pay *information in the Medicaid Management Information System (MMIS)*, if applicable; and
- seeing that the Medicaid card is forwarded to the institution for the enrollee's use.

List Of Secure Juvenile Detention Facilities In Virginia

Superintendent
Chesterfield Detention Home
9780 Krause Road
Chesterfield, VA 23832

Director of Detention Services
Crater Youth Care Commission
6102 County Drive
Disputanta, VA 23842

Superintendent
Fairfax Detention Home
10650 Page avenue
Fairfax, VA 22030

Superintendent
Henrico Detention Home
P.O. Box 27032
Richmond, VA 23273

Superintendent
Highlands Juvenile Detention Home
P.O. Box 248
Bristol, VA 24203

Superintendent
Loudoun Detention Home
42020 Loudoun Center Place
Leesburg, VA 22075

Superintendent
Lynchburg Juvenile Detention Home
1400 Florida Avenue
Lynchburg, VA 24501

Superintendent
New River Valley Juvenile Detention Home
650 Wades Lane, N.W.
Christiansburg, VA 24073

Superintendent
Newport News Detention Home
228 15th Street
Newport News, VA 23607

Superintendent
Norfolk Detention Home
1313 Child Care Court
Norfolk, VA 23502

Superintendent
Northern Virginia Detention Home
200 S. Whiting Street
Alexandria, VA 22304

Superintendent
Prince William Detention Home
14873 Dumfries Road
Manassas, VA 22110

Superintendent
Rappahannock Detention Home
400 Bragg Hill Drive
Fredericksburg, VA 22401

Superintendent
Richmond Detention Home
2100 Mecklenburg Street
Richmond, VA 23223

Superintendent
Roanoke Juvenile Detention Home
4345 Coyner Springs Road
Roanoke, VA 24012

Superintendent
Shenandoah Valley Juvenile Detention Home
1110 Montgomery Avenue
Staunton, VA 24401

Superintendent
Tidewater Detention Home
420 Albemarle Drive
Chesapeake, VA 23320

Superintendent
W.W. Moore Home for Juveniles
603 Colquohoun Street
Danville, VA 24541

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MEDICAID COVERED GROUPS
SUBCHAPTER 10

GENERAL RULES & PROCEDURES

M0310 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	Appendix 4
TN #95	3/1/11	Pages 30, 30a
TN #94	9/1/10	pages 21-27c, 28
TN #93	1/1/10	page 35 Appendix 5, page 1
Update (UP) #2	8/24/09	Table of Contents page 39
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M0310.000 GENERAL RULES & PROCEDURES

M0310.001 GENERAL PRINCIPLES OF MEDICAID COVERED GROUPS

A. Introduction

An individual who meets all the non-financial eligibility requirements in Chapter M02 and who is not an ineligible person listed in M0210.100, must meet a Medicaid covered group in order to be eligible for Medicaid. Chapter M03 explains in detail each of the Medicaid covered groups and how to determine if an individual meets the covered group requirements.

The Medicaid covered groups are divided into two classifications: the categorically needy (CN) and the medically needy (MN). The CN classification is divided into subclassifications of *categorically needy,* categorically needy non-money payment (CNNMP) and medically indigent (MI). Within some covered groups are several definitions of eligible individuals. The agency must verify the individual meets a definition and a covered group's requirements.

B. Refugees

If the Medicaid applicant is a refugee, first determine if the refugee meets the requirements in a Medicaid covered group using the policy and procedures in this chapter. If the refugee does not meet the requirements of a Medicaid covered group, the refugee is not eligible for Medicaid under a Medicaid covered group. Go to the Refugee Resettlement Program Manual Volume XVIII to determine the refugee's eligibility for assistance under the Refugee Resettlement Program.

The requirements for the Refugee Other (Cash Assistance) and Refugee Medicaid Other and Refugee Medicaid Unaccompanied Minors programs are found in another manual: the Refugee Resettlement Program Manual Volume XVIII.

C. Procedure

This subchapter contains the general principles for determining if the individual meets a definition and covered group(s).

- M0310.002 contains the list of Covered Groups;
- M0310.100 - M0310.131 contains the Definitions;
- M0320 contains the detailed policy and procedures for the Categorically Needy Groups;
- M0330 contains the detailed policy and procedures for the Medically Needy Groups.

M0310.002 LIST OF MEDICAID COVERED GROUPS

A. Categorically Needy (CN)

The Aged, Blind and Disabled (ABD) and the Families & Children (F&C) covered groups in the CN classification are listed below.

1. ABD Groups

a. former Old Age Assistance (OAA), Aid to the Blind (AB), or Aid to the Permanently and Totally Disabled (APTD) money payment recipients who currently receive Supplemental Security Income (SSI) or Auxiliary Grants (AG).

b. SSI cash assistance recipients who meet more restrictive Medicaid resource eligibility requirements.

c. Auxiliary Grants (AG) cash assistance recipients.

2. F&C Groups

a. foster care children receiving IV-E money payments;

b. adoption assistance children receiving IV-E money payments.

B. Categorically Needy Non Money Payment(CNNMP)

The Aged, Blind and Disabled (ABD) and the Families & Children (F&C) covered groups in the CN classification are listed below.

1. ABD Groups

a. ABD individuals who are institutionalized in a medical institution, who meet all Medicaid eligibility requirements and have income before exclusions that is less than 300% of the SSI individual payment limit.

b. ABD individuals who receive or are applying for Medicaid-approved community-based care waiver services, who meet all Medicaid eligibility requirements and who have income before exclusions that is less than 300% of the SSI individual payment limit.

c. ABD individuals who have a protected status:

1) individuals who received OAA, AB, APTD, or ADC as of August 1972, and meet specified requirements.

2) individuals who are former SSI/AG recipients and meet specified requirements.

3) individuals who are widows(ers) and meet specified requirements.

4) individuals who are classified as 1619(b) by Social Security and meet specified requirements.

5) individuals who are adult disabled children and meet specified requirements.

d. Hospice--a hospice patient is a person who is terminally ill and has elected to receive hospice care; if the individual is not aged, presume that the individual is disabled.

2. F&C Groups

a. Low income families with children (LIFC) eligible children, parents, non-parent caretaker-relatives, and EWBs.

b. Children under age 1 born on or after October 1, 1984, to mothers who were eligible for and receiving Medicaid as categorically needy or categorically needy non-money payment at the time of the child's birth.

c. Non-IV-E Foster Care or Juvenile Justice Department children, or Non-IV-E Adoption Assistance children.

d. Individuals under age 21 in an ICF or ICF-MR.

e. F&C individuals who are institutionalized in a medical institution, who meet all Medicaid eligibility requirements and have income before exclusions that is less than 300% of the SSI individual payment limit.

f. F&C individuals who receive or are applying for Medicaid-approved community-based care waiver services, who meet all Medicaid eligibility requirements and who have income before exclusions that is less than 300% of the SSI individual payment limit.

C. Medically Indigent (MI)

The Aged, Blind and Disabled (ABD) and the Families & Children (F&C) covered groups in the MI classification are listed below.

1. ABD Groups

a. Qualified Medicare Beneficiaries (QMBs).

b. Special Low-income Medicare Beneficiaries (SLMBs).

c. Qualified Disabled and Working Individuals (QDWIs).

d. Qualified Individuals (QIs).

e. ABD With Income ≤ 80% Federal Poverty Limit (ABD 80% FPL*)*.

f. MEDICAID WORKS.

2. F&C Groups

a. Pregnant women and newborns under age 1 year.

b. Family Planning Services.

c. Children under age 19 years.

3. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)

Women screened and diagnosed with breast or cervical cancer under the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP) and eligible to receive Medicaid under the BCCPTA.

D. Medically Needy (MN)

The Aged, Blind and Disabled (ABD) and the Families & Children (F&C) covered groups in the MN classification are listed below.

1. ABD Groups

a. Aged - age 65 years or older.

b. Blind - meets the blind definition

c. Disabled - meets the disability definition.

d. Individuals who received Medicaid in December 1973 as AB/APTD-related medically needy and who continue to meet the December 1973 eligibility requirements.

2. F&C Groups

a. Children under age 18.

b. Children under age 1.

c. Pregnant Women.

d. Non-IV-E Foster Care/Adoption Assistance children and Juvenile Justice Department children.

e. Individuals under age 21 in an ICF or ICF-MR.

E. Refugees

"Refugees" are a special group of individuals who have an alien status of "refugee", and are eligible for Medicaid under a different federal funding source. Virginia receives full federal funding with no state matching funds for the medical assistance provided to these individuals during the first 8 months they are in the U.S.

There are two *aid categories (ACs)* for this group. *AC 07*8 is used for Refugee Other and Refugee Medicaid Other and *AC 07*9 is used for Refugee Medicaid Unaccompanied Minors. The policy and procedures used to determine whether an individual is eligible in this group are found in the Refugee Resettlement Program Manual, Volume XVIII.

M0310.100 DEFINITION OF TERMS

A. Introduction

The terms used in the covered groups policy and procedures and the procedures for determining if an individual meets a definition are stated in sections M0310.101 through 131 below.

M0310.101 ABD

A. ABD Definition

"ABD" is the short name used to refer to aged, blind or disabled individuals.

B. Procedures

See the following sections for the procedures to use to determine if an individual meets an ABD definition:

- M0310.105 Age and Aged.
- M0310.106 Blind.
- M0310.112 Disabled.

M0310.102 ADOPTION ASSISTANCE

A. Definition

Adoption Assistance is a Title XX of the Social Security Act social services program that provides cash assistance and/or social services to adoptive

parents who adopt "hard to place" foster care children who were in the custody of a local department of social services or a child placing agency licensed by the state of Virginia.

1. Residing in Virginia

Adoption assistance children are children who reside in Virginia who are adopted under a Title IV-E *or Non-IV-E (state-local)* adoption assistance agreement with a department of social services or in conjunction with a child-placing agency.

2. Child-placing Agency Definition

A child placing agency is an agency that is licensed by the State Department of Social Services for child placing services. Not all child placing agencies provide adoption services; some may provide foster home placement. The services offered must be identified in the description given for the license. The foster care service unit of the local department of social services should be familiar with the function of the child placing agency, and whether or not it is licensed.

3. When Adoption Assistance Is Effective

A child under 21 is *usually considered* an adoption assistance child when the adoption assistance agreement is signed, even if the interlocutory or judicial decree of adoption has not been issued or *adoption* subsidy payments are not being made. *The adoptive parents are considered to be the adoption assistance child's parent(s) as of the date the adoption agreement is signed.*

If the child is not eligible because of the adoptive family's income, treat the adoption assistance child as a foster care child until the interlocutory or judicial decree of adoption has been issued. As a foster child, the child's assistance unit consists of one person and the adoptive parent's income is not deemed to the child.

NOTE: if the child is a foster child for income eligibility, the child must be treated as a foster child for all other Medicaid eligibility criteria including Virginia residence. A non-IV-E foster care child who is in the custody of another state is NOT a Virginia resident. See M0230.

B. *IV-E and Non-IV-E*

1. IV-E Adoption Assistance

a. Definition

The following children meet the IV-E adoption assistance definition:

1) Children adopted under a IV-E adoption assistance agreement with a Virginia local department of social services or in conjunction with a private child placing agency, who reside in Virginia. Eligibility begi when the IV-E adoption assistance agreement is signed even if an interlocutory or judicial decree of adoption has not been issued, or subsidy payments are not being made.

2) Children adopted under a IV-E adoption assistance agreement with another state's department of social services, who now reside in Virginia.

b. IV-E Adoption Assistance payment not required

The IV-E adoption assistance definition is met when the adoption assistance agreement specifies that *cash and medical assistance is required or that* the only assistance required is medical assistance. *Receipt of c*ash assistance is not required *to meet the Adoption Assistance definition.*

2. Non-IV-E Adoption Assistance

a. Non-IV-E definition

The following children meet the Non-IV-E adoption assistance definition:

1) *Children who reside in Virginia who are adopted under a Non-IV-E adoption assistance agreement with a Virginia local department of social services or in conjunction with a Virginia private child placing agency.*

2) "Special Medical Needs" children adopted under a Non IV-E Adoption Assistance agreement with a Virginia local department of social services *or* a *Virginia* private, non-profit child placement agency in conjunction with a local department of social services, in accordance with policies established by the State Board of Social Services.

b. Special Medical Needs definition

A child with "special medical needs" is a child who was determined unlikely to be adopted because of:

- a physical, mental or emotional condition that existed prior to adoption; or

- a hereditary tendency, genetic defect, congenital problem or birth injury leading to a substantial risk of future disability.

c. Agreement must specify "special medical need(s)"

The adoption assistance agreement must specify that the child has a special medical need; the agreement does NOT need to specify a particular diagnosis or condition.

d. Virginia Medicaid coverage for Special Medical Needs children

Medicaid coverage is to be provided to any child who has been determined to be a Non-IV-E Special Medical Needs *adoption assistance* child for whom there is in effect an adoption assistance agreement between *a local Virginia department of social services (LDSS) or a Virginia child-placing agency* and an adoptive parent(s).

Virginia Medicaid coverage MAY be provided to a special medical needs child for whom there is in effect an adoption assistance agreement between another state's child-placing agency and an adoptive parent(s) IF the other state reciprocates with Virginia per the Interstate Compact on Adoption and Medical Assistance (ICAMA).

3. Verification

a. Adoption assistance agreement with Virginia agency

A child's status as an adoption assistance child is verified by the *LDSS* agency foster care/adoption assistance worker. Documentation of the child's *IV-E or Non-IV-E* adoption assistance eligibility must be part of the Medicaid case record.

Verification of a child's status as a Virginia IV-E, *Non-IV-E or Special Medical Needs* adoption assistance recipient is obtained through the local agency's Service Programs Division.

b. IV-E adoption assistance agreement with another state

When the IV-E adoption assistance agreement is with another state and the IV-E child resides in Virginia, verification of the child's status as a Title IV-E adoption assistance recipient is verified through the Deputy Compact Administrator, Adoption Unit, Division of Family Services, Virginia Department of Social Services.

c. Non-IV-E adoption assistance agreement with another state

Verification of the child's Non-IV-E adoption assistance status with another state, and the state's reciprocal agreement under the Interstate Compact *on Adoption and Medical Assistance (ICAMA)*, is obtained through the Deputy Compact Administrator, Adoption Unit, Division of Family Services, Virginia Department of Social Services.

If the state that signed the non-IV-E adoption assistance agreement does NOT reciprocate Non-IV-E adoption assistance eligibility with Virginia, then the Non-IV-E Adoption Assistance child is not eligible for Virginia Medicaid in the Adoption Assistance classification of the "Individuals Under Age 21" covered group.

M0310.103 AFDC

A. Aid To Families With Dependent Children (AFDC)

AFDC is the short name of the Aid to Families With Dependent Children cash assistance program that was operated in Virginia prior to the February 1, 1997, implementation of TANF (Temporary Assistance to Needy Families). It was a federally funded assistance program under Title IV-A of the Social Security Act. In Virginia, AFDC was replaced by TANF on February 1, 1997.

B. Procedure

AFDC is defined here because of the occasional references in Medicaid policy to the AFDC program that was in effect on July 16, 1996. There are no current recipients of AFDC because the AFDC program no longer exists.

M0310.104 AG

A. Auxiliary Grants (AG)

"AG" is the short name for the Auxiliary Grants Program. AG is Virginia's assistance program that supplements the federal Supplemental Security Income (SSI) assistance program. AG is Virginia's "State Supplementation of SSI." AG is available only to ABD financially eligible individuals who reside in licensed Adult Care Residences (ACRs).

B. Procedure

Check the local agency records of AG recipients. If the individual is eligible for and receiving an AG payment, he is an AG recipient for Medicaid purposes.

M0310.105 AGE and AGED

A. Age

"Age" is the individual's age reached on the anniversary of birth. If the year but not the month and day of the individual's birth is known, July 1 is assigned for both eligibility determination and enrollment.

Eligibility in a Medicaid covered group often depends on an individual's age.

B. Aged

"Aged," means age 65 years or older.

C. Procedures

For individuals under age 21, accept the date of birth provided on the application/redetermination form. No verification is required.

For aged individuals, verify the individual's age by Social Security records or documents in the individual's possession. Acceptable documents include:

- birth certificate or notification of birth;
- hospital or physician's record;
- court record of adoption;
- baptismal record;
- midwife's record of birth;
- form VS95 from state Bureau of Vital Statistics; or
- marriage records.

M0310.106 BLIND

A. Definition

Blindness is defined as having best corrected central visual acuity of 20/200 or less in the better eye.

The Medicaid blindness definition is the same as that of the Supplemental Security Income (SSI) blindness definition.

B. Procedures

An SSI recipient who receives SSI as blind meets the blindness definition for Medicaid. Verify the SSI recipient's SSI eligibility via SVES (State Verification Exchange System).

Individuals who meet the visual eligibility are certified by the Department for the Blind and Vision Impaired (DBVI) and are listed in the Virginia Registry of the Blind. Call DBVI at 1-800-622-2155 to verify that an individual has been certified as blind.

An individual who requires a determination of blindness must be referred to the Disability Determination Services (DDS) using the procedure in M0310.112 E. 1.

M0310.107 CARETAKER-RELATIVE

A. Definitions

1. Caretaker-relative

A "caretaker-relative" is an individual who is not a parent, but who

- is a relative, of a specified degree, of a dependent child (as defined in M0310.111) and
- is living with and assuming continuous responsibility for day to day care of the dependent child (as defined in M0310.111) in a place of residence maintained as his or their own home.

A caretaker-relative is also referred to as a "non-parent caretaker" to distinguish the caretaker-relative from the parent.

2. Specified Degree

A relative of specified degree of the dependent child is

- any blood relative, including those of half-blood and including first cousins, nephews or nieces and persons of preceding generations as denoted by prefixes of grand, great, or great-great;
- a stepfather, stepmother, stepbrother, and stepsister;
- a relative by adoption following entry of the interlocutory or final order, whichever is first; the same relatives by adoption as listed above: including first cousins, nephews or nieces and persons of preceding generations as denoted by prefixes of grand, great, or great-great, and stepfather, stepmother, stepbrother, and stepsister.
- spouses of any persons named in the above groups even after the marriage is terminated by death or divorce.

Neither severance of parental rights nor adoption terminates the relationship to biological relatives.

B. Procedures

1. Relationship

The relationship *as declared on the application/redetermination form is used to determine the* caretaker-*relative's relationship to the child. No verification is required.*

2. Living in the Home

A child's presence in the home as declared on the application/ redetermination form is used to determine if the child is living in the home with a parent or a caretaker-relative. No verification is required.

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M0310.108 CATEGORICALLY NEEDY (CN & CNNMP)

A. CN Definition

"CN" is the short name for "categorically needy." CN is one of the two federal classifications of Medicaid covered groups. The CN covered groups in Virginia include the mandatory cash assistance categorically needy groups listed in the federal Medicaid regulations. "Mandatory" groups are groups of individuals that a state's Medicaid state plan must cover.

A categorically needy (CN) individual is one who is eligible for and usually receiving some type of cash assistance (money payment), or is deemed to be a cash assistance recipient, and is not precluded from eligibility because of a property transfer that occurred prior to July 1, 1988.

B. CNNMP Definition

"CNNMP" is the short name for "categorically needy non money payment." CNNMP is the name Virginia uses for the federal "optional" categorically needy covered groups and the mandatory categorically needy covered groups that do not receive cash assistance. "Optional" means the state can choose whether or not to cover a particular group of individuals in its state plan.

A CNNMP individual is one who is not receiving a cash assistance money payment and is usually not eligible for cash assistance, but who meets the requirements of a CNNMP covered group and is not precluded from eligibility because of a property transfer that occurred prior to July 1, 1988.

C. Procedures

See subchapter M0320 for the policy and procedures to use to determine if an individual meets a categorically needy or CNNMP covered group.

M0310.109 COVERED GROUP

A. Definition

The federal Medicaid law and the State Plan for Medicaid describe the groups of individuals who may be eligible for Medicaid benefits. These groups of individuals are the Medicaid covered groups. The individuals in the covered groups must meet specified definitions, such as age or disability, and other specified requirements such as living in a medical facility.

The covered groups are classified in Virginia as categorically needy (CN), categorically needy non money payment (CNNMP), medically indigent (MI) and medically needy (MN). The covered groups are divided into the ABD and F&C covered groups for financial eligibility purposes.

B. Procedure

The covered groups are listed in section M0310.002.

The detailed requirements of the covered groups are in subchapters M0320 and M0330.

M0310.110 CHILD

A. Definition

An individual under age 21 years who has not been legally emancipated from his/her parent(s) is a child.

A married individual under age 21 is a child unless he/she has been legally emancipated from his/her parents by a court. Marriage of a child does not emancipate a child from his/her parents and does not relieve the parents of their legal responsibility to support the child.

M0310.111 DEPENDENT CHILD

A. Definition

The definition of "dependent child" is the definition in section 406(a) of the Social Security Act: the term "dependent child" means a child who is:

- under the **age of 18**, OR
- under the **age of 19** and is a **full-time student** in a secondary school or in the equivalent level of vocational or technical training, or in a General Educational Development (GED) program IF he may be reasonably expected to complete the secondary school, training or program before *or in the month* he attains age 19; **AND**

  NOTE: The above definition of a full-time student does NOT apply when determining student status for the student earned income exclusion. See sections M0720.500 B.2 and M0720.510 for the student income exclusion requirements.

- **living in the home of a parent or a caretaker-relative** of the first, second, third, fourth or fifth degree of relationship in a place of residence maintained by one or more of such relatives as his or their own home. See section M0310.107 for the definition of a caretaker-relative.

B. Age & School Enrollment

1. Age

The child's date of birth declared on the application/redetermination form is used to determine if the child meets the age requirement. No verification is required.

A child who becomes 18 after the first day of his birth month meets the age requirement in the month of his 18th birthday; he is still considered under age 18 during his birth month. If he becomes age 18 on the first day of his birth month, he is age 18 for the whole birth month.

An 18 year old child does **not** meet the age requirement in the month following the month in which his 18th birthday occurs unless the child is enrolled full-time in a secondary school or vocational/technical school of secondary equivalency, AND the child is reasonably expected to complete the program of secondary school or vocational/technical training before or in the month he attains age 19.

2. School Enrollment

Accept the declaration of school enrollment.

C. Living With a Parent or Caretaker-Relative

1. Relationship

The child's relationship to the parent or caretaker-relative with whom he lives as declared on the application or redetermination document is used to determine if the child is living with a relative. No verification is required.

For the purpose of determining a relationship, neither death, divorce, or adoption terminates relationship to the biological relatives.

***2.* Child's Father**

Virginia law considers a man who is legally married to the mother of a child on the date of the child's birth to be the legal father of the child **UNLESS** DCSE or a court has determined that another man is the child's father. NOTE: The mother's marriage at the time of the child's birth does not require verification; the mother's declaration is sufficient.

The man listed on the application form as the child's father is considered the father when:

- the mother was not married to another man on the child's birth date, or
- the mother was married to another man on the child's birth date but DCSE or a court determined that the man listed on the application is the child's father

unless documentation, such as the child's birth certificate, shows that another man is the child's father.

See M0310.123 for the definition of a parent.

3. **Living in the Home**

A child's presence in the home as declared on the application/ redetermination is used to determine if the child is living in the home with a parent or caretaker-relative. No verification is required.

A child who is living away from the home is considered living with his parents in the household if:

- the child is not emancipated, and
- the absence is temporary and the child intends to return to the parent's home when the purpose of the absence (such as vacation, visit, education, rehabilitation, placement in a facility for less than 30 days) is complete.

  NOTE: If the stay in the medical facility has been or is expected to be 30 days or more, go to M1410.010 to determine if the child is institutionalized in long-term care.

Children living in foster homes or non-medical (residential) institutions are NOT temporarily absent from the home. They are indefinitely absent from home and are NOT living with their parents or siblings for Medicaid purpose.

Children placed in residential treatment facilities are considered absent from their home if their stay in the residential facility has been 30 days or more. A child who is placed in a residential facility is considered NOT living with his parents for Medicaid eligibility purposes as of the first day of the month in which the 30th day of residential placement occurs. Long-term care rules do not apply to children in residential treatment facilities.

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M0310.112 DISABLED

A. *Introduction*

For individuals who meet no other full-benefit covered group and claim to have a disabling condition, Medicaid eligibility uses the same definition of "being disabled" that the Social Security Administration (SSA) uses.

1. *Definition of a Disabled Individual*

For an individual 18 or older, the SSA defines "being disabled" as an individual's inability to do any substantial gainful activity (SGA) or work because of a severe, medically determinable physical or mental impairment or combination of impairments. This impairment(s) has lasted or is expected to last for a continuous period of not less than 12 months, or the impairment is expected to result in death.

For a child under 18, the SSA defines "being disabled" as having a medically determinable physical or mental impairment or combination of impairments that causes marked and severe functional limitations. These limitations must have lasted or be expected to last for a period of not less than 12 continuous months, or the impairment is expected to result in death. However, a child cannot be found disabled if, at application, the child is performing SGA and is not currently entitled to Supplemental Security Income (SSI) benefits.

2. *Disability Determination Services*

Disability Determination Services (DDS) is a division of the Virginia Department of Rehabilitative Services (DRS). DDS is charged with making disability determinations for individuals who allege they are disabled for the purpose of qualifying for Social Security Disability Insurance (SSDI) and/or Supplemental Security Income (SSI) disability or blindness benefits, and/or Medicaid. An individual must file separate applications for SSDI/SSI benefits with SSA and for Medicaid with LDSS.

The Department of Medical Assistance Services (DMAS) contracts with DRS to have DDS process disability and blindness claims and make determinations of "disabled" or "not disabled" based upon federal regulations. DDS uses the same definitions of disability and blindness and the same evaluation criteria for all three programs. See M0310.106 for the definition of blindness.

3. *Factors Involved in a Disability Decision*

The LDSS does not determine whether or not an individual meets the disability requirements. DDS determines whether or not an individual is disabled as defined by the SSA by evaluating a series of factors in sequential order. The following information is intended to provide a general overview for the LDSS worker of this sequential process and does not provide a complete explanation of the disability determination process:

a. *Engaged in Substantial Gainful Activity (SGA)?*

Is the individual currently engaged in substantial gainful activity (SGA)?
SGA means work that: (1) involves doing significant and productive physical or mental duties and (2) is done (or intended) for pay or profit and (3) earnings are above a certain amount. If an individual is working and earning SGA, a finding must be made that the person is not disabled, and no medical evaluation is done. If the individual is not earning SGA, DDS proceeds to the next step.

b. *Severe Impairment?*

Does the individual have a severe impairment, as defined by SSA, that meets the durational requirement (i.e. has lasted or is expected to last for a continuous period of not less than 12 months, or which is expected to result in death)? If no, the person is not disabled. If yes, DDS will proceed to the next step.

c. *Impairment Equals Severity Requirements?*

Does the individual have an impairment that meets or equals the severity requirements of a medical condition contained in the Social Security Listing of Impairments? If yes, a finding of disability is made. If no, DDS will proceed to the next step.

d. *Prevents Performing Past Relevant Work?*

Does the individual have an impairment that prevents him from performing past relevant work? If the individual can perform past relevant work, the person will be found not disabled. If the individual cannot perform past relevant work, DDS will proceed to the next step.

e. *Prevents Performing Any Work?*

Does the individual have an impairment that prevents him from performing any substantial gainful employment? If the individual cannot perform any work, the person will be found disabled. If the person has the capacity to adjust to other types of work, the person will be found not disabled. Age, education, training and skills acquired in past work are considered in making this determination.

4. Other Benefits Related to Disability

a. Benefits Administered by the SSA

The SSA uses the SSA disability definition in the determination of eligibility for SDDI and SSI benefits.

b. Benefits Administered by the Railroad Retirement Board (RRB)

The RRB makes disability determinations for railroad employees who have applied for the Railroad Retirement (RR) disability benefits. A determination of "total" disability means the individual is disabled for all regular work. "Occupational" disability means the individual is disabled for regular railroad occupation, but is not "totally" disabled. Individuals who receive a ***"total"*** *disability determination are disabled using the SSA criteria.*

B. Policy

The following individuals meet the definition of being disabled for the purposes of meeting a Medicaid covered group and are ***not to*** *be referred to DDS:*

- *individuals who receive SSDI or SSI as a disabled individual or receive RR* ***total*** *disability benefits.*

- *individuals who received SSDI or SSI disability benefits or RR total disability benefits in one or more of the 12 months preceding the Medicaid application and whose benefits were terminated for a reason* ***other than no longer meeting the disability or blindness requirements****.*

- *individuals who have been determined disabled or blind by DDS for Medicaid or for SSA, without a subsequent decision by SSA reversing the disability determination, and*

- *individuals who have been determined "totally" disabled by the RRB.*

C. Procedures for Verifying Disability Status

1. Receives SSDI/SSI Disability Benefits

Verify SSDI/SSI disability status through a SVES (State Verification Exchange System) or SOLQ (State Online Verification Query) request or through documentation provided to the applicant by the SSA.

2. Receives RRB Disability Benefits

Verify RRB disability by contacting the RRB at 804-771-2997 or 1-800-808-0772, or through documentation provided to the applicant by the RRB.

3. Determined Disabled by DDS

If disability status cannot be ascertained ***after*** *reviewing SVES or SOLQ, contact your regional DDS office to verify disability status (see Appendix 5 to this subchapter for DDS Regional Offices).*

D. When a DDS Disability Determination is Required

The DDS makes a disability determination for Medicaid when:

- *the individual alleges a disabling condition and has never applied for disability benefits from SSA or has not been denied disability within the past 12 months;* ***or***
- *the individual alleges a disabling condition and SSA has not yet made a determination on a pending SSDI/SSI claim;* ***or***
- *the individual alleges a disabling condition which is different from that considered by SSA or is in addition to that considered by SSA.*

1. Individual Age 19 Years or Older

An individual age 19 years or older must have his disability determined by DDS if he:

- *is claiming to have a disabling condition but does not receive SS/SSI disability benefits or RR total disability benefits,* ***and***

- *has not been denied SSDI or SSI disability benefits in the past 12 months.*

2. Individual Under Age 19

A child under age 19 who is claiming to have a disabling condition must have his disability determined by DDS:

- *if he is not eligible for FAMIS Plus or FAMIS,* ***or***

- *if it is 90 calendar days prior to his 19th birthday.*

*Do **NOT** refer a disabled child under age 19 to DDS for the sole purpose of participation in the Health Insurance Premium Payment (HIPP) program*

E. When an LDSS Referral to DDS is Required

1. Disability Determination Has Not Been Made

The DDS must make a determination of disability when the applicant alleges a disability and a disability determination has not been made by SSA or the RRB. The DDS must make a disability determination within a time frame that will allow the LDSS to process the application within 90 days, provided all medical information has been submitted.

2. SSA Denied Disability Within the Past 12 Months

SSA decisions made within the past 12 months are final decisions for Medicaid purposes unless:

*a) The applicant alleges a condition that is **new** or **in addition** to the condition(s) already considered by SSA,*

OR

*b) The applicant alleges his condition has **changed** or **deteriorated** causing a new period of disability **AND** he requested SSA reopen or reconsider his claim **AND** has refused to do so or denied it for non-medical reasons. Proof of decision made by SSA is required.*

If the conditions in a. or b exist, DDS must make a disability determination.

If the conditions in a or b above do not exist, the SSA denial of disability is final for Medicaid purposes. ***Do NOT make a referral to DDS for a disability determination. Deny the Medicaid application because SSA denied the applicant's disability and the applicant meets no other covered group.***

3. SSA Denied Disability More Than 12 Months Ago

If the applicant alleges a disability and SSA denied the disability more than 12 months ago, the eligibility worker must follow the procedure in M0310.112 G. below to make a referral to DDS.

F. Decision Pathway for DDS Referrals

When determining whether or not a referral to DDS is required, the worker should ask the following questions:

Has the individual applied for SSDI or SSI?

If no, refer to DDS.

*If yes and a decision **has not** been made, refer to DDS.*

*If yes and a decision **has** been made, was the disability allowed or denied?*

If allowed, refer to M0310.112 B, because another determination of disability may not be necessary.

If denied, look at the date of the last determination.

If the last SSA denial determination was made more than 12 months in the past, refer to DDS.

If the last SSA denial determination was made less than 12 months in the past, and there is a new condition that has not been evaluated by SSA, refer to DDS.

If the last SSA denial determination was made less than 12 months in the past, and there has not been a worsening of a condition already evaluated by SSA, do not refer to DDS.

If the last SSA denial determination was made less than 12 months in the past, but there is a worsening of a condition already evaluated by SSA, ask if the individual has filed for a reconsideration or reopening of his case with SSA.

If yes and the case is currently under reconsideration, do not refer to DDS. The SSA decision remains binding unless SSA reverses the decision.

If yes and the SSA refused to reconsider his case <u>because he does not meet the SSI eligibility requirements,</u> refer to DDS.

*If no, do **NOT** refer to DDS. The individual must initiate an appeal of his denial with SSA. Unless SSA refuses the appeal request or turns it down for non-disability related reasons, the disability determination remains binding for 12 months.*

G. LDSS Procedures When a Disability Determination is Required

There are two types of DDS referrals for the purposes of Medicaid eligibility: non-expedited and expedited. Most referrals are non-expedited. Expedited referrals are limited to individuals who are hospitalized and require a Medicaid disability determination so they can be transitioned directly from the hospital to a rehabilitation facility.

For both types of referrals, the eligibility worker must request the necessary verifications needed to determine eligibility so that the application can be processed when the disability determination is received.

1. *LDSS Referrals to DDS for Non-expedited Cases*

a. Send the following forms to the applicant for completion immediately, giving the applicant 10 calendar days to return the completed forms:

- *a copy of the Frequently Asked Questions—Disability Determinations for Medicaid (form #032-03-0426), available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi, explaining the disability determination process and the individual's obligations;*
- *the Disability Report Adult SSA-3368-BK (see Appendix 1 to this subchapter) or the Disability Report Child SSA-3820-BK, (see Appendix 2 to this subchapter).*
- *a minimum of 3 signed, original forms: Authorization to Disclose Information to the Social Security Administration form SSA-827 (4-2009) (see Appendix 3 to this subchapter)* **or** *a form for each medical provider if more than 3.*

b. Complete the DDS Referral Form, available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi Use the DDS Referral Form that corresponds with the DDS Regional Office to which the LDSS has been assigned (#032-03-0095, #032-03-0096, #032-03-0097, or #032-03-0098). To the form, attach the following:

- *the completed Disability Report*
- *the signed copies of the Authorization to Disclose Information*
- *copies of paystubs, if the applicant is currently working.*

If the individual's application was filed with the assistance of a hospital- based eligibility assistance organization, a copy of the consent to release information to the organization must be included with the referral so DDS staff can communicate with them, if necessary.

Mail the DDS Referral form and attachments to the appropriate DDS Regional Office. See Appendix 2 to this subchapter for the locality assignments and addresses for DDS Regional Offices.

Do not send referrals to DDS via the courier.

2. *Expedited Referrals for Hospitalized Individuals Awaiting Transfer to a Rehabilitation Facility*

The 2004 Budget Bill mandated that DDS make a disability determination within seven (7) working days of the receipt of a referral from the LDSS when the Medicaid applicant is hospitalized and needs to be transferred directly to a rehabilitation facility. To ensure that the DDS is able to make the disability determination within the mandated timeframe, the procedures below shall be followed:

a. *Hospital staff shall simultaneously send:*

- *the Medicaid application and a cover sheet (see Appendix 4 for an example of the cover sheet) to the LDSS or the hospital outstationed eligibility worker*
- *the medical documentation (disability report, authorizations to release information and medical records) and cover sheet to the DDS.*

b. *LDSS shall **immediately** upon receipt of the Medicaid application:*

- *fax a completed DDS Referral Form (#032-03-0095, #032-03-0096, #032-03-0097, or #032-03-0098) to the appropriate DDS region, available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi, to verify receipt of the Medicaid application; and*

- *give priority to processing the applications and immediately request any verifications needed; and*

- *process the application as soon as the DDS disability determination and all necessary verifications are received; and*

- *notify the hospital contact identified on the cover sheet of the action on the application and provide the Medicaid enrollee number, if eligible.*

c. *DDS shall make a disability determination within seven (7) working days and fax the result of the disability decision to the LDSS. DDS is not responsible for notifying either the applicant or the hospital of the outcome of the disability determination.*

If DDS is unable to render a decision within 7 working days, DDS will send a communication to the LDSS advising that the disability determination has been delayed.

3. Application Processing When DDS Referral is Pending

If the completed forms are not returned by the applicant within 45 calendar days from the date of application, the applicant is considered not to meet the covered group and the application must be denied.

Individuals who require a disability determination must meet all non-financial requirements other than covered group, within 45 calendar days or the application must be denied. If these requirements are met, the application timeframe may be extended to 90 days while DDS is making the disability determination. If any non-financial requirement other than covered group is not met by the 45th calendar day, his application must be denied and DDS must be notified of the denial.

DDS does NOT stop the disability determination process when the individual meets all non-financial requirements, but has excess resources (see M0130.100 B.4) because he might reduce his resources while the

application is pending for the disability determination. DDS does NOT stop the disability determination when the individual has excess income because of possible spenddown eligibility

4. ***LDSS Responsibilities for Communication with DDS*** — *The LDSS must make every effort to provide DDS with complete and accurate information and shall report all changes in address, medical condition, and earnings to the DDS on pending applications.*

H. Notification of DDS Decision to LDSS

1. ***Hospitalized Individuals*** — *The DDS will advise the agency of the applicant's disability status as soon as it is determined by either SSA or the DDS. For hospitalized individuals who meet the requirements for an expedited disability determination, DDS will fax the outcome of the disability determination directly to the LDSS responsible for processing the application and enrolling the eligible individual.*

2. ***Individuals Not Hospitalized*** — *For all other disability determinations, DDS will mail the determination to LDSS responsible for processing the application and enrolling the eligible individual. If the claim is denied, DDS will also send a personalized denial notice to be sent to the applicant explaining the outcome of his disability determination.*

3. ***Disability Cannot Be Determined Timely*** — *A disability determination cannot be completed within the allotted time when there is missing or incomplete medical information. In the event that this situation occurs, the DDS will notify the applicant on or about 75 days from the application date of the delay and/or the need for additional information. A copy of the DDS's notice to the applicant will also be sent to the LDSS. The LDSS shall send the applicant a Notice of Action to extend the pending application.*

4. ***DDS Rescinds Disability Denial*** — *DDS will notify the agency if it rescinds its denial of an applicant's disability to continue an evaluation of the individual's medical evidence. If the Medicaid application has been denied, the agency must reopen the application and notify the applicant of the action. The application continues to pend until notification is received from DDS of the disability determination. If an appeal has been filed with DMAS, the agency must notify the DMAS Appeals Division so that the appeal may be closed (see M1650.100).*

I. LDSS Action & Notice to the Applicant — *The eligibility worker must complete the Medicaid eligibility determination immediately after receiving notice of the applicant's disability status and send the applicant a Notice of Action regarding the disability determination and the agency's decision on the Medicaid application.*

J. Applicant is Deceased — *When a Medicaid applicant who has been referred to DDS dies or when the applicant is deceased at the time of the Medicaid application, DDS will determine if the disability requirement for Medicaid eligibility was met. The LDSS must immediately notify DDS of the individual's death and make every effort to provide a copy of the death certificate.*

K. Subsequent SSA or RRB Disability Decisions

When SSA or the RRB make a disability decision subsequent to the Medicaid decision which differs from the Medicaid decision, the SSA or RRB decision must be followed in determining Medicaid eligibility unless one of the conditions in M0310.112 E. 2 above applies.

1. SSA/RRB Approval

If SSA approves disability or the RRB approves total disability, the disability definition is met. If DDS initially denied disability and the decision is reversed, re-evaluate the denied Medicaid application. The individual's Medicaid entitlement is based on the Medicaid application date, including the retroactive period, if all eligibility requirements were met during the retroactive period. However, eligibility as a disabled individual cannot begin prior to the disability onset date (month) established by SSA. Do not send the claim back to DDS for an earlier onset date.

Disability Approved More Than 12 Months Past

If, based upon the re-evaluation, the individual is determined to be eligible and more than 12 months have passed since the application was filed, complete an eligibility renewal to determine whether or not the individual remains eligible.

Spenddown

If, based upon the re-evaluation, the individual is determined not eligible for Medicaid but met the requirements in Chapter M13 for placement on a spenddown, a first prospective and additional 6 month spenddown budget periods may be established to cover the period of time between the date of application and the date action is taken on his case. A new application is not required for each 6 month spenddown budget period leading up to the date of processing, however, verification of all income and resources for those time periods must be obtained.

2. SSA Denial or Termination And Appeal

If SSA denies disability, the disability definition is not met. If the individual has been enrolled in Medicaid as disabled and is not eligible in another covered group, send an advance notice to the enrollee to cancel Medicaid.

If the individual appeals the SSA's disability decision timely (within 60 calendar days from the SSA notification or with good cause for exceeding 60 days) and SSA agrees to reconsider the decision, the Medicaid coverage must be reinstated until the final decision on the SSA appeal is made. ***The individual must provide verification that he filed the appeal and SSA agreed to reconsider the case****. The individual must also provide verification of the decisions made at all levels of appeal in order for Medicaid to continue during the process. The Medicaid coverage will continue until a final decision is made and the individual has no right to further SSA appeals.*

The levels of administrative review are in the following order:

a. reconsideration,
b. the hearing before an administrative law judge (ALJ), and
c. the Appeals Council

For example: An individual is enrolled in Medicaid as disabled. However, his SSA claim is denied at the ALJ hearing level. If the individual fails to appeal the ALJ decision to the Appeals Council and the Appeals Council does not decide on its own to review the case, the ALJ decision becomes the final decision once the 60-day deadline for requesting further review has passed. Because the individual no longer meets the disabled definition for another covered group, his Medicaid coverage must be canceled.

3. RRB Denial, Termination and RRB Appeal

If RRB denies disability, the disability definition is not met. If the individual has been enrolled in Medicaid as disabled and is not eligible in another covered group, send an advance notice to the recipient to cancel Medicaid.

Persons who believe that their claims have not been adjudicated correctly may ask for reconsideration by the Board's Office of Programs. If not satisfied with that review, the applicant may appeal to the Board's Bureau of Hearings and Appeals. Further, if the individual timely appeals the RRB disability decision, Medicaid coverage must be reinstated until the final decision on the RRB appeal is made. The individual must provide verification that he filed a timely appeal with RRB and must provide verification of the decisions made at all levels of appeal in order for Medicaid to continue during the process.

M0310.113 EWB

A. Essential to The Well-Being (EWB)

EWB is the short name for a person who is "essential to the well-being" of a child in the household. An EWB who is living in the household and who is providing services which are essential to the well-being of the dependent, deprived child(ren) in the household may be eligible for Medicaid in the LIFC covered group, if the individual

- does not meet any other Medicaid covered group, and
- the individual to whom the EWB provides the service(s) is eligible for Medicaid in the CNNMP LIFC covered group. Services which are essential to the well-being of the dependent, deprived child(ren) in the household are listed in item B.

B. Services Essential to Well-Being

Services which are essential to the well-being of the dependent, deprived child(ren) in the household are limited to:

- provision of care for an incapacitated family member in the home;
- provision of child care which enables the caretaker to work on a full-time basis outside the home;
- provision of child care which enables the caretaker to receive training full-time;
- provision of child care which enables the caretaker to attend high school or GED classes full-time;
- provision of child care for a period not to exceed 2 months to enable the caretaker to participate in employment search.

C. Procedure

Section M0320.306 contains the detailed requirements for the LIFC covered group in which an EWB can be eligible for Medicaid.

M0310.114 FAMILIES & CHILDREN (F&C)

A. Families & Children (F&C)

"Families & Children (F&C)" is the group of individuals that consists of

- eligible members of families with dependent children,
- pregnant women, and
- specified subgroups of children under age 21.

B. Procedures

See the following sections for definitions of F&C individuals and families:

- M0310.102 Adoption Assistance,
- M0310.107 Caretaker-relative,
- M0310.110 Child,
- M0310.111 Dependent Child,
- M0310.113 EWB,
- M0310.115 Foster Care,
- M0310.118 LIFC,
- M0310.123 Parent,
- M0310.124 Pregnant Woman
- M0310.133 BCCPTA

M0310.115 FOSTER CARE

A. Definition

Foster Care provides maintenance and care for children whose custody is held by:

- a local board of social services;
- a licensed private, non-profit child placement agency;
- the Department of Juvenile Justice; or
- the child's parent(s), under a non-custodial agreement.

Federal regulations define "foster care" as "24-hour substitute care for children placed away from their parents or guardians and for whom the State agency has placement and care responsibility" (45 C.F.R. §1355.20). Transfer of the legal custody of the child is not a component when determining if a child is considered to be in foster care. The federal definition is based upon the child being placed outside of the home and who has placement and care responsibility for the child. If a child is placed outside of the home and LDSS is the case manager with placement and care responsibility, then the federal government considers the child to be in foster care. For the federal government, the term "placement and care" means that LDSS is legally accountable for the day-to-day care and protection of the child through either a court order or a voluntary placement agreement.

1. Custody

Custody may be given *to an agency* by the court or *may be retained by the parent(s) or guardian when a non-custodial agreement is involved. If custody is retained by the parent under a parental agreement with the Community Policy and Management Team (CPMT), the child is NOT in foster care.*

2. Child Placing Agency

A child placing agency is an agency that is licensed by the State Department of Social Services for child placing services. Not all child placing agencies provide adoption services; some may provide foster home placement. The services offered must be identified in the description given for the license. The foster care service unit of the local department of social services should be familiar with the function of the child placing agency, and whether or not it is licensed.

3. Independent Living

A foster care child who is under age 21, who is in an Independent Living arrangement and receives full or partial support from a local social services agency, continues to meet the foster care definition and may be eligible in the covered group of Individuals Under Age 21.

4. Non-custodial and Parental Agreements

a. Non-custodial Agreement

A non-custodial agreement is an agreement between the child's parent or guardian and the local Board of Social Services. The parent(s) or guardian retains legal custody of the child. The social services agency agrees to provide financial assistance and/or services to the child, such as placement in and payment for residential facility services.

Non-custodial agreements are used when LDSS serves as the case manager and has placement and care responsibilities to place a child outside of his home for treatment.

Children with non-custodial agreements are considered to be in foster care for Medicaid eligibility purposes.

b. Parental Agreement

A parental agreement is an agreement between the child's parent or guardian and an agency **other than DSS** which is designated by the CPMT. The other agency designated by the CPMT has placement and care responsibility for the child and agrees to provide financial assistance and/or services to the child, such as placement in and payment for residential facility services.

Parental agreements are used when an agency other than LDSS is designated by the CPMT as case manager and the child is placed outside of the home for treatment.

Children with parental agreements ARE NOT considered to be in foster care for Medicaid eligibility purposes.

c. Placement

Federal Title IV-E funds can only be claimed if LDSS has placement and care responsibility for the child **and** the child is placed by LDSS outside the child's home. If the LDSS has placement and care responsibility for the child and the child is placed in the child's home, the child is not eligible for Title IV-E funds and is a Non-IV-E foster child for Medicaid eligibility purposes.

5. Department of Juvenile Justice

A child in the custody of the Virginia Department of Juvenile Justice or who is the responsibility of a court is a "Department of Juvenile Justice (DJJ) child."

B. Procedures

1. IV-E Foster Care

Children who are eligible for and receive Title IV-E (AFDC-FC) foster care maintenance payments are IV-E Foster Care for Medicaid eligibility purposes. *A child of a IV-E foster care child is also considered to be a IV-E foster care child when the mother's IV-E payment includes an allocation for her child.*

A child who is eligible for IV-E Foster Care but who does not receive a IV-E Foster Care maintenance payment is considered a "Non-IV-E Foster Care" child.

Children in the custody of another state's social services agency, who are eligible for and receive Title IV-E Foster Care maintenance payments and who now reside in Virginia, are IV-E Foster Care for Medicaid eligibility purposes. Verify the child's IV-E eligibility from the other state's department of social services which makes the IV-E payment.

2. Non IV-E Foster Care

Children who are eligible for but do not receive IV-E maintenance payments or who are eligible for Non-IV-E (state/local) Foster Care (whether or not they receive a Non-IV-E payment), and who reside in Virginia are Non-IV-E Foster Care for Medicaid eligibility purposes.

3. Non-IV-E Children in Another State's Custody

Children in the custody of another state's social services agency who are not receiving IV-E foster care maintenance payments, do NOT meet the Virginia residency requirement for Medicaid (M0230) and are not eligible for Virginia Medicaid.

4. Trial Home Visits

A foster care or DJJ child continues to meet the foster care definition *(either IV-E or non-IV-E)* when placed by the agency in the child's own home for a trial period of up to six months*, if the child continues to be in the agency's custody or remains the financial responsibility of DJJ or the court.* Do not redetermine Medicaid eligibility during the 6 month trial home visit.

M0310.116 HOSPICE

A. Definition

"Hospice" is a CNNMP covered group of terminally ill individuals whose life expectancy is 6 months or less and who have voluntarily elected to receive hospice care. The term "hospice" is also used to refer to the covered service for a terminally ill Medicaid recipient, regardless of his covered group. Hospice services can be provided in the individual's home or in a medical facility, including a nursing facility.

1. Hospice Care

"Hospice care" means items and services are provided to a terminally ill individual by, or by others under arrangements made by, a hospice program under a written plan of care for the individual that is established and periodically reviewed by the individual's attending physician and the hospice program's medical director:

2. Hospice Program

A "hospice program" is a public agency or private organization which

- is primarily engaged in providing hospice care, makes hospice care services available as needed on a 24-hour basis, and provides bereavement counseling for the terminally ill individual's immediate family;
- provides hospice care in individuals' homes or in medical facilities on a short-term inpatient basis;
- meets federal and state staffing, record-keeping and licensing requirements.

B. Procedure

The individual must elect hospice care in a non-institutional setting. Election of hospice care is verified either verbally or in writing from the hospice care provider. If verification is verbal, document the case record.

M0310.117 INSTITUTION

A. Definition

An **institution** is an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor.

B. Medical Institution (Facility)

A **medical institution** is an institution that:

- is organized to provide medical care, including nursing and convalescent care,
- has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
- is authorized under state law to provide medical care, and
- is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

C. Procedures

The procedures used to determine if an individual meets a covered group of individuals in institutions are contained in subchapters M0320 and M0330.

M0310.118 LIFC

A. Low Income Families with Children (LIFC)

Low Income Families with Children (LIFC) is a covered group of individuals in families who have a dependent child(ren) living in the home, and whose income is within the Medicaid F&C income limits.

B. Procedure

Section M0320.304 contains the detailed requirements for the LIFC covered group.

M0310.119 MEDICALLY INDIGENT (MI)

A. Definition

"MI" is the short name for "medically indigent." MI is the name Virginia uses for the subclassification of federally mandated categorically needy covered groups that do not receive cash assistance and that have income within a percentage of the federal poverty income guidelines.

An MI individual is one who is not eligible for cash assistance, but who meets the requirements of an MI covered group and has income within the specified percentage of the federal poverty limit.

B. Procedure The procedures used to determine if an individual meets an MI covered group are in subchapter M0320.

M0310.120 MEDICALLY NEEDY (MN)

A. Definition "MN" is the short name for "medically needy." MN is one of the two federal classifications of Medicaid covered groups. All MN covered groups are optional; the state can choose whether or not to cover MN individuals in its state plan. However, if the state chooses to cover MN individuals, it must at least cover children under age 18, pregnant women and the protected group of individuals who were eligible as MN blind or disabled in December 1973 and continue to meet the December 1973 eligibility criteria. The state may choose to cover additional groups of individuals as MN.

The MN individual is one who has income and resources enough to meet his maintenance needs, but not enough to meet his medical needs. He is not eligible for a cash assistance payment because his income and/or resources exceed the cash assistance limits. MN individuals whose income exceeds the MN income limit may become eligible by incurring medical and/or remedial care expenses to establish eligibility (spenddown).

B. Procedure The procedures used to determine if an individual meets a MN covered group are in subchapter M0330.

M0310.121 MEDICARE BENEFICIARY

A. Definition A Medicare beneficiary is an individual who is entitled to Medicare (Title XVIII of the Social Security Act). Medicare is a federally funded and administered health insurance program and consists of hospital insurance (Part A), medical insurance (Part B) *and, beginning January 1, 2006, prescription drug coverage (Part D).*

1. Part A A person is entitled to Medicare Part A if he

a. is age 65 or older and:

- eligible for monthly Social Security benefits on the basis of covered work under the Social Security Act,
- a qualified Railroad Retirement beneficiary,
- not eligible for *S*ocial *S*ecurity or Railroad Retirement benefits but meets the requirements of a special transitional provision,
- not eligible for Social Security or Railroad Retirement benefits but voluntarily enrolls and pays a monthly premium, or

- would be eligible for Social Security benefits if his governmental employment were covered work under the Social Security Act; OR

b. is under age 65, disabled and

- entitled to or deemed entitled to Social Security disability benefits for more than 24 months,
- would be entitled to Social Security disability benefits for more than 24 months if his governmental employment were covered work under the Social Security Act,
- under specified circumstances, entitled to Railroad Retirement benefits because of disability,
- loses his entitlement to disability benefits and Medicare Part A solely because he is engaging in substantial gainful employment but voluntarily elects to enroll and pay a monthly premium; OR

c. is any age and has end-stage renal disease treated by a kidney transplant or a regular course of kidney dialysis and meets the special insured status requirements.

2. Part B

A person is eligible to enroll in Medicare Part B if he

a. is entitled to premium-free Medicare Part A or pays a premium for Medicare Part A, OR

b. is age 65 or older, a resident of the U.S., and either

- a citizen of the U.S., or
- an alien lawfully admitted for permanent residence who has resided in the U.S. continuously during the 5 years immediately prior to the month in which he or she applies for enrollment.

3. Part D

A person is eligible to enroll in Medicare Part D if he:

a. is entitled to Medicare Part A and/or enrolled in Medicare Part B; and

b. is a resident of the United States.

B. Procedures

A Medicare beneficiary may be eligible for Medicaid if he meets all of the Medicaid eligibility requirements including any one or more of the covered groups. Four of the Medicaid covered groups are specifically for Medicare beneficiaries and *provide a limited benefit package that pays costs related to Medicare, such as premiums, copays, and deductibles. These groups include Qualified Medicare Beneficiaries (QMBs), Special Low- income Medicare Beneficiaries (SLMBs), Qualified Disabled and Working Individuals (QDWIs) and Qualified Individuals (QI). QMBs, SLMBs, and QIs are also referred to as Medicare Savings Programs (MSP).*

See sections *M0320.206, 207 and 208 for the procedures to use to determine if an individual meets an MSP covered group. See section M0320.209 for the procedures to use to determine if an individual meets the QDWI covered group*.

M0310.122 OASDI

A. Old Age, Survivors & Disability Insurance (OASDI)

Old Age, Survivors & Disability Insurance (OASDI) is the federal insurance benefit program under Title II of the Social Security Act that provides cash benefits to workers and their families when the workers retire, become disabled or die.

OASDI is sometimes called RSDI - Retirement, Survivors & Disability Insurance. Because Title II of the Social Security Act is still officially called "Old Age, Survivors & Disability Insurance", the Medicaid manual uses the abbreviation "OASDI" interchangeably with "Title II" to refer to Title II Social Security benefits.

B. Entitlement

An individual is fully insured if he has at least 1 credit for each calendar year after 1950, or if later, after the year in which he attained age 21, and prior to the year in which he or she attains age 62 or dies or becomes disabled, whichever occurs earlier.

A worker is entitled to retirement insurance benefits if he is at least age 62, is fully insured and files an application for retirement insurance benefits.

A claimant who is the worker's spouse is entitled to spouse's benefits on the worker's record if the claimant is age 62 or over, has in care a child under age 16 or disabled who is entitled to benefits on the worker's record, and the claimant has been married to the worker for at least 1 year before filing the claim or the claimant is the natural mother or father of the worker's biological child.

A child is entitled to child's insurance benefits on a parent's work record if an application for child's benefits is filed, the child is or was dependent on the parent, the child is unmarried, the child is under age 18 or is age 18-19 and a full-time elementary or secondary school student or age 18 or over and under a disability which began before the child attained age 22; and the parent is entitled to retirement or disability insurance benefits, or died and was either fully or currently insured at the time of death.

When an insured worker dies, monthly cash benefits may be paid to eligible survivors as follows: widow(er)'s benefits, surviving child's benefits, mother's or father's benefits, and parent's benefits.

C. Procedures

Verify an individual's entitlement to OASDI by inquiring the MMIS computer system or entering the required data into the State Verification Exchange System (SVES). The individual's award letter from SSA is acceptable verification of OASDI entitlement

M0310.123 PARENT

A. Definition

Under federal regulations, a parent means either the mother or the father, married or unmarried, natural or adoptive following entry of the interlocutory or final adoption order, whichever comes first.

1. Mother Married on Child's Birth Date

A mother who was married at the time of her child's birth may name on the application someone other than her husband as the child's father. The man to whom she was married at the time of the child's birth, however, is considered the child's father unless DCSE or a court determines otherwise. DCSE or the court must exclude the mother's husband, considered the legal father, as the child's father before the paternity status of the man named on the application is determined.

2. Mother NOT Married on Child's Birth Date

If the mother was NOT married when the child was born, the man who is living in the home and who is listed on the application as the child's father is the child's acknowledged father, unless the agency receives evidence that contradicts the application, such as the child's birth certificate that has another man named as the child's father.

3. Paternity Evidence

If evidence of paternity is required to establish eligibility or ineligibility, such evidence must be entered in the eligibility case record.

B. Procedures

NOTE: The mother's marital status at the time of the child's birth does not require verification; her declaration of her marital status is sufficient.

Section M0320.*304* contains the detailed requirements for the LIFC covered group in which a parent of a dependent child can be eligible for Medicaid.

M0310.124 PREGNANT WOMAN

A. Definition

A woman of any age who is medically determined to be pregnant meets the definition of a pregnant woman.

1. Effective Date

The pregnant woman definition is met the first day of the estimated month of conception as medically verified, or the first day of the earliest month which the medical practitioner certifies as being a month in which the woman was pregnant.

The definition of "pregnant woman" is met for sixty days following the last day the woman was pregnant regardless of the reason the pregnancy ended, and continues to be met until the last day of the month in which the 60th day occurs.

Example #3: a pregnant woman applies for Medicaid in May 1997; she received medical treatment in March and April 1997. The physician gives her a written statement dated May 20, 1997 saying that he "treated her in March 1997. She was approximately 3 months pregnant at that time. She is still pregnant this date." Therefore, her pregnancy is

medically verified for February - April 1997, since the doctor's statement verifies that she was pregnant in February, March, April, and May.

B. Procedures

1. Verification

Verification of pregnancy, including the expected delivery date, must be provided. Acceptable verification is a written or verbal statement from a physician, nurse or similar *health* practitioner. Documentation of how the pregnancy was verified must be included in the case record.

If retroactive converge is requested the statement must also include an estimated month of conception since the pregnant woman definition is not met in any month prior to the conception month. If the medical practitioner cannot or will not give an estimated month of conception, the practitioner's certification that the woman was and is pregnant in the specific months for which Medicaid coverage is requested will suffice as pregnant woman definition verification.

Proof of the birth of a child to the mother is sufficient verification of the mother's pregnancy in the three months prior to the child's birth month.

2. Covered Groups Eligibility

A pregnant woman may be eligible for Medicaid if she meets all of the Medicaid eligibility requirements including any one or more of the covered groups. Two of the Medicaid covered groups are specifically for pregnant women: MI Pregnant Women and MN Pregnant Women.

See section M0320.301 for the MI pregnant woman covered group requirements, and section M0330.301 for the MN pregnant woman covered group requirements.

M0310.125 QDWI

A. Qualified Disabled & Working Individuals (QDWI)

QDWI is the short name used to designate the Medicaid covered group of Medicare beneficiaries who are "Qualified Disabled and Working Individuals." A qualified disabled and working individual means an individual

- who is entitled to enroll for Medicare Part A,
- whose resources do not exceed twice the maximum amount of resources that an individual or couple may have and be eligible for SSI,
- whose income does not exceed 200% of the federal poverty limit,
- who is NOT otherwise eligible for Medicaid.

B. Procedure

QDWI is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary's Medicare Part A premium. See section M0320.209 for the procedures to use to determine if an individual meets the QDWI covered group.

M0310.126 Qualified Individuals

A. Qualified Individuals (QI)

QI-1 *is* the short names used to designate the Medicaid covered group of "Qualified Individuals." A qualified individual means a Medicare beneficiary

- who is entitled to Medicare Part A,
- whose resources do not exceed twice the maximum amount of resources that an individual or couple may have and be eligible for SSI, and
- whose income is equal to or more than 120% of the federal poverty level (FPL) and is less than 135% FPL.

B. Procedure

Qualified individuals is a mandatory covered group that the State Plan must cover for the purpose of paying the Medicare Part B premium for the QI. See section M0320.208 for the procedures to used to determine if an individual meets the QI covered group.

M0310.127 QMB

A. Qualified Medicare Beneficiary (QMB)

QMB is the short name used to designate the Medicaid covered group of "Qualified Medicare Beneficiary." A qualified Medicare beneficiary means an individual

- who is entitled to enroll for Medicare Part A,
- whose resources do not exceed twice the maximum amount of resources that an individual or couple may have and be eligible for SSI, and
- whose income does not exceed *100%* of the FPL.

B. Procedure

QMB is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary's Medicare premiums and cost sharing expenses. See section M0320.206 for the procedures to use to determine if an individual meets the QMB covered group.

M0310.128 RSDI

A. Retirement, Survivors & Disability Insurance (RSDI)

Retirement, Survivors & Disability Insurance (RSDI) is another name for Old Age, Survivors & Disability Insurance (OASDI) - the federal insurance benefit program under Title II of the Social Security Act that provides cash benefits to workers and their families when the workers retire, become disabled or die.

B. Procedure

RSDI Is not used in the Medicaid manual. Because Title II of the Social Security Act is still officially called "Old Age, Survivors & Disability Insurance", the Medicaid manual uses the abbreviation "OASDI" interchangeably with "Title II" to refer to Title II Social Security benefits.

M0310.129 SLMB

A. Special Low- income Medicare Beneficiary (SLMB)

SLMB is the short name used to designate the Medicaid covered group of "Special Low-income Medicare Beneficiary". A special low-income Medicare beneficiary means an individual

- who is entitled to enroll for Medicare Part A,
- whose resources do not exceed twice the maximum amount of resources that an individual or couple may have and be eligible for SSI,
- whose income exceeds the QMB income limit *(100% of the FPL)* but does NOT exceed the higher SLMB income limit, which is *120%* of the FPL.

B. Procedure

SLMB is a mandatory covered group that the state plan must cover for the purpose of paying the beneficiary's Medicare Part B premium. See section M0320.208 for the procedures to use to determine if an individual meets the SLMB covered group.

M0310.130 SSI

A. Supplemental Security Income (SSI)

Supplemental Security Income (SSI) is the federal cash assistance benefit program under Title XVI of the Social Security Act that provides cash assistance to eligible aged, blind or disabled individuals to meet their shelter, food and clothing needs.

B. Procedures

Individuals who receive SSI (SSI recipients) are not "automatically" eligible for Medicaid in Virginia. SSI recipients must meet all of the Medicaid nonfinancial eligibility requirements and must meet the Medicaid resource eligibility requirements that are more restrictive than SSI's resource requirements. See section M0320.200 for the procedures to use to determine if an SSI recipient meets a covered group.

M0310.131 STATE PLAN

A. Definition

The State Plan for Medical Assistance is a comprehensive written statement submitted by the Department of Medical Assistance Services (DMAS) describing the nature and scope of Virginia's Medicaid program. It contains all the information necessary for the federal *Centers for Medicare and Medicaid Services (CMS)* to determine whether the state plan can be approved for federal financial participation (FFP) in the state's Medicaid program expenses.

B. State Plan Governs Medicaid Eligibility Rules

The State Plan consists of preprinted material that covers the basic Medicaid requirements and individualized material written by DMAS that reflects the particular requirements and choices made by Virginia for its Medicaid program. The State Plan is included in DMAS' state regulations promulgated according to the Virginia Administrative Process Act (APA). The State Plan is kept and updated by DMAS.

The State Plan shows the eligibility requirements for Virginia Medicaid, including the mandatory and optional groups of individuals covered by Virginia Medicaid and the medical services covered by Medicaid for those groups. The covered groups eligibility requirements in this chapter are based on the State Plan.

M0310.132 TANF

A. Temporary Assistance for Needy Families (TANF)

TANF is the federally-funded (with matching funds from the states) block grant program in Title IV Part A of the Social Security Act that provides temporary cash assistance to needy families. In Virginia, TANF replaced the previous Title IV-A program called Aid to Families With Dependent Children (AFDC) on February 1, 1997.

M0310.133 BCCPTA

A. Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)

The BCCPTA created a Medicaid covered group for women age 18 through 64 who have been identified by the Centers for Disease Control and Prevention's (CDC) Breast and Cervical Cancer Early Detection Program (BCCEDP) as being in need of treatment for breast or cervical cancer.

B. Procedures

Section M0320.312 contains the detailed requirements for the BCCPTA covered group.

M0310.134 VIEW PARTICIPANT

A. *Virginia Initiative for Employment not Welfare (VIEW) Participants*

A VIEW participant is an individual who has signed the TANF Agreement of Personal Responsibility. VIEW participants have a higher earned income limit than non-VIEW participants. An individual under a TANF VIEW sanction is a VIEW participant for Medicaid purposes. An individual only receiving TANF transitional support services is not a VIEW participant for Medicaid purposes.

M0310.135 HIPP PROGRAM

A. Health Insurance Premium Payment (HIPP) Program

HIPP is a cost savings program administered by the DMAS for Medicaid enrollees which reimburses some or all of the employee portion of group health insurance premiums. HIPP is available to Medicaid enrollees when a family member is employed at least 30 hours per week and is enrolled in an employer's group health plan. Eligibility for HIPP is determined by the HIPP Unit at DMAS. Participation in HIPP is voluntary.

B. Procedures

M0130.200 G contains additional information about HIPP.

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0579

DISABILITY REPORT ADULT

For SSA Use Only
Do not write in this box.
Related SSN _____
Number Holder _____

SECTION 1- INFORMATION ABOUT THE DISABLED PERSON

A. **NAME** *(First, Middle Initial, Last)*

B. **SOCIAL SECURITY NUMBER**

C. **DAYTIME TELEPHONE NUMBER** *(If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)*

Area Code _____ *Number* _____ ☐ Your Number ☐ Message Number ☐ None

D. Give the name of a **friend or relative** that we can contact (other than your doctors) **who knows about your illnesses, injuries or conditions** and can help you with your claim.

NAME _____ RELATIONSHIP _____

ADDRESS _____
(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)

_____ _____ _____ DAYTIME PHONE _____ _____
City *State* *ZIP* *Area Code* *Number*

E. What is your **height** without shoes? _____ *feet* _____ *inches*

F. What is your **weight** without shoes? _____ *pounds*

G. Do you have a **medical assistance card**? (For Example, Medicaid or Medi-Cal) If "YES," show the **number** here: ☐ YES ☐ NO _____

H. Can you **speak English**? ☐ YES ☐ NO If "NO," what languages can you speak? _____

If you **cannot speak English**, is there someone we may contact who speaks English and will give you messages? *(If this is the same person as in "D" above show "SAME" here.)*

NAME _____ RELATIONSHIP _____

ADDRESS _____
(Number, Street, Apt. No.(If any), P.O. Box, or Rural Route)

_____ _____ _____ DAYTIME PHONE _____ _____
City *State* *ZIP* *Area Code* *Number*

I. Can you **read English**? ☐ YES ☐ NO J. Can you **write more than your name in English**? ☐ YES ☐ NO

SECTION 2
YOUR ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT YOU

A. What are the **illnesses, injuries or conditions** that limit your ability to work? _____

B. How do your illnesses, injuries or conditions limit your ability to work? _____

C. Do your illnesses, injuries or conditions cause you **pain** or other symptoms? ☐ YES ☐ NO

D. When did your illnesses, injuries or conditions **first bother you**? | *Month* | *Day* | *Year* |

E. When did you become **unable to work** because of your illnesses, injuries or conditions? | *Month* | *Day* | *Year* |

F. Have you **ever worked**? ☐ YES ☐ NO *(If "NO," go to Section 4.)*

G. Did you **work at any time** after the date your illnesses, injuries or conditions first bothered you? ☐ YES ☐ NO

H. If "YES," did your illnesses, injuries or conditions cause you to: *(check all that apply)*

- ☐ **work fewer hours?** *(Explain below)*
- ☐ **change your job duties?** *(Explain below)*
- ☐ **make any job-related changes such as your attendance, help needed, or employers?** *(Explain below)*

I. Are you **working now**? ☐ YES ☐ NO

If "NO," when did **you stop working**? | *Month* | *Day* | *Year* |

J. Why did you **stop working**? _____

SECTION 3 - INFORMATION ABOUT YOUR WORK

A. List the **kinds of jobs** that you have had in the **last 15 years that you worked.**

JOB TITLE *(Example, Cook)*	TYPE OF BUSINESS *(Example, Restaurant)*	DATES WORKED *(month & year)* From	To	HOURS PER DAY	DAYS PER WEEK	RATE OF PAY *(Per hour, day, week,month or year)*	
						$	
						$	
						$	
						$	
						$	
						$	
						$	

B. Which job did you do the longest? _____

C. Describe this job. What did you do all day? (If you need more space, write in the "Remarks" section.)

_____

_____

D. In **this job**, did you:

Use machines, tools or equipment? ☐ YES ☐ NO

Use technical knowledge or skills? ☐ YES ☐ NO

Do any writing, complete reports, or perform duties like this? ☐ YES ☐ NO

E. In **this job**, how many total hours each day did you:

Walk? ____ Stoop? *(Bend down & forward at waist.)* ____ Handle, grab or grasp big objects? ____

Stand? ____ Kneel? *(Bend legs to rest on knees.)* ____ Reach? ____

Sit? ____ Crouch? *(Bend legs & back down & forward.)* ____ Write, type or handle small objects? ____

Climb? ____ Crawl? *(Move on hands & knees.)* ____

F. Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

_____

_____

G. Check **heaviest** weight lifted:

☐ Less than 10 lbs ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ 100 lbs. or more ☐ Other _____

H. Check weight **frequently** lifted: *(By frequently, we mean from 1/3 to 2/3 of the workday.)*

☐ Less than 10 lbs ☐ 10 lbs ☐ 25 lbs ☐ 50 lbs. or more ☐ Other _____

I. Did you supervise other people in this job? ☐ YES (Complete items below.) ☐ NO (Skip to next page.)

How many people did you supervise? _____

What part of your time was spent supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

J. Were you a lead worker? ☐ YES ☐ NO

SECTION 4 - INFORMATION ABOUT YOUR MEDICAL RECORDS

A. Have you been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions that limit your ability to work? ☐ YES ☐ NO

B. Have you been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? ☐ YES ☐ NO

If you answered "NO" to both of these questions, go to Section 5.

C. List **other names** you have used on your medical records. _____

_____

Tell us who may have medical records or other information about your illnesses, injuries or conditions.

D. **List each DOCTOR/HMO/THERAPIST/OTHER.** Include your **next appointment.**

1.

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE Area Code Phone Number		**CHART/HMO #** (If known)	NEXT **APPOINTMENT**
REASONS FOR VISITS			
WHAT **TREATMENT** WAS RECEIVED?			

2.

NAME			DATES
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE Area Code Phone Number		**CHART/HMO #** (If known)	NEXT **APPOINTMENT**
REASONS FOR VISITS			
WHAT **TREATMENT** WAS RECEIVED?			

SECTION 4-INFORMATION ABOUT YOUR MEDICAL RECORDS

DOCTOR/HMO/THERAPIST/OTHER

3.

NAME			DATES
STREET ADDRESS			FIRST VISIT
CITY	STATE	ZIP	LAST SEEN
PHONE ____ (Area Code) ____ (Phone Number)	CHART/HMO # (If known)		NEXT APPOINTMENT
REASONS FOR VISITS			
WHAT TREATMENT WAS RECEIVED?			

If you need more space, use Remarks, Section 9.

E. **List each HOSPITAL/CLINIC.** Include your **next appointment.**

1.

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ **INPATIENT** STAYS *(Stayed at least overnight)*	DATE IN	DATE OUT
STREET ADDRESS					
CITY	STATE	ZIP	☐ **OUTPATIENT** VISITS *(Sent home same day)*	DATE FIRST VISIT	DATE LAST VISIT
PHONE ____ (Area Code) ____ (Phone Number)			☐ **EMERGENCY ROOM** VISITS	DATE OF VISITS	

Next **appointment** _____ Your hospital/clinic **number** _____

Reasons for visits _____

What **treatment** did you receive? _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

SECTION 4-INFORMATION ABOUT YOUR MEDICAL RECORDS

HOSPITAL/CLINIC

2.

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			☐ **INPATIENT** STAYS *(Stayed at least overnight)*	DATE IN	DATE OUT
STREET ADDRESS					
CITY	STATE	ZIP	☐ **OUTPATIENT** VISITS *(Sent home same day)*	DATE FIRST VISIT	DATE LAST VISIT
PHONE ____ ____ *Area Code* *Phone Number*			☐ **EMERGENCY ROOM** VISITS	DATE OF VISITS	

Next **appointment** _____ Your hospital/clinic **number** _____

Reasons for visits _____

What **treatment** did you receive? _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

If you need more space, use Remarks, Section 9.

F. Does **anyone else have medical records or information** about your illnesses, injuries or conditions (Workers' Compensation, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else?

☐ YES *(If "YES," complete information below.)* ☐ NO

NAME			**DATES**
STREET ADDRESS			**FIRST** VISIT
CITY	**STATE**	**ZIP**	**LAST** SEEN
PHONE ____ ____ *Area Code* *Phone Number*			NEXT APPOINTMENT
CLAIM NUMBER (If any)			
REASONS FOR VISITS			

If you need more space, use Remarks, Section 9.

SECTION 5 - MEDICATIONS

Do you currently take any **medications** for your illnesses, injuries or conditions? ☐ YES
If "YES," please tell us the following: *(Look at your medicine bottles, if necessary.)* ☐ NO

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need more space, use Remarks, Section 9.

SECTION 6 - TESTS

Have you had, or will you have, any **medical tests** for illnesses, injuries or conditions?
☐ YES ☐ NO If "YES," please tell us the following: *(Give approximate dates, if necessary.)*

KIND OF TEST	WHEN DONE, OR WHEN WILL IT BE DONE? (Month, day, year)	WHERE DONE? (Name of Facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY--Name of body part _____			
HEARING TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY--Name of body part _____			
MRI/CT SCAN Name of body part _____			

If you have had other tests, list them in Remarks, Section 9.

SECTION 7-EDUCATION/TRAINING INFORMATION

A. Check the highest grade of **school** completed.

Grade school: 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11 ☐ 12 ☐ GED ☐

College: 1 ☐ 2 ☐ 3 ☐ 4 or more ☐

Approximate **date** completed: _____

B. Did you attend **special education** classes? ☐ YES ☐ NO *(If "NO," go to part C)*

NAME OF SCHOOL _____

ADDRESS _____
(Number, Street, Apt. No.(if any), P.O. Box or Rural Route)

_____
City *State* *Zip*

DATES ATTENDED _____ TO _____

TYPE OF PROGRAM _____

C. Have you completed any type of **special job training, trade or vocational school?**

☐ YES ☐ NO If "YES," what type? _____

Approximate date completed: _____

SECTION 8 - VOCATIONAL REHABILITATION, EMPLOYMENT, or OTHER SUPPORT SERVICES INFORMATION

Are you participating in the Ticket Program or another program of vocational rehabilitation services, employment services or other support services to help you go to work?

☐ YES (Complete the information below) ☐ NO

NAME OF ORGANIZATION _____

NAME OF COUNSELOR _____

ADDRESS _____
(Number, Street, Apt. No.(if any), P.O. Box or Rural Route)

_____
City *State* *Zip*

DAYTIME PHONE NUMBER _____ _____
Area Code *Number*

DATES SEEN _____ TO _____

TYPE OF SERVICES OR TESTS PERFORMED _____
(IQ, vision, physicals, hearing, workshops, etc.)

SECTION 9 - REMARKS

Use this section for any added information you did not show in earlier parts of the form. When you are done with this section (or if you don't have anything to add), be sure to go to the next page and complete the signature block.

SECTION 9 - REMARKS

ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW.

Signature of **claimant** or person filing on claimant's behalf ***(parent, guardian)***	**Date** *(Month, day, year)*

Witnesses are required **ONLY** if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below, giving their full addresses.

1. Signature of **Witness**	2. Signature of **Witness**
Address *(Number and street, city, state, and ZIP code)*	**Address** *(Number and street, city, state, and ZIP code)*

DISABILITY REPORT - ADULT - Form SSA-3368-BK

PLEASE READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

IF YOU NEED HELP

If you need help with this form, do as much of it as you can, and your interviewer will help you finish it. However, if you have access to the Internet, you may access the Disability Report Form Guide at http://www.ssa.gov/disability/3368/.

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can.

- Please fill out as much of this form as you can before your interview appointment.
- Print or type.
- **DO NOT LEAVE ANSWERS BLANK**. If you do not know the answers, or the answer is "none" or "does not apply," please write: "don't know," or "none," or "does not apply."
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HOSPITAL/CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from other people, like a friend or family member.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you or mail it ahead of time, if you were told to do so.
- When a question refers to "you," "your" or the "Disabled Person," it refers to the person who is applying for disability benefits. If you are filling out the form for someone else, please provide information about him or her.
- Be sure to explain an answer if the question asks for an explanation, or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use the "REMARKS" section on Pages 9 and 10, and show the number of the question being answered.

ABOUT YOUR MEDICAL RECORDS

If you have any medical records and copies of prescriptions at home for the person who is applying for disability benefits, send them to our office with your completed forms or bring them with you to your interview. Also, bring any prescription bottles with you. If you need the records back, tell us and we will photocopy them and return them to you.

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do that for you. The information we ask for on this form tells us to whom we should send a request for medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and prescription bottles.

WHAT WE MEAN BY "DISABILITY"

"Disability" under Social Security is based on your inability to work. For purposes of this claim, we want you to understand that "disability" means that you are unable to work as defined by the Social Security Act. You will be considered disabled if you are unable to do any kind of work for which you are suited and if your disability is expected to last (or has lasted) for at least a year or to result in death. So when we ask, "when did you become unable to work," we are asking when you became disabled as defined by the Social Security Act.

The Privacy And Paperwork Reduction Acts

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Department of Veterans Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

PAPERWORK REDUCTION ACT: This information collection meets the clearance requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You are not required to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take you about 60 minutes to read the instructions, gather the necessary facts, and answer the questions.

PLEASE REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0577

DISABILITY REPORT - CHILD

SECTION 1 – INFORMATION ABOUT THE CHILD

A. **CHILD'S NAME** *(First, Middle Initial, Last)*

B. **CHILD'S SOCIAL SECURITY NUMBER**

C. **YOUR NAME** *(If agency, provide name of agency and contact person)*

YOUR MAILING ADDRESS *(Number and Street, Apt. No. (if any), P.O. Box, or Rural Route)*

CITY | STATE | ZIP CODE

D. **YOUR DAYTIME PHONE NUMBER** *(If you have no phone number, give us a daytime number where we can leave a message for you.)*

Area Code *Number* ☐ Your Number ☐ Message Number ☐ None

E. What is **your relationship to the child**?

F. Can you **speak English**? YES ☐ NO ☐ If "NO," what languages can you speak?

If you **cannot speak English**, give us the name of someone we may contact who speaks English and will give you messages.

NAME RELATIONSHIP TO CHILD

ADDRESS
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City *State* *ZIP* DAYTIME PHONE *Area Code* *Phone Number*

Can you **read English**? YES ☐ NO ☐

G. Does the child live with you? YES ☐ NO ☐ If "NO," with whom does the child live?

NAME RELATIONSHIP TO CHILD

ADDRESS
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

City *State* *ZIP* DAYTIME PHONE *Area Code* *Phone Number*

Can this person **speak English**? YES ☐ NO ☐

If "NO," what languages can this person speak?

Can this person **read English**? YES ☐ NO ☐

SECTION 1 – INFORMATION ABOUT THE CHILD

H. Can the child speak English? YES ☐ NO ☐

If "NO," what languages can the child speak? _____

I. What is child's height *(without shoes)*? _____ What is child's weight *(without shoes)*? _____

J. Does the child have a **medical assistance card**? (for example, Medicaid, Medi-Cal)

YES ☐ NO ☐

If "YES," show the **number** here: _____

SECTION 2 – CONTACT INFORMATION

Give the name of a person that we can contact (other than the child's doctors, such as legal guardian) who knows about the child's illnesses, injuries, or conditions and can help you with his/her claim.

NAME OF CONTACT _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____
City *State* *ZIP*

DAYTIME PHONE NUMBER _____ _____
Area Code *Number*

RELATIONSHIP TO CHILD _____

SECTION 3 – THE CHILD'S ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT HIM/HER

A. What are the child's disabling **illnesses, injuries, or conditions**? _____

_____

_____

B. How do the child's illnesses, injuries or conditions **limit his/her daily activities**? _____

_____

_____

C. When did the child become disabled?

Month	*Day*	*Year*

D. Do the child's illnesses, injuries or conditions cause **pain**? YES ☐ NO ☐

SECTION 4 – INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

A. Has the child been seen by a **doctor/hospital/clinic** or anyone else for the illnesses, injuries or conditions?

YES ☐ NO ☐

B. Has the child been seen by a **doctor/hospital/clinic** or anyone else for emotional or mental problems?

YES ☐ NO ☐

Tell us who may have medical records or other information about the child's illnesses, injuries or conditions.

C. List **each DOCTOR/HMO/THERAPIST**. Include the child's **next appointment**.

1.

NAME			DATES
STREET ADDRESS			FIRST VISIT
CITY	STATE	ZIP	LAST SEEN
PHONE _____ Area Code _____ Phone Number		CHART/HMO #	NEXT APPOINTMENT
REASONS FOR VISITS _____			
WHAT TREATMENT WAS RECEIVED? _____			

2.

NAME			DATES
STREET ADDRESS			FIRST VISIT
CITY	STATE	ZIP	LAST SEEN
PHONE _____ Area Code _____ Phone Number		CHART/HMO #	NEXT APPOINTMENT
REASONS FOR VISITS _____			
WHAT TREATMENT WAS RECEIVED? _____			

SECTION 4 – INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

DOCTOR/HMO/THERAPIST

3.

NAME		DATES
STREET ADDRESS		FIRST VISIT
CITY STATE ZIP		LAST SEEN
PHONE (Area Code) (Phone Number)	CHART/HMO #	NEXT APPOINTMENT
REASONS FOR VISITS		
WHAT TREATMENT WAS RECEIVED?		

If you need more space, use Remarks, Section 10

D. **List each HOSPITAL/CLINIC.** Include child's **next appointment.**

1.

HOSPITAL/CLINIC	TYPE OF VISIT	DATES
NAME	☐ **INPATIENT** STAYS *(Stayed at least overnight)*	DATE IN / DATE OUT
STREET ADDRESS	☐ **OUTPATIENT** VISITS *(Sent home same day)*	DATE FIRST VISIT / DATE LAST VISIT
CITY STATE ZIP	☐ **EMERGENCY ROOM** VISITS	DATES OF VISITS
PHONE (Area Code) (Phone Number)		

Next **appointment** _____ The child's hospital/clinic **number** _____

Reasons for visits _____

What **treatment** did the child receive? _____

What **doctors** does the child see at this hospital/clinic on a regular basis? _____

SECTION 4 – INFORMATION ABOUT THE CHILD'S MEDICAL RECORDS

HOSPITAL/CLINIC

2.

HOSPITAL/CLINIC	TYPE OF VISIT	DATES
NAME	☐ **INPATIENT** STAYS *(Stayed at least overnight)*	DATE IN / DATE OUT
STREET ADDRESS	☐ **OUTPATIENT** VISITS *(Sent home same day)*	DATE FIRST VISIT / DATE LAST VISIT
CITY STATE ZIP	☐ **EMERGENCY ROOM** VISITS	DATES OF VISITS
PHONE (Area Code) (Phone Number)		

Next **appointment** _____ The child's hospital/clinic **number** _____

Reasons for visits _____

What **treatment** did the child receive? _____

What **doctors** does the child see at this hospital/clinic on a regular basis? _____

If you need more space, use Remarks, Section 10

E. Does **anyone else have medical records or information** about the child's illnesses, injuries or conditions (Workers' Compensation, insurance companies, counselors, detention centers, attorneys, and/or tutors) or is the child scheduled to see anyone else?

YES ☐ *(If "YES," complete the information below.)* NO ☐

NAME	DATES
ADDRESS	FIRST VISIT
CITY STATE ZIP	LAST SEEN
PHONE (Area Code) (Phone Number)	NEXT APPOINTMENT
CLAIM NUMBER *(If any)*	
REASONS FOR VISITS?	

If you need more space, use Remarks, Section 10

SECTION 5 – MEDICATIONS

Does the child currently take any **medications** for the illnesses, injuries or conditions? YES ☐ NO ☐
If "YES," tell us the following. *(Look at the child's medicine bottles, if necessary.)*

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS THE CHILD HAS

If you need more space, use Remarks, Section 10

SECTION 6 – TESTS

Has the child had, or will he/she have, any **medical tests** for the illnesses, injuries or conditions?
YES ☐ NO ☐ If "YES," please tell us the following: (give approximate dates, if necessary).

KIND OF TEST	WHEN DONE, OR WHEN IT WILL BE DONE (Month, day, year)	WHERE DONE (Name of Facility)	WHO SENT THE CHILD FOR THIS TEST
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY Name of body part _____			
SPEECH/ LANGUAGE			
HEARING TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY Name of body part _____			
MRI/CAT SCAN Name of body part _____			

If the child has had other tests, list them in Remarks, Section 10.

SECTION 7 – ADDITIONAL INFORMATION

A. Has the child been **tested or examined** by any of the following?

1. Headstart (Title V)	YES ☐	NO ☐
2. Public or Community Health Department	YES ☐	NO ☐
3. Child Welfare or Social Service Agency	YES ☐	NO ☐
4. Women, Infant and Children (WIC) Program	YES ☐	NO ☐
5. Program for Children with Special Health Care Needs	YES ☐	NO ☐
6. Mental Health/Mental Retardation Center	YES ☐	NO ☐
7. Vocational Rehabilitation	YES ☐	NO ☐
If "NO" to 7 above and the child is over age 15, do you want the child to be referred to Vocational Rehabilitation?	YES ☐	NO ☐

If you answered "YES" to any of the above, complete B below.

B. 1. NAME OF AGENCY _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____
City *State* - *ZIP*

PHONE NUMBER _____ _____
Area Code *Number*

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

FILE OR RECORD NUMBER _____

2. NAME OF AGENCY _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____
City *State* *ZIP*

PHONE NUMBER _____ _____
Area Code *Number*

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

FILE OR RECORD NUMBER _____

If there are any other agencies, show them in Remarks, Section 10.

SECTION 8 – EDUCATION

A. What is the child's **current grade** in school or the **highest grade** completed? _____

B. Is the child currently attending school *(other than summer school)*? YES ☐ NO ☐

If "NO" explain why the child is not attending school. _____

_____

_____

_____

_____

_____

C. List the name of the school the child is **currently attending** and give dates attended. If the child is no longer in school, list the name of the last school attended and give dates attended.

NAME OF SCHOOL _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____
City *County* *State* *ZIP*

PHONE NUMBER _____ _____
Area Code *Number*

DATES ATTENDED _____

TEACHER'S NAME _____

Has the child been tested for behavioral or learning problems? YES ☐ NO ☐
If "YES," complete the following:

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

Is the child in special education? YES ☐ NO ☐
If "YES," and the teacher's name is different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Is the child in speech therapy? YES ☐ NO ☐
If "YES," and the therapist's name is different from above, give:

NAME OF SPEECH THERAPIST _____

SECTION 8 – EDUCATION

D. List the names of all other schools **attended in the last 12 months** and give dates attended.

NAME OF SCHOOL _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____
City *County* *State* *ZIP*

PHONE NUMBER _____ _____
Area Code *Number*

DATES ATTENDED _____

TEACHER'S NAME _____

Was the child tested for behavioral or learning problems? YES ☐ NO ☐
If "YES," complete the following:

TYPE OF TEST _____ WHEN DONE _____

TYPE OF TEST _____ WHEN DONE _____

Was the child in special education? YES ☐ NO ☐
If "YES," and the teacher's name is different from above, give:

NAME OF SPECIAL EDUCATION TEACHER _____

Was the child in speech therapy? YES ☐ NO ☐
If "YES," and the therapist's name is different from above, give:

NAME OF SPEECH THERAPIST _____

If there are other schools, show them in Remarks, Section 10.

E. Is the child attending Daycare/Preschool? YES ☐ NO ☐
If "YES," complete the following:

NAME OF DAYCARE/
PRESCHOOL/CAREGIVER _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____
City *County* *State* *ZIP*

PHONE NUMBER _____ _____
Area Code *Number*

DATES ATTENDED _____

TEACHER'S/CAREGIVER'S NAME _____

SECTION 9 – WORK HISTORY

A. Has the child ever worked (including sheltered work)? YES ☐ NO ☐
If "YES", complete the following:

DATES WORKED _____

NAME OF EMPLOYER _____

ADDRESS _____
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)

_____
City *State* *ZIP*

PHONE NUMBER _____ _____
Area Code *Number*

NAME OF SUPERVISOR _____

B. List the job title, and briefly describe the work and any problems the child may have had doing the job.

SECTION 10 – REMARKS

Use this section for any added information you did not show in the earlier parts of this form. When you are done with this section (or if you don't have anything to add), be sure to go to the next page and complete the signature block.

SECTION 10 – REMARKS

ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW.

Signature of **claimant** or person filing on claimant's behalf *(parent, guardian)*	**Date** *(Month, day, year)*

Witnesses are required **ONLY** if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below giving their full addresses.

1. Signature of **Witness**	2. Signature of **Witness**
Address *(number and street, city, state, and ZIP code)*	**Address** *(number and street, city, state, and ZIP code)*

DISABILITY REPORT – CHILD - Form-SSA-3820-BK

READ ALL OF THIS INFORMATION BEFORE YOU BEGIN COMPLETING THIS FORM

IF YOU NEED HELP

If you need help with this form, complete as much of it as you can, and your interviewer will help you finish it.

HOW TO COMPLETE THIS FORM

The information that you give us on this form will be used by the office that makes the disability decision on your disability claim. You can help them by completing as much of the form as you can.

- Fill out this form before your interview appointment.
- Print or type.
- **Do Not Leave Answers Blank**. If you do not know the answers or the answer is "none" or "does not apply," write: "don't know," or "none," or "does not apply."
- **IN SECTION 4, PUT INFORMATION ON ONLY ONE DOCTOR/HOSPITAL/ CLINIC IN EACH SPACE.**
- Each address should include a ZIP code. Each telephone number should include an area code.
- **DO NOT ASK A DOCTOR OR HOSPITAL TO COMPLETE THE FORM.** However, you can get help from a friend or family member.
- If your appointment is for an interview by telephone, have the form ready to discuss with us when we call you.
- If your appointment is for an interview in our office, bring the completed form with you or mail it ahead of time, if you were told to do so.
- Be sure to explain an answer if the question asks for an explanation or if you want to give additional information.
- If you need more space to answer any questions or want to tell us more about an answer, please use the "REMARKS" section on Pages 10 and 11, and show the number of the question being answered.

ABOUT THE CHILD'S MEDICAL AND OTHER RECORDS

If you have any of the following records for the child at home, send them to our office with your completed forms or bring them with you to the interview. If you need the records back, tell us and we will photocopy them and return them to you.

- The child's medical records.
- Copies of the child's prescriptions.
- The child's Individualized Education Program
- The child's Individualized Family Service Plan

YOU DO NOT NEED TO ASK DOCTORS OR HOSPITALS FOR ANY MEDICAL RECORDS THAT YOU DO NOT ALREADY HAVE. With your permission, we will do

that for you. The information we ask for on this form tells us from whom to request medical and other records. If you cannot remember the names and addresses of any of the doctors or hospitals, or the dates of treatment, perhaps you can get this information from the telephone book, or from medical bills, prescriptions and prescription bottles.

The Privacy and Paperwork Reduction Acts

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d) and 1631(e)(1) of the Social Security Act. The information on this form is needed by Social Security to make a decision on the named claimant's claim. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named claimant's claim. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the Social Security Administration as follows: (1) to enable a third party or agency to assist Social Security in establishing rights to Social Security benefits and/or coverage; (2) to comply with Federal Laws requiring the release of information from Social Security records (e.g., to the General Accounting Office and the Department of Veteran Affairs); and (3) to facilitate statistical research and such activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract to Social Security).

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, State, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it. Explanations about these and other reasons why information you provide us may be used or given out are available in Social Security offices.

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB control number. We estimate that it will take you about 40 minutes to complete this form. This includes the time it will take to read the instructions, gather the necessary facts, and fill out the form.

REMOVE THIS SHEET BEFORE RETURNING THE COMPLETED FORM.

Form Approved
OMB No. 0960-0623

WHOSE *Records to be Disclosed*

First *Middle* *Last*

NAME

SSN | Birthday (mm/dd/yy)

SSA USE ONLY NUMBER HOLDER (If other than above)

NAME

SSN

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):

OF WHAT ***All my medical records;*** **also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *including*, and not limited to:**
   - **Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)**
   - **Drug abuse, alcoholism, or other substance abuse**
   - **Sickle cell anemia**
   - **Human immunodeficiency virus (HIV) infection (including acquired immunodeficiency syndrome (AIDS) or tests for HIV) or sexually transmitted diseases**
   - **Gene-related impairments (including genetic test results)**
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called 'disability determination services'), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits,** including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances where this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

INDIVIDUAL authorizing disclosure

SIGN ▶

IF not signed by subject of disclosure, specify basis for authority to sign

☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)**

(Parent/guardian sign here if two signatures required by State law) ▶

Date Signed	Street Address		
Phone Number (with area code)	City	State	ZIP

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶

Phone Number (or Address)

IF needed, second witness sign here (e.g., if signed with "X" above)

SIGN ▶

Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Explanation of Form SSA-827,
"Authorization to Disclose Information to the Social Security Administration (SSA)"

We need your written authorization to help get the information required to process your application for benefits, and to determine your capability of managing benefits. Laws and regulations require that sources of personal information have a signed authorization before releasing it to us. Also, laws require specific authorization for the release of information about certain conditions and from educational sources.

You can provide this authorization by signing a Form SSA-827. Federal law permits sources with information about you to release that information if you sign a single authorization to release all your information from all your possible sources. We will make copies of it for each source. A few States, and some individual sources of information, require that the authorization specifically name the source that you authorize to release personal information. In those cases, we may ask you to sign one authorization for each source and we may contact you again if we need you to sign more authorizations.

You have the right to revoke this authorization at any time, except to the extent a source of information has already relied on it to take an action. To revoke, send a written statement to any Social Security Office. If you do, also send a copy directly to any of your sources that you no longer wish to disclose information about you; SSA can tell you if we identified any sources you didn't tell us about. Information disclosed prior to revocation may be used by SSA to decide your claim.

It is SSA's policy to provide service to people with limited English proficiency in their native language or preferred mode of communication consistent with Executive Order 13166 (August 11, 2000) and the Individuals with Disabilities Education Act. SSA makes every reasonable effort to ensure that the information in the SSA 827 is provided to you in your native or preferred language.

IMPORTANT INFORMATION, INCLUDING NOTICE REQUIRED BY THE PRIVACY ACT

All personal information collected by SSA is protected by the Privacy Act of 1974. Once medical information is disclosed to SSA, it is no longer protected by the health information privacy provisions of 45 CFR part 164 (mandated by the Health Insurance Portability and Accountability Act (HIPAA). SSA retains personal information in strict adherence to the retention schedules established and maintained in conjunction with the National Archives and Records Administration. At the end of a record's useful life cycle, it is destroyed in accordance with the privacy provisions, as specified in 36 CFR part 1228.

SSA is authorized to collect the information on form SSA-827 by sections 205(a), 223 (d)(5)(A),1614(a)(3)(H)(i), 1631(d)(1) and 1631 (e)(1)(A) of the Social Security Act. We use the information obtained with this form to determine your eligibility for benefits, and your ability to manage any benefits received. This use usually includes review of the information by the State agency processing your case and quality control people in SSA. In some cases, your information may also be reviewed by SSA personnel that process your appeal of a decision, or by investigators to resolve allegations of fraud or abuse, and may be used in any related administrative, civil, or criminal proceedings.

Signing this form is voluntary, but failing to sign it, or revoking it before we receive necessary information, could prevent an accurate or timely decision on your claim, and could result in denial or loss of benefits. Although the information we obtain with this form is almost never used for any purpose other than those stated above, the information may be disclosed by SSA without your consent if authorized by Federal laws such as the Privacy Act and the Social Security Act. For example, SSA may disclose:

1. To enable a third party (e.g., consulting physicians) or other government agency to assist SSA to establish rights to Social Security benefits and/or coverage;
2. Pursuant to law authorizing the release of information from Social Security records (e.g., to the Inspector General, to Federal or State benefit agencies or auditors, or to the Department of Veterans Affairs(VA));
3. For statistical research and audit activities necessary to assure the integrity and improvement of the Social Security programs (e.g., to the Bureau of the Census and private concerns under contract with SSA).

Other than the above limited circumstances, SSA will not redisclose without proper prior written consent information (1) relating to alcohol and/or drug abuse as covered in 42 CFR part 2, or (2) from educational records for a minor obtained under 34 CFR part 99 (Family Educational Rights and Privacy Act (FERPA)), or (3) regarding mental health, developmental disability, AIDS or HIV.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other Federal, state, or local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if you do not agree to it.

Explanations about possible reasons why information you provide us may be used or given out are available upon request from any Social Security Office.

PAPERWORK REDUCTION ACT

This information collection meets the requirements of 44 U.S.C. §3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 10 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING IN THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. The office is listed under U. S. Government agencies in your telephone directory or you may call Social Security at 1-800-772-1213.** ***You may send comments on our time estimate above to: SSA, 1338 Annex Building, Baltimore, MD 21235-0001. Send only comments relating to our time estimate to this address, not the completed form.***

SAMPLE

Cover Sheet for Expedited Referral to DDS and DSS

This is an example of a cover sheet that is used when a Medicaid Disability Determination is required to transition a hospitalized patient to a rehabilitation facility. The address, phone number and fax number for the appropriate Regional DDS Office will be included in the cover letter. *Expedite procedures do not apply if the person will be discharged home, to long term care, or to hospice.*

Patient: _____ SSN: _____

DISABILITY is defined as:
The inability to do any substantial gainful work, because of a severe, medically determinable physical or mental impairment which can be expected to result in death, or which has lasted or is expected to last for a continuous period of not less than 12 months.

All of these conditions must be met for a Medicaid claim to qualify as an Expedite.

1. *The patient is hospitalized.*
2. *The patient is able to participate in rehabilitative activities, requires transitioning to a rehabilitation facility, and cannot be discharged without a determination of Medicaid eligibility.*
3. *The patient's impairment is so severe it can be expected to prevent all work activity for at least one year.*
4. *The hospital has provided sufficient evidence to document an impairment that is expected to prevent work activity for at least one year.*

Physician's Signature: _____ *Date:* _____

The Medicaid application has been faxed/sent to this Dept. of Social Services (DSS):

DSS Name: _____ Address: _____

FAX Number: _____ Date Faxed: _____

The information checked below is being faxed *or sent overnight* to DDS:

DDS Address :_____ FAX Number: _____

_____ Form SSA-3368 Disability Report Form
_____ SSA-827 Authorizations to Disclose Information
_____ Medical Reports
- _____ Medical History & Physical, including consultations
- _____ Clinical Findings (such as physical/mental status examination findings)
- _____ Laboratory findings (such as latest x-rays, scans, pathology reports.)
- _____ Diagnosis.
- _____ *Signed Expedite Cover Sheet with physician's certification that the claim meets the conditions necessary to be treated as an Expedite.*

Name of Hospital: _____ Date Completed: _____

Your Name Printed: _____ *Your Signature:* _____

Your Telephone: (_____) _____ *Your* Fax: (_____) _____

DDS Regional Offices

Send all expedited and non-expedited disability referrals to the DDS Regional Office to which the local DSS agency is assigned, as indicated in the table below.

DDS Regional Office	Local DSS Agency Assignments
Central Regional Office Disability Determination Services 9960 Mayland Drive, Suite 200 Richmond, Virginia 23233 Phone: 800-523-5007 804-367-4700 FAX: 866-323-4810	Amelia, Brunswick, Buckingham, Charles City, Charlotte, Chesterfield, Colonial Heights, Cumberland, Danville, Dinwiddie, Emporia, Essex, Goochland, Greensville, Halifax, Hanover, Henrico, Hopewell, King and Queen, King William, Lancaster, Lunenburg, Mecklenburg, Middlesex, New Kent, Northumberland, Nottoway, Petersburg, Pittsylvania, Powhatan, Prince Edward, Prince George, Richmond County, Richmond City, South Boston, Surry, and Sussex
Tidewater Regional Office Disability Determination Services 5850 Lake Herbert Drive, Suite 200 Norfolk, Virginia 23502 Phone: 800-379-4403 757-466-4300 FAX: 866-773-0244	Accomack, Chesapeake, Franklin, Gloucester, Hampton, Isle of Wight, James City, Mathews, Newport News, Norfolk, Northampton, Portsmouth, Poquoson, Southampton, Suffolk, Courtland, Virginia Beach, Williamsburg, York
Northern Regional Office Disability Determination Services 11150 Fairfax Boulevard, Suite 200 Fairfax, Virginia 22030 Phone: 800-379-9548 703-934-7400 FAX: 866-843-3075	Albemarle, Alexandria, Arlington, Augusta, Caroline, Charlottesville, Clarke, Culpepper, Fairfax City, Fairfax County, Falls Church, Fauquier, Fluvanna, Frederick, Fredericksburg, Greene, Harrisonburg, Highland, King George, Loudoun, Louisa, Madison, Manassas City, Orange, Page, Prince William, Rappahannock, Rockingham, Shenandoah, Spotsylvania, Stafford, Staunton, Warren, Waynesboro, Westmoreland, and Winchester
Southwest Regional Office Disability Determination Services *612 S. Jefferson Street, Suite 300* Roanoke, Virginia 24011-2437 Phone: 800-627-1288 540-857-7748 FAX: 866-802-5842	Alleghany, Amherst, Appomattox, Bath, Bedford City, Bedford County, Bland, Botetourt, Bristol, Buchanan, Buena Vista, Campbell, Carroll, Covington, Craig, Dickenson, Floyd, Franklin, Galax, Giles, Grayson, Henry, Lee, Lexington, Lynchburg, Martinsville, Montgomery, Nelson, Patrick, Pulaski, Radford, Roanoke County, Roanoke City, Rockbridge, Russell, Salem, Scott, Smyth, Tazewell, Washington, Wise, and Wythe

CHAPTER M03
MEDICAID COVERED GROUPS
SUBCHAPTER 20

CATEGORICALLY NEEDY GROUPS

M0320 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	Table of Contents pages 46f-50b page 50c deleted
TN #95	3/1/10	pages 11, 12, 42c, 42d, 50, 53, 69 pages 70, 71 page 72 added.
TN #94	9/1/10	pages 49-50b
UP #3	3/1/10	pages 34, 35, 38, 40, 42a, pages 42b, 42f
TN #93	1/1/10	pages 11-12, 18, 34-35, 38 pages 40, 42a-42d, 42f-44, 49 pages 50c, 69-71
UP #2	8/24/09	pages 26, 28, 32, 61, 63, 66
Update (UP) #1	7/1/09	pages 46f-48
TN #91	5/15/09	pages 31-34 pages 65-68

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M0320.000 CATEGORICALLY NEEDY GROUPS

M0320.001 GENERAL POLICY PRINCIPLES

A. Overview

A State Plan for Medicaid must include the mandatory federal categorically needy (CN) groups of individuals. Most of the CN groups are mandatory; some are optional which Virginia has chosen to cover in its Medicaid state plan.

Two of the Virginia Medicaid "subclassifications," the "categorically needy non-money payment (CNNMP)" and the "medically indigent (MI)," are actually categorically needy covered groups according to the federal Medicaid law and regulations. This subchapter divides the covered groups which are classified as CN into "protected," "ABD" and "F&C" groups.

B. Procedure

Determine an individual's eligibility first in a categorically needy covered group. If the individual is not eligible as categorically needy, go to the medically needy groups in subchapter M0330.

The following sections in this chapter contain the policy and procedures for determining whether an individual meets a Medicaid categorically needy covered group:

- M0320.100 Protected Covered Groups
- M0320.101 Former Money Payment Recipients August 1972
- M0320.102 Conversion Cases
- M0320.103 Former SSI/AG Recipients
- M0320.104 Protected Widows or Widowers
- M0320.105 Qualified Severely Impaired Individuals (QSII-1619(b))
- M0320.106 Protected Adult Disabled Children
- M0320.107 Protected SSI Disabled Children

- M0320.200 ABD Categorically Needy Groups
- M0320.201 SSI Recipients
- M0320.202 AG Recipients
- M0320.203 ABD In Medical Institution, Income $\leq$ 300% SSI
- M0320.204 ABD Receiving Waiver Services
- M0320.205 ABD Hospice
- M0320.206 QMB (Qualified Medicare Beneficiary)
- M0320.207 SLMB (Special Low-income Medicare Beneficiary)
- M0320.208 QI (Qualified Individuals)
- M0320.209 QDWI (Qualified Disabled & Working Individual)
- M0320.210 ABD With Income $\leq$ 80% FPL
- M0320.211 MEDICAID WORKS

- M0320.300 Families & Children Categorically Needy Groups
- M0320.301 MI Pregnant Women & Newborn Child
- M0320.302 Plan First - Family Planning Services
- M0320.303 MI Child Under Age 19 (FAMIS Plus)
- M0320.304 Low Income Families With Dependent Children (LIFC)

- M0320.307 Individuals Under Age 21
- M0320.308 Special Medical Needs Adoption Assistance Children
- M0320.309 F&C In Medical Institution, Income ≤ 300% SSI
- M0320.310 F&C Receiving Waiver Services
- M0320.311 F&C Hospice

- M0320.312 Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)

M0320.100 PROTECTED COVERED GROUPS

A. Legal base

Federal law and regulations require that the Medicaid eligibility status of certain groups of persons be protected even though they may not meet current eligibility requirements. These groups, and the applicable eligibility requirements, are described in this section.

B. Procedure

- M0320.101 Former Money Payment Recipients August 1972
- M0320.102 Conversion Cases
- M0320.103 Former SSI/AG Recipients
- M0320.104 Protected Widows or Widowers
- M0320.105 Qualified Severely Impaired Individuals (QSII)-1619(b)
- M0320.106 Protected Adult Disabled Children
- M0320.107 Protected SSI Disabled Children.

M0320.101 FORMER MONEY PAYMENT RECIPIENTS AUGUST 1972

A. Policy

42 CFR 435.114 and 42 CFR 435.134--The agency must provide Medicaid to individuals who meet the following conditions:

1. Entitled to OASDI In August 1972 & Received Cash Assistance

In August 1972, the individual was entitled to OASDI and

- he was receiving AFDC, Old Age Assistance (OAA), Aid to the Blind (AB), or Aid to the Permanently and Totally Disabled (APTD); or

- he would have been eligible for one of those programs if he had applied and the Medicaid plan covered this optional group. The Virginia plan covered this group; or

- he would have been eligible for one of those programs if he was not in a medical institution or intermediate care facility and the Medicaid plan covered this optional group. The Virginia plan covered this group.

2. Would Currently Be Eligible If Increase Were Excluded

The individual *would meet the F&C income limits for LIFC* or currently eligible for SSI or AG except that the increase in OASDI under P.L. 92-336 raised his income over the *F&C income limits or* SSI. This includes an individual who

- meets all *LIFC* requirements or current SSI requirements except for the requirement to file an application; or

- would meet all *current LIFC* or SSI requirements if he were not in a medical institution or intermediate care facility and the Medicaid plan covers this optional group. The Virginia plan covers this group.

B. Nonfinancial Requirements

The protected individual must meet all of the following criteria:

- he was a recipient of OAA, AB, APTD, or AFDC cash assistance as of August, 1972;
- his money payment was subsequently discontinued as a result of the 20% increase in Social Security benefits received in October, 1972;
- his current countable resources are less than or equal to the current resource limit for Medicaid; and
- his current countable income is less than or equal to the *F&C income limit or the current* SSI income limit, as appropriate, after excluding the 20% increase amount received in 1972. The current SSI standards are in subchapter S0810; the *F&C income limits* are in subchapter M0710, Appendix 3.

C. Procedures

1. Nonfinancial

The individual must meet all nonfinancial eligibility requirements in chapter M02.

Verify the individual's receipt of OAA, AB, APTD, or AFDC cash assistance in August 1972 via agency records. Verify the cancellation of cash assistance due to the October 1972 increase in OASDI via agency records.

2. Resources

Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI) for aged, blind or disabled individuals, or policy in chapter M06 for Families & Children. Calculate resources according to the assistance unit policy in chapter M05.

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this protected group; he/she may be eligible in another Medicaid covered group.

3. Income

Determine income using policy in S08 for ABD individuals, or chapter M07 for F&C individuals. Calculate income according to the assistance unit policy in chapter M05, including deeming of spouse's or parent(s)' income. Disregard the amount of the October 1972 OASDI increase and subtract the other appropriate income exclusions.

Compare the total countable income to the appropriate current SSI income limit for an ABD individual or to the *F&C* income limit for an F&C individual. If countable income is within the limit, the protected individual is eligible for Medicaid in this protected covered group.

If countable income exceeds the limit, determine the individual's eligibility in another covered group.

D. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). Program designation is

- 21 for an aged individual;
- 41 for a blind individual;
- 61 for a disabled individual;
- 81 for an LIFC-related individual;
- 83 for an LIFC-UP-related individual.

M0320.102 CONVERSION CASES

A. Policy

42 CFR 435.131, 435.133--Conversion cases are classified as categorically needy and consist of the following individuals:

- blind or disabled individuals eligible in December 1973;
- individuals eligible as essential spouses of aged, blind or disabled individuals in December 1973.

B. Eligibility Determination

The agency must continue the individual's Medicaid if

- the ABD individual continues to meet the December 1973 eligibility requirements of the applicable cash assistance program; and
- the essential spouse continues to meet the conditions that were in effect in December 1973 under the applicable cash assistance plan for having his needs included in computing the payment to the ABD individual.

C. Essential Spouse

The agency must provide Medicaid to any person who was eligible for Medicaid in December 1973 as an essential spouse of an aged, blind or disabled individual who was receiving cash assistance, if the conditions below are met. An "essential spouse" is defined as one who is living with the individual, whose needs were included in determining the amount of cash payment to the individual under OAA, AB, or APTD in December 1973, and who is determined essential to the individual's well-being.

The spouse of the protected conversion person is included in the conversion case if:

- his/her needs were included in the OAA, AB, or APTD grant as of December, 1973, and
- he/she continues to live in the home of the protected individual.

D. Blind or Disabled In December 1973

The agency must provide Medicaid to individuals who:

- meet all current Medicaid eligibility requirements except the criteria for blindness or disability;
- were eligible for Medicaid in December 1973 as blind or disabled individuals; and
- for each consecutive month after December 1973, continue to meet the criteria for blindness or disability and the other eligibility requirements used under the Medicaid plan in December 1973.

1. December 1973 Nonfinancial Eligibility Requirements

a. The individual must meet the nonfinancial eligibility requirements:

- Citizenship/alien status (M0220);
- Virginia residency (M0230);
- Social security number provision/application requirements (M0240);
- Cooperation in pursuing support *from an absent parent (M0250);*
- Application for other benefits (M0270);
- Institutional status requirements (M0280).

b. It is not necessary to re-establish the blindness or disability requirement unless:

- the decision of the APTD Review Team or the Commission for the Visually Handicapped ophthalmologist was for a limited period, or
- the local department of social services has reason to believe the physical impairment or the visual handicap has been overcome or substantially improved.

If one of the above conditions exists, contact the Medicaid Disability Unit of the Department of Rehabilitative Services or the Department for the Visually Handicapped, as appropriate by the usual method to redetermine the individual's eligibility using the criteria followed by the former APTD Review Team or Commission for the Visually Handicapped in December, 1973.

2. Resources

a. Resource Limits

Total resources (real and personal property) may not exceed $600 for a single person, $900 for two persons and $100 for each additional person in the family unit.

b. Home Property

Ownership of a dwelling occupied by the applicant as his home does not affect eligibility. A home is considered to be the house and lot or adjacent land, including a garden and outbuildings used in connection with the dwelling. It does not include land and outbuildings used for farming purposes.

c. Income-Producing Real Property

Ownership of income-producing real property, other than the home, such as may be used for farming or business, precludes eligibility if the equity therein of a family unit is $10,000 or more. Real property cannot be considered income-producing unless there is a reasonable annual income of approximately 10% of the market value of the property or gross income comparable to that received from similar property located in the community.

d. Other Real Property

Ownership of any other real property precludes eligibility unless the property cannot be sold, or sale would involve undue monetary sacrifice, or unless the market value of the property, if added to the personal property, does not exceed the allowable amount of personal property.

e. Personal Property

Personal property includes bank accounts, bonds, and other cash liquidable assets, and nonliquidable assets such as motor vehicles, stocks, cash value of life insurance.

When evaluating personal property, exclude

- life insurance policies with total face value of $5,000 or less for an individual,
- household equipment and furnishings,
- one motor vehicle,
- livestock providing food for family consumption
- farming or business equipment or livestock which are income-producing.

Life Insurance - When insurance (life, retirement, and other related types) has a total face value of over $5,000 for an individual, ascertain the cash value and count it as a resource. If, however, income benefits such as

disability payments are currently available under the provisions of a policy, the cash surrender value of such policy does not necessarily have to be counted as a resource, if it is in the best interest of the client and the agency for the provisions of the policy to remain unchanged.

3. Income

a. Income Limits

The annual income limits were $1,900 for one person and $2,500 for two persons.

b. Unearned Income

Social Security and Railroad Retirement benefits - For OAA and APTD-related persons who receive Social Security or Railroad Retirement benefits the first $4.00 monthly of such benefits for each recipient is excluded EXCEPT for the individual who is in a nursing facility and now receives $30.00 a month clothing and personal care allowance from SSI. Do not exclude $4.00 of the SSA or RR benefit received by an individual in a medical facility who now receives a $30 SSI check.

This exclusion is **not** applicable to the ineligible spouse who does not meet a Medicaid covered group.

c. Earned Income Exclusion for OAA and APTD-related Persons

The earned income exclusion for OAA and APTD-related individuals is the first $20 a month plus 1/2 the remainder up to a maximum of $35 per month.

4. Resource or Income Ineligible

If the individual no longer meets the December 1973 nonfinancial or financial eligibility requirements, the individual is not eligible in this covered group. Determine his/her eligibility in another covered group.

E. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). Program designation is

- 21 for an aged individual;
- 41 for a blind individual;
- 61 for a disabled individual.

M0320.103 FORMER SSI/AG RECIPIENTS

A. Policy

1. Nonfinancial Requirements

The protected former SSI/AG recipient must meet the nonfinancial eligibility requirements in chapter M02. The protected former SSI recipient is one who was eligible for and received **either:**

- SSA and SSI, or
- SSA and AG, or
- SSA, SSI, and AG

concurrently, but who became ineligible for SSI or AG due to any reason on or after April, 1, 1977. The individual did not have to be receiving Medicaid at that time.

An individual who concurrently received these benefits does not meet this covered group's requirements if one of the benefit payments was later recouped because the individual was not entitled to the payment.

2. Financial Requirements

The former SSI/AG recipient is eligible for Medicaid as categorically needy non-money payment if:

a. the individual meets the Medicaid resource requirements currently in effect, and the individual's income, less all SSA cost-of-living adjustments (COLAs) received since the most recent month SSI or AG was cancelled (including the COLA received in the month SSI or AG was cancelled) is within the current SSI income limit; OR

b. the individual meets the AG requirements in effect at the time of application or redetermination, including residing in an approved AG home, and the individual's income less the amount of all SSA COLAs received since the most recent month SSI or AG was cancelled (including the COLA received in the month SSI or AG was cancelled) is within the current AG income limit applicable to a resident of that home.

c. Any change in SSA benefits other than cost-of-living increases are not excluded, such as an increase due to change from disability benefits to widow's benefits.

EXAMPLE #1: Ms. C is age 71. She has never been enrolled in Medicaid before. She applied for Medicaid on February 12, 1997. She received SSA on her own record, in the amount of $280, until March 1, 1994 when she began receiving widow's benefits of $410. She received SSI until March 1, 1994, when SSI was cancelled due to her increased SSA benefit. She received COLA increases in her SSA in January of 1995, 1996, and 1997.

Her current SSA is $537. Her countable resources are less than the current Medicaid resource limit.

Ms. C meets the former SSI recipient protected individual criteria because she was eligible for and received SSA and SSI concurrently. Her countable income is her SSA amount prior to the January 1, *1995* COLA - $410 - less the $20 disregard. The result, $390, is compared to the current SSI individual limit.

Because her resources are within the Medicaid limit, and her countable income of $390 is within the current SSI limit, she is eligible for Medicaid as a CNNMP protected former SSI recipient.

B. Eligibility Procedures

1. Assistance Unit

If the protected individual lives with his/her spouse (or parent in the case of a blind/disabled child) whose resources and income would be counted or deemed in determining the individual's SSI or AG eligibility, the SSA cost-of-living increase(s) (COLAs) received by the spouse (or parent) since the individual lost SSI or AG eligibility is also excluded in determining the protected individual's income eligibility under this section.

Use the assistance unit composition and resource deeming procedures policy in chapter M05 to determine when a spouse's resources or income are counted or deemed in determining the individual's eligibility.

The resources and income of a parent living in the home are always deemed available in determining the blind/ disabled child's eligibility. Therefore, a parent's SSA COLAs are always excluded when determining a protected blind or disabled child's income eligibility.

2. Resource Eligibility

Resource eligibility is determined by comparing the former SSI recipient's resources to the current Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). Calculate resources according to the assistance unit policy in chapter M05. If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this protected covered group; he/she may be eligible as ABD medically indigent (which has more liberal resource methods and standards).

3. Income Eligibility

a. Allocation For NBD Child(ren)

When determining the amount of a spouse's or parent's deemable income, the allocation for a non blind or disabled (NBD) child(ren) in the home is the same regardless of locality (see M0530, Appendix 1). On the income worksheet, insert the SSI individual payment limit whenever the worksheet calls for the Medicaid income limit.

b. Countable Income

In figuring income to compare to the current SSI or AG income limit, the income exclusions in chapter S08 are applicable including the $20 exclusion.

When the individual meets the above criteria for a protected case and the individual's assistance unit's resources are within the Medicaid resource limit:

1) Identify the individual's, and the individual's spouse's (or parent's when applicable), amount of Social Security Title II benefits at the time of SSI termination.

   If this amount is unknown and cannot be obtained, see item 4. below.

2) When the amount of Social Security Title II benefits at the time of SSI termination is determined:

   - add the Medicare premium amount to the Title II check amount if only the check amount is known (see item 5. below for Medicare premium amounts);

   - determine if any change in benefit had occurred between loss of SSI and the point of application. If questionable, multiply the prior Title II amount by the COLA percentages and compare to current entitlement. If the figures are significantly different, use the procedures in 4. below to obtain the amount of Title II at the time SSI was terminated;

   - if there were no changes, count the Title II amount at the time of SSI loss. Subtract the $20 general exclusion;

   - count all other current sources of income, apply appropriate exclusions, total countable income.

c. Income Limit

Countable income is compared to the AG or SSI income limit for an individual or couple, as appropriate.

The SSI limit for a couple is used whenever evaluating a couple when both meet an ABD definition and both request Medicaid. The SSI limit for an individual is used when only one member of a couple applies or meets an ABD definition.

The SSI income limit reduced by one-third is used whenever an applicant/recipient lives in the home of another person throughout a month and does not pay his/her pro rata share of food and shelter expenses.

Compare total countable income to current appropriate SSI or AG income limit/payment amount as follows:

1) for a protected individual living with a protected or aged, blind, disabled (ABD) spouse who applies for Medicaid, compare the countable income to the current SSI payment limit for a couple. The SSI couple limit is reduced by one-third only if both members of the couple have their shelter and food provided by another person.

   If income is within the appropriate limit, the individual spouse who meets the protected group criteria is eligible. If both spouses meet the protected group criteria, each is eligible as a CNNMP former SSI recipient.

   The non-protected spouse's eligibility is evaluated in another covered group.

2) for an individual living with a spouse and/or minor dependent children who meet a families and children category or do not apply for Medicaid, count only the individual's income and the spouse's deemed income (as determined by deeming procedures in chapter M05) and compare it to the SSI limit for an individual or couple as appropriate. If all food and shelter needs are provided by the spouse or someone else, compare the countable income to the SSI limit for an individual, reduced by one-third.

3) for a blind or disabled child living with a parent, calculate the parent's income (as determined by deeming procedures in chapter M05) and compare the child's countable income to the SSI payment limit for an individual. If all food and shelter needs are provided by the child's parent(s) or someone else, compare the total countable income to the SSI limit for an individual, reduced by one-third.

4. COLA Formula

If only the current Title II benefit amount is known OR the benefit was changed or recalculated after loss of SSI, use the formula below to figure the base Title II amount to use in determining financial eligibility. Divide the current Title II entitlement amount by the percentages given. Then follow the steps in item B.3.b. above to determine income eligibility.

Note: There was no COLA in 2010 *or 2011*.

Cost-of-living calculation formula:

a. $\frac{\text{Current Title II Benefit}}{1.058\ (1/09\ \text{Increase})} = \text{Benefit Before 1/09 COLA}$

b. $\frac{\text{Benefit before 1/09 COLA}}{1.023\ (1/08\ \text{Increase})} = \text{Benefit Before 1/08 COLA}$

c. Benefit Before1/08 COLA = Benefit Before
1.033 (1/07 Increase) 1/07 COLA

d. Benefit Before 1/07 COLA = Benefit Before
1.041 (1/06 Increase) 1/06 COLA

e. Benefit Before 1/06 COLA = Benefit Before
1.027 (1/05 Increase) 1/05 COLA

Contact a Medical Assistance Program Consultant for amounts for years prior to *2005*.

5. Medicare Premiums

a. Medicare Part B premium amounts:

*1-1-11 $115.40**
1-1-10 $110.50
1-1-09 $96.40
1-1-08 $96.40
1-1-07 $93.50
1-1-06 $88.50
1-1-05 $78.20

*****This amount is for individuals enrolled in Medicare on or after 1-1-*11* or for individuals subject to increased Medicare premiums based on their income. The Medicare Part B premium for individuals enrolled in Medicare prior to January 1, 2010 remains $96.40 for 2010 *and 2011. The Medicare Part B premium for individuals enrolled in Medicare between January 1, 2010 and December 31, 2010 remains $110.50 for 2011. Verify the individual's Medicare Part B premium in SVES or SOLQ-I if it is necessary to know the premium amount for Medicaid eligibility or post-eligibility purposes.*

b. Medicare Part A premium amounts:

1-1-10 $461.00
1-1-09 $443.00
1-1-08 $423.00
1-1-07 $410.00
1-1-06 $393.00
1-1-05 $375.00

Contact a Medical Assistance Program Consultant for amounts for years prior to 2005.

6. Classification

Individuals who are eligible when a cost-of-living increase is excluded are eligible as categorically needy non-money payment (CNNMP).

Individuals who are ineligible because of excess income after the cost-of-living increase(s) is excluded can only become Medicaid-eligible in another covered group. If they do not meet an F&C MI covered group, are not institutionalized, are not receiving CBC or do not have Medicare Part A, they must be determined eligible in a medically needy covered group.

The cost-of-living increase(s) is not excluded when determining income eligibility in ANY other covered group. However, these individuals must be identified for possible future CNNMP protection as the SSI and AG income limits increase.

C. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible former SSI or AG recipients in this group are classified as categorically needy non-money payment (CNNMP). *The aid categories (ACs) are*:

- 021 for an aged individual;
- 041 for a blind individual;
- 061 for a disabled individual.

D. Eligibility for Non-Protected Family Members

The amount of an SSA cost-of-living increase that must be excluded when determining eligibility for a former SSI recipient **cannot** be excluded when determining Medicaid eligibility of the individual's non-protected spouse and/or children living with the former SSI recipient.

The former SSI recipient is included in his/her non-protected spouse's unit if the non-protected spouse is aged, blind, or disabled.

The former SSI recipient is included as a member of the family unit when determining a child's eligibility in an F&C covered group. All of the protected recipient's income, including the cost-of-living increase(s), is counted.

M0320.104 PROTECTED WIDOWS OR WIDOWERS

A. Policy

Two groups of disabled widow(er)s who lost SSI eligibility because of receipt of or increase in Title II disabled widow(er)s' or Title II widow(er)'s benefits have their Medicaid categorically needy eligibility protected.

The first group consists of disabled widow(er)s who would be eligible for SSI except for the increase in disability benefits resulting from elimination of the reduction factor under P.L. 98-21 in January 1984.

The second group consists of *(1)* disabled widow(er)s age *60* through 64 *years* and *(2) disabled widow(er)s age 50 through 59 years* who would be eligible for SSI except for early receipt of Social Security benefits.

B. July 1989 Protected Widow(er)s

42 CFR 435.137 - A "July 1989 protected widow(er)" is an individual who became entitled to SSA benefits when he/she had attained age 50 but not age 60 years, and

- who applied for Medicaid before July 1, 1989,

- was entitled to monthly OASDI benefits under Title II of the Social Security Act for December 1983,
- was entitled to and received widow's or widower's disability benefits under section 202(e) or 202(f) of the Social Security Act for January 1984,
- lost SSI and/or AG because of the January 1984 increase in disabled widow(er)'s benefits due to elimination of the reduction factor,
- has been continuously entitled to an SSA widow(er)'s disability benefit under section 202(e) or 202(f) of the Social Security Act since the first month that increase was received, and
- would be eligible for SSI or AG if the amount of the increase and any subsequent COLAs in the widow(er)s' SSA benefits were excluded.

1. Nonfinancial Eligibility

Determine the widow(er)'s eligibility using the procedures below. The widow(er):

a. meets the nonfinancial eligibility requirements in chapter M02;

b. applied for Medicaid as a protected individual prior to July 1, 1989;

c. was entitled to and received a widow's or widower's benefit based on a disability under Section 202 (e) or (f) of the Social Security Act, for January 1984;

d. became ineligible for SSI and/or AG payments because of the increase in the amount of his/her widow(er)'s benefit and:

- the increase resulted from the elimination of the reduction factor for disabled widow(er)s entitled before age 60,
- he/she became ineligible for SSI and/or AG payments in the first month in which that increase was paid to him/her, and
- a retroactive payment of that increase for prior months was not mad in that month;

e. has been continuously entitled to a widow(er)'s disability benefit under Section 202 (e) or (f) of the Social Security Act from the first month tha the increase in his/her widow(er)'s benefit was received;

f. would be eligible for SSI or AG if the amount of that increase, and any subsequent cost-of-living adjustments (COLAs) in the widow(er)'s benefits, were deducted from his/her income.

2. Financial Eligibility

a. Assistance Unit

Determine whose resources and income will be counted or deemed available according to the assistance unit policy in chapter M05.

b. Resource Eligibility

Resource eligibility is determined by comparing the widow(er)'s resources to the current Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this protected group; he/she may be eligible as medically indigent (which has more liberal resource methods and standards).

c. Income Eligibility

1) If the individual received SSI (or SSI and AG) and is not currently residing in an approved AG home, the individual's gross SSA benefit amount that was effective in December 1983 plus other current countable income must be within the current SSI individual limit, or couple limit if the individual is married and living with his/her spouse. Calculate income according to the assistance unit policy in chapter M05. Instead of the protected individual's current SSA benefit amount, use the amount effective in December 1983.

   Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this protected CNNMP covered group.

2) If the individual received AG (or AG and SSI) and is currently residing in an approved AG home, the individual's income must be within the current AG limit (home's rate plus personal care allowance). Instead of the protected individual's current SSA benefit amount, use the amount effective in December 1983.

   Compare the total countable income to the current AG limit (home's rate plus personal care allowance). If countable income is within that limit, the protected individual is eligible for Medicaid in this protected CNNMP covered group.

3) If the individual is not income-eligible, Medicaid eligibility may exist in another covered group. However, when determining eligibility in another covered group, count all current income including the current SSA benefit amount. If the individual does not meet an F&C MI covered group, is not institutionalized, is not receiving CBC or does not have Medicare Part A, he/she must be determined eligible in a medically needy covered group.

C. Protected Disabled Widow(er)

42 CFR § 435.138 *specifies that categorically needy eligibility for Medicaid is protected for the group of disabled widow(er)s age 60 through 64 years who meet the criteria specified below. Under 42 USC § 1383c(d), Medicaid protected status was extended to the group of disabled widower(er)s age 50 through 59 years who meet the same criteria.*

A protected disabled widow(er) is an individual who:

- is at least age 50 years (and has not attained age 65);
- is **not** eligible for Medicare Part A hospital insurance;
- becomes ineligible for SSI and/or AG because of mandatory application for and receipt of SSA Title II widow(er)'s disability benefits under section 202(e) or 202(f) of the Social Security Act (or any other provision of section 202 if they are also eligible for benefits under subsections (e) or (f) of the Act).
- would be eligible for SSI or AG if the SSA widow(er)’s benefit were excluded from income.

1. Nonfinancial Eligibility

The protected disabled widow(er) must:

a. meet the nonfinancial eligibility requirements in chapter M02;

b. have received SSI and/or AG for the month before the month in which he/she began receiving SSA Title II disabled widow(er)'s benefits or widow(er)'s benefits;

c. be eligible for SSI or AG if the SSA widow(er)s disability benefit were not counted as income.

2. Financial Eligibility

a. Assistance Unit

Determine whose resources and income will be counted or deemed available according to the assistance unit policy in chapter M05.

b. Resource Eligibility

Financial eligibility is determined by comparing the widow(er)'s resources to the current Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this protected group; he/she may be eligible as medically indigent (which has more liberal resource methods and standards).

c. Income Eligibility

When determining a protected widow(er)'s eligibility in this covered group, the agency must deduct from the individual's income all of the Social Security benefits that made him or her ineligible for SSI.

1) If the individual received SSI (or SSI and AG) and is not currently residing in an approved AG home, the individual's SSA benefit that made him/her ineligible for SSI must be excluded. Other current countable income must be within the current SSI individual limit, or couple limit if the individual is married and living with his/her spouse. Exclude the protected individual's current SSA widow(er)'s benefit amount.

   Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this protected CNNMP covered group.

2) If the individual received AG (or AG and SSI) and is currently residing in an approved AG home, the individual's countable income must be within the current AG limit (home's rate plus personal care allowance). Exclude the protected individual's current SSA widow(er)'s benefit amount.

   Compare the total countable income to the current AG limit (home's rate plus personal care allowance). If countable income is within that limit, the protected individual is eligible for Medicaid in this protected group.

3) If the individual is not income eligible, the individual must be evaluated for Medicaid eligibility in other covered groups. However, when determining eligibility in another covered group, count all current income including the current SSA benefit amount.

D. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). *The ACs are:*

- 021 for an aged individual;
- 041 for a blind individual;
- 061 for a disabled individual.

M0320.105 QUALIFIED SEVERELY IMPAIRED INDIVIDUALS (QSII)-1619(B) STATUS

A. Introduction

42 CFR 435.121 - Under Section 1619(a) of the Social Security Act, a disabled individual who would otherwise lose SSI because of work and the demonstration of the ability to perform substantial gainful activity but continue*s* to have a disabling impairment can continue to receive special SSI benefits if he continue*s* to be financially eligible for SSI benefits based on income.

Section 1619(b) of the Act allows a disabled individual whose income is too high to retain financial eligibility for the special SSI benefit under Section 1619(a) and a blind individual who lost regular SSI payments to continue to receive Medicaid benefits under certain criteria specified in Section 1619(b).

The Social Security Administration (SSA) determines whether an individual who lost SSI because of earned income is eligible for 1619(b) status.

The local department of social services determines whether an individual who has a 1619(b) status continues to be eligible for Medicaid.

B. Identifying QSII Individuals

To identify a QSII individual, check the "Medicaid Test Indicator" field on the State Verification Exchange System (SVES) WMVE9068 screen *or the State Online Query Internet (SOLQ-I) screen.* If there is a code of A, B, or F, the individual has 1619(b) status.

Since eligibility for 1619(b) can change, check the SVES *or SOLQ-I* at each redetermination and when there is an indication that a change may have occurred.

C. Determining Eligibility

1. Nonfinancial Eligibility

The QSII individual must:

- meet the nonfinancial eligibility requirement in chapter M02, and
- have been eligible for and receiving Medicaid coverage as an SSI recipient (must have met the more restrictive real property requirement) in the month immediately preceding the first month of the 1619(b) status. The "Current Pay Status Effective Date" field on the SVES WMVE9065 screen shows the first month of the 1619(b) status.

NOTE: If you cannot determine the first month of 1619(b) status, contact SSA.

2. Financial Eligibility

a. Resource Eligibility

Use the following to determine if the QSII recipient has real property resource(s):

1) equity in a non-exempt property contiguous to *the individual's* home which exceeds $5,000 *and* none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 *are* appl*icable* to the property;

2) interest in undivided heir property and the equity value of *the individual's* share *that,* when added to all other countable resources, exceeds the appropriate Medicaid resource limit. (The interest in the estate must be legally available.) If a partition suit is necessary to sell the interest, costs of partition and attorneys' fees may be deducted as described in M1120.215;

3) ownership (equity value) of *an individual's* former residence *when* the *QSII* recipient is in an institution for longer than 6 months. Determine if the former *residence* is excluded under policy in section M1130.100 D;

4) equity value in property owned jointly *by the QSII recipient and* another person *who is not the individual's spouse as* tenants in common or joint tenants with the right of survivorship at common law. Determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;

5) other real property; determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property.

When a *QSII* recipient has any of the real property listed in 1) through 5) *previously*, ALL of the recipient's resources must be verified, evaluated, and counted together to determine if the recipient meets the Medicaid resource requirements. Calculate resources according to the assistance unit policy in chapter M05. If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically indigent (which has more liberal resource methods and standards).

When a QSII recipient has no real property resource listed in 1) through 5) previously, do NOT determine the recipient's resources. The QSII recipient meets the Medicaid resource requirements because his resource eligibility for QSII has been determined by SSA and he does not have a real property resource as listed previously.

b. Income Eligibility

There are no income eligibility requirements for QSII individuals once they have been determined eligible as 1619(b).

D. Entitlement & Enrollment

Eligible individuals are entitled to full Medicaid coverage. They are classified as categorically needy non-money payment (CNNMP) recipients. The program designation is:

- 21 for an aged individual;
- 41 for a blind individual; or
- 61 for a disabled individual.

***E.* Individuals Ineligible as QSII**

Individuals who are ineligible as QSII because they:

- did not receive Medicaid in the month immediately preceding the month in which SSA first determined them eligible under 1619(b) or

- lost 1619(b) status

must be evaluated for Medicaid eligibility in other covered groups.

NOTE: An individual who has 1619(b) status continues to meet the disabled definition. An individual who no longer has 1619(b) status may not meet the disabled definition.

M0320.106 PROTECTED ADULT DISABLED CHILDREN

A. Policy

Section 1634(c) of the Social Security Act was amended in 1987 (P.L. 99-643 §6(b)) to state that if any individual who has attained the age of 18 and is receiving benefits under Title XVI (the Supplemental Security Income program) on the basis of blindness or a disability which began before he or she attained the age of 22

- becomes entitled, on or after the effective date of this subsection (July 1, 1987), to child's insurance benefits which are payable under section 202(d) on the basis of such disability or to an increase in the amount of the child's insurance benefits which are so payable; and

- ceases to be eligible for SSI because of such child's insurance benefits under the title or because of the increase in such child's insurance benefits,

shall be treated as receiving SSI benefits for Medicaid eligibility purposes so long as he/she would be eligible for SSI in the absence of such child's insurance benefits or such increase.

B. Nonfinancial Eligibility

A protected adult disabled child is one who:

- meets the nonfinancial eligibility requirements in chapter M02;

- has reached the age of 18 years and receives SSI payments on the basis of blindness or a disability which began before he or she reached the age of 22 years;

- on or after July 1, 1987, becomes entitled to SSA Title II disabled child's insurance benefits on the basis of such disability, or receives an increase in Title II disabled child's insurance benefits;

- becomes ineligible for SSI on or after July 1, 1987 because of the receipt of, or increase in, Title II disabled child's benefits;

- has resources within the current Medicaid resource limit; and

- has income which, in the absence of the Title II disabled child's benefit, or in the absence of the increase in such benefit, is within the current SSI income limit.

C. Financial Eligibility

Determine whose resources and income will be counted or deemed available according to the assistance unit policy in chapter M05.

1. Resources

a. Asset Transfer

The protected individual must meet the asset transfer policy in *subchapter M1450.*

b. Resource Eligibility

Financial eligibility is determined by comparing the protected individual's resources to the current Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). Calculate resources according to the assistance unit policy in chapter M05. If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this protected covered group; he/she may be eligible as medically indigent (which has more liberal resource methods and standards).

2. Income

a. Receipt of SSA Child's Benefits Causes SSI Ineligibility

If the individual began receiving adult disabled child's benefits and this receipt caused SSI ineligibility, then the entire adult disabled child's benefit amount and any subsequent increases in the benefit are excluded when determining the individual's countable income.

In determining whether the adult disabled child's income, in absence of the Title II adult disabled child's benefit is within the current SSI income limit, all of the adult disabled child's other current countable income must be within the current SSI individual limit, or couple limit if the individual is married and living with his/her spouse. Calculate income according to the assistance unit policy in chapter M05, including deeming of parent(s)' income when the individual is under age 21 and living with a parent(s). **Exclude all of the protected individual's current SSA adult disabled child's benefit amount.**

Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this CNNMP protected covered group.

If countable income exceeds the SSI limit, determine the individual's eligibility in another Medicaid covered group.

b. Increase In SSA Child's Benefits Causes SSI Ineligibility

If the individual received an increase in disabled child's benefits and this increase caused SSI ineligibility, only the increase which caused SSI

ineligibility is excluded when determining the individual's countable income. Calculate income according to the assistance unit policy in chapter M05, including deeming of parent(s)' income when the individual is under age 21 and living with a parent(s). Exclude the amount of the increase which caused SSI ineligibility.

1) Compare the total countable income to the appropriate SSI income limit. If countable income is within the SSI limit, the protected individual is eligible for Medicaid in this CNNMP protected covered group.

   In this situation, the adult disabled child received SSI and SSA concurrently, and lost SSI because of an increase in SSA disabled child's benefits. The amount of the increase that caused SSI ineligibility is excluded. No subsequent increases in the disabled child's benefit are excluded when reviewing the individual's eligibility as a protected adult disabled child. However, if the protected adult disabled child becomes ineligible for Medicaid, evaluate his/her Medicaid eligibility as a protected former SSI recipient using the policy and procedures in Section M0320.103 of this chapter.

2) If countable income exceeds the SSI limit, determine the individual's eligibility in another covered group. If the individual does not meet an F&C MI covered group, is not institutionalized, is not receiving CBC or does not have Medicare Part A, he/she must be evaluated in a medically needy covered group.

D. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). Program designation is

- 21 for an aged individual;
- 41 for a blind individual;
- 61 for a disabled individual.

M0320.107 *PROTECTED SSI DISABLED CHILDREN*

A. Introduction

The Balanced Budget Act of 1997 (P.L. #105-33) created a new covered group which protects Medicaid eligibility for disabled children who received SSI, whose SSI is canceled solely because the children do not meet the SSI definition of childhood disability (revised per section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996), and who would be paid SSI but for the change in the childhood disability definition.

B. Nonfinancial Eligibility Requirements

To be eligible in this protected covered group, the protected SSI disabled child must

- *have had his/her SSI canceled solely because he/she does not meet the SSI definition of childhood disability (revised per section 211(a) of the Personal Responsibility and Work Opportunity Act of 1996);*
- *meet the nonfinancial Medicaid eligibility requirements in chapter M02;*
- *continue to meet the SSI childhood disability definition and regulations that were in effect prior to the effective date of the change in the disability definition (August 22, 1996); and*
- *be under age 18 years.*

1. Disability Determination

An SSI disabled child is presumed to meet the childhood disability definition in effect prior to August 22, 1996, until he/she reaches age 18 years, unless there is an improvement in the child's condition. If the child's condition improves, complete

- *the "Disability Referral Form" (form #032-03-095);* ***and***
- *the "Medical History and Disability Report" (form #032-03-007) and the "Psychological/Psychiatric Supplement" if appropriate;* ***and***
- *a "General Authorization for Medical Information" (form #032-03-311) for each medical practitioner reported by the individual on the report.*

Send the report(s) and authorization forms to the MDU.

2. MDU Decision

If the MDU decides that the child continues to meet the childhood disability definition in effect prior to August 22, 1996, the child continues eligible in the CNNMP protected group of SSI disabled children, provided the child meets the financial eligibility requirements in item C. below.

If the MDU decides that the child no longer meets the childhood disability definition in effect prior to August 22, 1996, the child no longer meets the CNNMP protected group of SSI disabled children. Determine the child's eligibility in another covered group. If the child is not eligible in any covered group, send an advance notice to the authorized representative and take action to cancel the child's Medicaid coverage.

C. Financial Eligibility Procedures

1. Assistance Unit

Follow the policy and procedures in M0530.

. ***2. Resource Eligibility***

Resource eligibility is determined by comparing the SSI disabled child's countable resources to the current ABD Medicaid resource limit. Determine resources using policy in Chapter S11 (including the real property requirements that are more restrictive than SSI). Calculate resources according to the assistance unit policy in subchapter M0530. If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the child is NOT eligible in the protected SSI disabled children covered group; he/she may be eligible as F&C medically indigent if he/she is under age 19 years.

3. Income Eligibility

Income eligibility is determined by comparing the SSI disabled child's income to the current SSI payment limit for an individual. Determine countable income using policy in Chapter S08. Calculate income according to the assistance unit policy in subchapter M0530. If countable income is within the SSI payment limit, the child is eligible for Medicaid in the covered group of protected SSI disabled children.

D. Entitlement & Enrollment

Children eligible for Medicaid in the covered group of protected SSI disabled children are classified as categorically needy non-money payment (CNNMP). Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible protected SSI disabled children are enrolled with program designation "61."

M0320.200 ABD CATEGORICALLY NEEDY

A. Introduction

To be eligible in an ABD (aged, blind or disabled) covered group, the individual must first meet the "Aged," "Blind" or "Disabled" definition in subchapter M0310. If he/she does not, then go to the Families & Children Categorically Needy covered groups in section M0320.300 below.

B. Procedure

The policy and procedures for determining whether an individual meets an ABD CN covered group are contained in the following sections:

- M0320.201 SSI Recipients
- M0320.202 AG Recipients
- M0320.203 ABD In Medical Institution, Income ≤ 300% SSI
- M0320.204 ABD Receiving Waiver Services
- M0320.205 ABD Hospice
- M0320.206 QMB (Qualified Medicare Beneficiary)
- M0320.207 SLMB (Special Low-income Medicare Beneficiary)
- M0320.208 QI (Qualified Individuals)
- M0320.209 QDWI (Qualified Disabled & Working Individual)
- M0320.210 ABD with Income ≤ 80% FPL
- *M0320.211 MEDICAID WORKS*

M0320.201 SSI RECIPIENTS

A. Introduction

42 CFR 435.121 - SSI recipient are a mandatory CN covered group. However, in Virginia, not all SSI recipients are eligible for Medicaid. Virginia has chosen to impose real property eligibility requirements that are more restrictive than SSI real property eligibility requirements. Thus, Virginia SSI recipients must apply separately for Medicaid at their local department of social services.

B. Nonfinancial Eligibility

An individual who is receiving an SSI payment is eligible for Medicaid if he meets the following nonfinancial requirements:

1. Citizenship or Alien Status

The SSI recipient is a citizen of the United States or full benefit alien (see M0220).

2. Virginia Residency

The SSI recipient is a resident of Virginia (see M0230).

3. Assignment Of Rights

The SSI recipient meets the assignment of rights to medical support and third party payments requirements (see M0250).

4. Institutional Status

The SSI recipient meets the institutional status requirements in M0280.

5. Not Conditionally Or Presumptively Eligible

The SSI recipient is NOT conditionally or presumptively eligible for SSI, or is not presumptively disabled or blind. Conditionally eligible SSI recipients are being allowed time to dispose of excess resources. Presumptively blind or disabled SSI recipients are presumed to be blind or disabled; no final blindness or disability determination has been made.

6. SSI Entitlement

SSI payments for eligible individuals are effective the first day of the month following the month in which the SSI application was filed. When the Medicaid application is filed in the same month as the SSI application, the applicant is not eligible for Medicaid as an SSI recipient until the month for which he receives his first SSI payment. When the SSA record indicates a payment code of "C01" but shows no payment amount due to a recovery of an overpayment, the individual is considered to be an SSI recipient.

Eligibility for months prior to SSI entitlement must be evaluated in other covered groups.

C. Financial Eligibility

1. Resources

a. Asset Transfer

The SSI recipient must meet the asset transfer policy in subchapter M1450. See subchapter M1450 to determine if the asset transfer precludes Medicaid eligibility for *the* Medicaid payment of long-term services.

b. Resource Eligibility

Determine if the SSI recipient has the following real property resource(s):

1) equity in non-exempt property contiguous to *the individual's* home which exceeds $5,000 *and* none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 *are* appl*icable* to the property;

2) interest in undivided heir property and the equity value of *the individual's* share *that*, when added to all other countable resources, exceeds the appropriate Medicaid resource limit. (The interest in the estate must be legally available.) If a partition suit is necessary to sell the interest, costs of partition and attorneys' fees may be deducted as described in M1120.215;

3) ownership (equity value) of *the individual's* former residence *when* the SSI recipient is in an institution for longer than 6 months. Determine if the former *residence* is excluded under policy in section M1130.100 D;

4) equity value in property owned jointly *by the SSI recipient* with another person in *who is not the individual's spouse as* tenants in common or joint tenants with the right of survivorship at common law. Determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;

5) other real property; determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property.

When an SSI recipient has any of the real property listed in 1) through 5) above, ALL of the recipient's resources must be verified, evaluated, and counted together to determine if the SSI recipient meets the Medicaid resource requirements. Calculate resources according to the assistance unit policy in chapter M05. If current resources are within the limit, go on to determine income eligibility. If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he may be eligible as medically indigent (which has more liberal resource methods and standards).

When an SSI recipient has no real property resource listed in 1) through 5) above, do NOT determine the SSI recipient's resources. The SSI recipient meets the Medicaid resource requirements because he receives SSI and does not have a real property resource listed above.

2. Income

Verify the SSI recipient's eligibility for SSI payments by an SSI awards notice and inquiring the SDX (State Data Exchange) or SVES (State Verification Exchange System). If the recipient is eligible for SSI, he meets the Medicaid income eligibility requirement.

D. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month, including the receipt of, or entitlement to, an SSI payment in that month. *An individual is considered to be an SSI recipient when the SSA record indicates a payment code of "C01" but shows no payment amount due to a recovery of an overpayment.*

Retroactive coverage is applicable to this covered group. However, if the individual did not receive, or was not entitled to, an SSI payment in the retroactive period, the individual is not eligible for retroactive Medicaid in t SSI recipients covered group. His retroactive eligibility must be evaluated i another Medicaid covered group.

Eligible SSI recipients are categorically needy (CN). *The AC* is

- *0*11 for an aged SSI recipient;
- *0*31 for a blind SSI recipient;
- *0*51 for a disabled SSI recipient.

E. Ineligible as SSI Recipient

If a non-institutionalized SSI recipient is not eligible for Medicaid because of resources, evaluate the individual's eligibility in all other Medicaid covered groups including, but not limited to, the ABD with Income ≤ 80% FPL and QMB covered groups.

M0320.202 AG RECIPIENTS

A. Policy

42 CFR 435.234 - An Auxiliary Grants (AG) recipient is eligible for Medicaid if he meets the assignment of rights to medical support and third party payments requirements (see M0250). AG eligibility is determined using the AG eligibility policy in Volume II.

B. Procedure

Verify the AG recipient's eligibility for AG by agency records.

C. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

AG recipients are categorically needy (CN). *The AC* is:

- *0*12 for an aged AG recipient;
- *0*32 for a blind AG recipient;
- *0*52 for a disabled AG recipient.

M0320.203 ABD IN MEDICAL INSTITUTION, INCOME ≤ 300% SSI LIMIT

A. Policy

42 CFR 435.236 - The state plan includes the covered group of aged, blind or disabled individuals in medical institutions who

- meet the Medicaid resource requirements, and
- have income that does not exceed 300% of the SSI individual payment limit (see M0810.002 A. 3.).

B. Nonfinancial Eligibility

An individual is eligible in this covered group if he meets the nonfinancial requirements in M1410.020:

1. Citizenship/alien status;
2. Virginia residency;
3. Social Security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Is institutionalized in a medical institution that is not an IMD; *and*
8. Meets either the Aged, Blind, or Disabled definition in M0310.

C. Financial Eligibility

1. Asset Transfer

The individual must meet the asset transfer policy in *subchapter* M1450.

2. Resources

a. Resource Eligibility – Married Individual

If the individual is married, use the resource policy in subchapter M1480. Evaluate countable resources using ABD resource policy in chapter S11.

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he may be eligible in a medically indigent covered group (which has more liberal resource methods and standards).

b. Resource Eligibility - Unmarried Individual

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. Pay close attention to:

1) equity In non-exempt property contiguous to the individual's home which exceeds $5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property; and

2) ownership of his/her former residence when the individual is in an institution for longer than 6 months. Determine if the former home is excluded in M1130.100 D.

If the individual is a blind or disabled child, DO NOT DEEM any resources or income from the child's parent; count only actual resources the parent makes available to the child. If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically indigent (which has more liberal resource methods and standards).

3. Income

To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 *and subchapter M1460*.

DO NOT subtract the $20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Compare the total gross income to the *300% of SSI limit (see M0810.002 A. 3.)*. If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy.

D. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). If the individual has Medicare Part A, re-calculate the individual's income - subtract appropriate exclusions. Compare the countable income to the QMB limit.

1. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) - the individual has Medicare Part A and has countable income within the QMB income limit - the program designation is:

- 022 for an aged individual also QMB;
- 042 for a blind individual also QMB;
- 062 for a disabled individual also QMB.

2. Not QMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) - the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - the program designation is:

- 020 for an aged individual NOT also QMB;
- 040 for a blind individual NOT also QMB;
- 060 for a disabled individual NOT also QMB.

E. Ineligible In This Covered Group

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. If the individual is not eligible for Medicaid in this covered group because of resources, determine the individual's eligibility as QMB, SLMB, QDWI or QI if he/she has Medicare Part A.

M0320.204 ABD RECEIVING MEDICAID WAIVER SERVICES (CBC)

A. Policy

42 CFR 435.217 - The state plan includes the covered group of aged, blind or disabled individuals in the community who

- would be eligible for Medicaid if institutionalized;
- are screened and approved to receive Medicaid waiver services and have selected the option to receive Medicaid waiver services in lieu of nursing facility services;
- in the absence of the waiver services would require the level of care furnished in a hospital, nursing facility or ICF-MR; and
- have income that does not exceed 300% of the SSI individual payment limit (see M0810.002 A. 3.).

B. Nonfinancial Eligibility

An individual who receives Medicaid waiver services is eligible in this covered group if he/she meets the nonfinancial requirements in M1410:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Is not in a medical institution, may be in a residential institution that meets the institutional status requirements;
8. Meets either the Aged, Blind, or Disabled definition in M0310.

Do not wait until the individual starts to receive the waiver services to determine eligibility in this covered group. Determine eligibility in this covered group if the individual is screened and approved *(*see subchapter M1420) to receive Medicaid waiver services and has selected the option to receive Medicaid waiver services in lieu of nursing facility services. Presume the individual will receive the services and go on to determine financial eligibility using the policy and procedures in C. below.

If the individual's eligibility was determined as an institutionalized individual prior to the receipt of waiver services, the EW must verify the receipt of Medicaid CBC services within 30 days of the date of the Notice of Action on Medicaid. If Medicaid CBC services did not start within 30 days of the date of the Notice of Action on Medicaid, the individual's continued eligibility must be re-evaluated as a non-institutionalized individual.

C. Financial Eligibility

1. Asset Transfer

The individual must meet the asset transfer policy in *subchapter* M1450.

2. Resources

a. Resource Eligibility - Unmarried Individual

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements in chapter S11 (ABD Resources). Pay close attention to:

1) equity in non-exempt property contiguous to the individual's home which exceeds $5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property, and

2) ownership of his/her former residence when the individual has been away from his home property for longer than 6 months. Determine if the home property is excluded in M1130.100.

DO NOT DEEM any resources from a blind or disabled child's parent living in the home. Count actual resources the parent makes available to the child.

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible for Medicaid in this covered group. He/she may be eligible in a medically indigent covered group (which has more liberal resource methods and standards).

b. Resource Eligibility - Married Individual

If the individual is married *and has a community spouse*, use the resource policy in *subchapter M1480*. *If the individual is married, but has no community spouse, use the resource policy in subchapter M1460.* Evaluate countable resources using ABD resource policy in chapter S11.

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible in a medically indigent covered group (which has more liberal resource methods and standards).

3. Income

To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 *and subchapter M1460.*

DO NOT subtract the $20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Compare the total gross income to the *300% of SSI limit (see M0810.002 A. 3.)*. If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy.

D. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met AND they receive waiver services in that month. Retroactive coverage does not apply to this covered group because an individual cannot be eligible in this covered group until he/she applies for Medicaid. [The individual cannot have received Medicaid covered waiver services in the retroactive period because he was not receiving Medicaid on or before the date he applied.]

Eligible and entitled individuals in this group are classified as categorically needy non-money payment (CNNMP). If the individual has Medicare Part A, re-calculate the individual's income - subtract the appropriate exclusions. Compare the countable income to the QMB limit.

1. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) - the individual has Medicare Part A and has countable income within the QMB income limit - the program designation is:

- 022 for an aged individual also QMB;
- 042 for a blind individual also QMB;
- 062 for a disabled individual also QMB.

2. Not QMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) - the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - the *AC* is:

- 020 for an aged individual NOT also QMB;
- 040 for a blind individual NOT also QMB;
- 060 for a disabled individual NOT also QMB.

E. Ineligible In This Covered Group

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. Determine the individual's eligibility as QMB, SLMB, QDWI or QI if he/she has Medicare Part A.

M0320.205 ABD HOSPICE

A. Policy

SMM 3580-3584 - The state plan includes the covered group of aged, blind or disabled individuals who are terminally ill and elect hospice benefits.

The ABD Hospice covered group is for individuals who have a signed a hospice election statement in effect for at least 30 consecutive days, and who are not eligible in any other full-benefit Medicaid covered group. Hospice care is a covered service for individuals in all full-benefit covered groups; individuals who need hospice services but who are eligible in another full-benefit covered group do not meet the Hospice covered group.

Individuals receiving hospice services in the ABD Hospice Covered group may also receive services under the Elderly and Disabled with Consumer Direction (EDCD) Waiver, if the services are authorized by the Department of Medical Assistance Services (DMAS) (see M1440.101).

The individual must elect hospice care. Election of hospice care is verified either verbally or in writing from the hospice. If the verification is verbal, document the case record. Eligibility in the Hospice covered group is ongoing as long as the individual continues to receive hospice care, subject to a renewal of eligibility at least once every 12 months. The eligibility worker must verify that the hospice agreement is current at the time of the annual Medicaid renewal.

The 30-day requirement begins on the day the hospice care election statement is signed. Once the hospice election has been in effect for 30 consecutive days, the 300% of SSI income limit is used to determine Medicaid eligibility. If the individual's income is within 300% of SSI, eligibility in the Hospice covered group may be determined beginning with the month in which the hospice election was signed.

Individuals who already meet the definition of institutionalization in M1410.010 B.2 at the time of hospice election meet the 30-day requirement, provided there is no break between institutionalization and hospice election.

Individuals who meet the Hospice covered group may have their eligibility determined using the same financial requirements as institutionalized individuals.

B. Nonfinancial Eligibility

A terminally ill individual who elects hospice services is eligible in this covered group if he/she meets the following requirements:

1. Citizenship/alien status;
2. Virginia residency;
3. Social Security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Application for other benefits;
6. Institutional status requirements;
7. Meets either the Aged, Blind, or Disabled definition in M0310 or
8. **is "deemed" to be disabled because of the terminal illness. Do not refer the individual to the DDS for a disability determination**.

C. Financial Eligibility

1. Asset Transfer

The individual in the hospice covered group must meet the asset transfer policy in subchapter M1450.

2. Resources

The hospice services recipient is an assistance unit of 1 person. All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements.

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible for Medicaid in this covered group. He/she may be eligible in a medically indigent covered group (which has more liberal resource methods and standards).

a. Unmarried Individual

If the individual is unmarried or is married and has no community spouse, use the resource policy in chapter S11 and subchapter M1460.

b. Married Individuals

If the individual is married and has a community spouse, use the resource policy in chapter S11 and subchapter M1480.

3. Income

To determine if an individual has income within the 300% of SSI limit, use **gross** income, not countable income. Determine what is income according to chapter S08 and subchapter M1460.

DO NOT subtract the $20 general exclusion or any other income exclusions. The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Compare the total gross income to the 300% of SSI limit (see M0810.002 A. 3). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in this covered group. Evaluate his/her eligibility as medically needy.

D. Entitlement

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the month in which all eligibility requirements are met. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). If the individual has Medicare Part A, re-calculate the individual's income, applying the appropriate exclusions. Compare the countable income to the QMB limit.

E. Enrollment

Eligible individuals must be enrolled in the appropriate aid category (AC). If the individual is aged, blind, or disabled as defined in M0310, he is enrolled under that AC. AC (054) is used for "deemed-disabled" individuals only. *Use the appropriate Hospice AC when the individual is also authorized to receive EDCD Waiver services.*

For individuals who are ABD and entitled/enrolled in Medicare Part A, income must be recalculated (allowing appropriate disregards) to determine if the individual is dually eligible as a QMB.

1. ABD Individual

***a.* Dual-eligible As QMB**

If the individual is also a Qualified Medicare Beneficiary (QMB) - the individual has Medicare Part A and has countable income within the QMB income limit – the *AC* is:

- 022 for an aged individual also QMB;
- 042 for a blind individual also QMB;
- 062 for a disabled individual also QMB.

b. Not QMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit – the AC is:

- 020 for an aged individual NOT also QMB;
- 040 for a blind individual NOT also QMB;
- 060 for a disabled individual NOT also QMB;

2. "Deemed" Disabled Individual

An individual who is "deemed" disabled based on the hospice election is enrolled using AC 054. Individuals in this AC who have also been approved to receive services under the EDCD Waiver do not need a disability determination.

E. Post-eligibility Requirements (Patient Pay)

A patient pay must be calculated for individuals who receive hospice services in a nursing facility (see subchapter M1470). Individuals who receive hospice services outside of a nursing facility do not have a patient pay.

Individuals who have elected hospice services and who also receive Medicaid Long-term Care services available under the EDCD Waiver must have a patient pay calculation for the EDCD services (see subchapter M1470).

F. Ineligible In This Covered Group

There is no corresponding medically needy hospice covered group. If the individual is aged or has been determined blind or disabled, the individual must be evaluated in a medically needy covered group for medically needy spenddown.

M0320.206 QMB (QUALIFIED MEDICARE BENEFICIARY)

A. Policy

42 CFR 435.121 - Qualified Medicare Beneficiaries are a mandatory CN covered group. Medicaid will pay the Medicare Part A premium (as well as the Part B premium) and deductibles and coinsurance for individuals eligible as QMB only.

A QMB is an individual who:

- is entitled to Medicare Part A hospital insurance benefits, but not entitled solely because he/she is eligible to enroll in Part A under section 1818A of the Act (1818A is applicable to QDWI);
- has resources that are within the resource limits for the Medicare Savings Programs (MSPs). See *section M1110.003* for the current resource limits; and

has income that does not exceed 100% of the federal poverty limits.

B. Nonfinancial Eligibility

The Qualified Medicare Beneficiary must meet all the nonfinancial eligibility requirements in chapter M02.

1. Entitled to Medicare Part A

The individual must be entitled to or must be enrolled in Medicare Part A. The individual does not have to be aged, blind or disabled. However, Medicare entitlement is limited to individuals who are age 65 or older, or who have received Title II social security benefits because of a disability for 24 months, or who have end stage renal (kidney) disease.

Enrollment in Part A of Medicare is verified by the individual's Medicare card, or by communication (such as SVES) with the Social Security Administration (SSA).

2. Individual Not Currently Enrolled In Medicare Part A

Individuals who are not currently enrolled in Medicare Part A must apply for and enroll in Medicare Part A at the local Social Security Administration (SSA) office, and must present verification of Medicare Part A enrollment to

the local department of social services (DSS) in order to be eligible for Medicaid as QMB.

If an individual appears to be eligible for Medicare but is not enrolled in Medicare, refer him to the SSA district office to apply for Medicare enrollment.

If an individual must pay a monthly premium for Medicare Part A, and cannot afford the premium, the SSA office will give the individual a bill for the premium when the individual is enrolled. The individual must present this bill and the Medicare Part A enrollment verification to the local DSS worker in order to be eligible for Medicaid as a QMB.

NOTE: A disabled working individual who is enrolled or is eligible to enroll in Medicare Part A under Section 1818A of the Social Security Act **cannot** be enrolled as a QMB; he may be eligible as a Qualified Disabled and Working Individual (QDWI). See M0320.209 below for information on the QDWI covered group.0

3. Verification Not Provided

If the applicant does not provide information documenting enrollment in Medicare Part A within the application processing time standard, he is not eligible for Medicaid as QMB, but may be eligible for Medicaid in another covered group.

C. Financial Eligibility

1. Assistance Unit

The assistance unit policy in chapter M05 applies to QMBs.

If the QMB individual is living with his spouse who is aged, blind, or disabled, but does not have Medicare Part A, and both apply for Medicaid, two different financial calculations must be completed for the unit because of the different income limits used in the eligibility determinations. One is the medically indigent QMB determination; the other is for the ABD spouse's CN or MN covered group.

2. Resources

The asset transfer rules in subchapter M1450 must be met by the medically indigent Medicare beneficiary.

The resource requirements in chapter S11 and Appendix 2 to chapter S11 must be met by the medically indigent Medicare beneficiary. Some of the real and personal property requirements are different for QMBs. The different requirements are identified in Appendix 2.

The resource limit for an individual is the resource limit for the Medicare Savings Programs (MSPs). See *section M1110.003* for the current resource limits.

3. Income

The income requirements in chapter S08 must be met by QMBs. The income limits are in M0810.002. By law, for QMBs who have SSA benefits, the new QMB income limits are effective the first day of the second month following the month in which the federal poverty limit is updated. For QMBs who do NOT have SSA benefits, the new QMB income limits are effective the date the updated federal poverty level (FPL) is published. Local DSS are notified each year of the new FPL via the broadcast system. Check that system to ascertain when the SSA COLA must be counted in determining QMB income eligibility.

4. Income Exceeds QMB Limit

Spenddown does not apply to the medically indigent income limits. If the individual's income exceeds the QMB limit, he is not eligible as QMB and cannot spenddown to the QMB limit. Determine the individual's eligibility in the SLMB covered group below in M0320.207.

At application and renewal, if the eligible QMB individual's resources are within the medically needy limit and the individual meets a MN covered group, place the individual on two 6-month spenddown based on the MN income limit.

D. QMB Entitlement

Entitlement to Medicaid coverage for QMB only begins the first day of the month **following** the month in which Medicaid eligibility as a QMB is approved.

Because QMB coverage does not begin until the month following the month of approval, an applicant who is eligible for QMB coverage must apply for Extra Help in order to receive the subsidy for the month of QMB approval. See chapter M20 for more information on Extra Help.

Retroactive eligibility does **not** apply to the QMB covered group. To be eligible for Medicaid in the retroactive period, and in the application month, a QMB must meet the requirements of another Medicaid covered group.

E. Enrollment

1. *Aid Categories*

The following *ACs* are used to enroll individuals who are only eligible as qualified Medicare beneficiaries; they do not meet the requirements of another covered group:

- *0*23 for an aged QMB only;
- *0*43 for a blind QMB only;
- *0*63 for a disabled or end-stage renal disease QMB only.

2. Recipient's *AC* Changes To QMB

An enrolled recipient's *AC* cannot be changed to the QMB-only *AC* using a "change" transaction in the MMIS. If a Medicaid recipient becomes **ineligible** for full-coverage Medicaid because of an increase in income or resources, but is eligible as a QMB, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare premiums, deductibles and coinsurance amounts as a QMB.

Cancel the recipient's full coverage effective the last day of the month, using cancel reason "*0*07". Reinstate the recipient's coverage with the begin date as the first day of the month following the cancellation effective date. The *AC* is QMB-only.

3. QMB's *AC* Changes To Full Coverage *AC*

When an enrolled QMB-only becomes eligible in another classification and covered group which has full Medicaid coverage, except when he/she meets a spenddown, e.g., a QMB-only *individual's* resources change to below the MN limits:

- cancel the QMB-only coverage effective the last day of the month immediately **prior** to the month in which he/she became eligible in the full coverage classification and covered group, using cancel reason "*0*24";

- reinstate the recipient's coverage with the begin date as the first day of the month in which he/she became eligible in the full coverage classification and covered group, with the appropriate full coverage *AC*.

4. Spenddown Status

At application and redetermination, eligible QMBs who meet an MN covered group and who have resources that are within the lower MN resource limits are placed on two 6-month medically needy spenddowns. *All spenddown periods are based on the application or renewal date, as appropriate. See M1370.*

In order to be placed on spenddown, QMBs with end-stage renal disease must meet a medically needy covered group.

5. QMB Meets Spenddown

When an eligible QMB meets the spenddown, cancel the QMB-only coverage effective the day before the spenddown was met, using cancel reason "*0*24". Reinstate the recipient's coverage with the first date the spenddown was met as the begin date *of coverage*, *and enter the end date of the spenddown period as the end date of coverage*. *The aid category* is medically needy dual-eligible:

- *0*28 for an aged MN individual also eligible as QMB;
- *0*48 for a blind MN individual also eligible as QMB;
- *0*68 for a disabled MN individual also eligible as QMB.

6. Spenddown Period Ends

After the spenddown period ends, reinstate the QMB-only coverage using the appropriate QMB-only *AC*.

The begin date of the reinstated coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial QMB eligibility.

7. QMB Enters Long-term Care

The enrollment of a QMB who is admitted to long-term care and who becomes eligible for Medicaid in another classification and covered group is handled like a QMB who meets a spenddown. Cancel the QMB-only coverage effective the last day of the month before the month of admission to long-term care, reason "024". Reinstate the coverage with the begin date as the first day of the month of admission to long-term care.

M0320.207 SLMB (SPECIAL LOW INCOME MEDICARE BENEFICIARY)

A. Policy

1902(a)(10)(E)(iii) and 1905(p)(3)(A)(ii) of the Act - Coverage of Special Low-income Medicare Beneficiaries is mandated by the federal Medicaid law. Medicaid will only pay the Medicare Part B premium for individuals eligible as SLMB.

An SLMB is an individual who meets all of the eligibility requirements for QMB (M0320.206 above) EXCEPT for income that exceeds the QMB limit but is less than the higher limit for SLMB. Like QMBs, eligible SLMBs who meet an MN covered group are also placed on a medically needy spenddown if resources are within the medically needy limit.

An SLMB individual

- is entitled to Medicare Part A hospital insurance benefits, but not entitled solely because he/she is eligible to enroll in Part A under section 1818A of the Act (1818A is applicable to QDWI);
- has resources that are within the resource limits for the Medicare Savings Programs (MSPs). See *section M1110.003* for the current resource limits; and
- has income that exceeds the QMB limit (100% of the federal poverty limits) but is less than 120% of the poverty limits.

B. Nonfinancial Eligibility

The SLMB must meet all the nonfinancial eligibility requirements in chapter M02.

1. Entitled to Medicare Part A

The individual must be entitled to or must be enrolled in Medicare Part A. The individual does not have to be aged, blind or disabled.

Enrollment in Part A of Medicare is verified by the individual's Medicare card, or by communication (such as SVES) with the Social Security Administration (SSA).

2. Individual Not Currently Enrolled In Medicare Part A

Individuals who are not currently enrolled in Medicare Part A must apply for and enroll in Medicare Part A at the local Social Security Administration (SSA) office, and must present verification of Medicare Part A enrollment to the local department of social services (DSS) in order to be eligible for Medicaid as SLMB.

If an individual appears to be eligible for Medicare but is not enrolled in Medicare, refer him/her to the SSA district office to apply for Medicare enrollment.

If an individual must pay a monthly premium for Medicare Part A, and cannot afford the premium, the SSA office will give the individual a bill for the premium when the individual is enrolled. The individual must present this bill and the Medicare Part A enrollment verification to the local DSS worker in order to be eligible for Medicaid as an SLMB.

NOTE: A disabled working individual who is enrolled or is eligible to enroll in Medicare Part A under Section 1818A of the Social Security Act **cannot** be enrolled as SLMB; he/she may be eligible as a Qualified Disabled and Working Individual (QDWI). See M0320.209 below for information on the QDWI covered group.

3. Verification Not Provided

If the applicant does not provide information documenting enrollment in Medicare Part A within the application processing time standard, he/she is not eligible for Medicaid as SLMB, but may be eligible in another covered group.

C. Financial Eligibility

1. Assistance Unit

The assistance unit policy in chapter M05 applies to SLMBs.

If the SLMB individual is living with his/her spouse who is aged, blind, or disabled, but does not have Medicare Part A, and both apply for Medicaid, two different financial calculations must be completed for the unit because of the different income limits used in the eligibility determinations. One is the medically indigent SLMB determination; the other is for the ABD spouse's CN or MN covered group.

2. Resources

The asset transfer rules in *subchapter M1450* must be met by the medically indigent Medicare beneficiary.

The resource requirements in chapter S11 and Appendix *2* to Chapter S11 must be met by the SLMB. Some of the real and personal property requirements are different for SLMBs. The different requirements are identified in Appendix 2.

The resource limit are the resource limits for the Medicare Savings Programs (MSPs). See *section M1110.003* for the current resource limits.

3. Income

The income requirements in chapter S08 must be met by SLMBs. The income limits for SLMBs are in M0810.002. An SLMB's income must exceed the QMB limit and must be less than the SLMB limit.

By law, for SLMBs who have Title II benefits, the new SLMB income limits are effective the first day of the second month following the month in which the federal poverty limit is updated. For SLMBs who do NOT have Title II benefits, the new SLMB income limits are effective the date the updated federal poverty limit is published.

Local DSS are notified each year of the new poverty limits via the broadcast system. Check that system to ascertain when the Title II COLA must be counted in determining SLMB income eligibility.

4. Income Equals or Exceeds SLMB Limit

Spenddown does not apply to the medically indigent income limits. If the individual's income is equal to or exceeds the SLMB limit, he/she is not eligible as SLMB and cannot spenddown to the SLMB limit. At application and redetermination, if the individual's resources are within the medically needy limit and the individual meets a medically needy covered group, place the individual on two 6-month spenddown*s* based on the MN income limit.

D. SLMB Entitlement

If all eligibility factors are met in the application month, entitlement to Medicaid as an SLMB begins the first day of the application month.

SLMBs are entitled to retroactive coverage if they meet all the SLMB requirements in the retroactive period. However, coverage under this group cannot begin earlier than January 1, 1993.

The eligible SLMB will only receive Medicaid payment of his/her Medicare Part B premium through the Medicaid Buy-In Agreement with SSA. **The SLMB will not receive a Medicaid card.**

E. Enrollment

1. Aid Category

The AC for all SLMBs is "053".

2. Recipient's AC Changes To SLMB

An enrolled recipient's *AC* cannot be changed to AC "053" using a "change" transaction in the MMIS. If a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because

of an increase in income, but is eligible as an SLMB, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part B premiums as an SLMB.

Cancel the recipient's full coverage effective the last day of the month, using cancel reason "007." Reinstate the recipient's coverage with the begin date as the first day of the month following the cancellation effective date. The aid category (AC) is "053."

3. SLMB's AC Changes To Full Coverage AC

When an enrolled SLMB becomes eligible in another classification and covered group which has full Medicaid coverage, except when he/she meets a spenddown, e.g., an SLMB's resources change to below the MN limits:

- cancel the SLMB coverage effective the last day of the month immediately prior to the month in which he/she became eligible in the full coverage classification and covered group, using cancel reason "024";

- reinstate the recipient's coverage with the begin date as the first day of the month in which he/she became eligible in the full coverage covered group, with the appropriate full coverage AC.

4. Spenddown Status

At application and redetermination, eligible SLMBs who meet an MN covered group and who have resources that are within the lower MN resource limits are also placed on two 6-month medically needy spenddowns.
All spenddown periods are based on the application or renewal date, as appropriate. See M1370.

SLMBs who are not determined disabled must be determined disabled or blind, or must be pregnant, under age 18 or under age 21 if in foster care or adoption assistance in order to meet a medically needy covered group for spenddown.

5. SLMB Meets Spenddown

When an SLMB meets a spenddown, cancel his AC "053" coverage effective the date before the spenddown was met, using cancel reason "024". Reinstate the recipient's coverage with the first date the spenddown was met as the begin date *of coverage*, and enter the end date of the spenddown period *as the end date of coverage*. The AC is medically needy NOT dual-eligible:

- 018 for an aged MN individual NOT eligible as QMB;
- 038 for a blind MN individual NOT eligible as QMB;
- 058 for a disabled MN individual NOT eligible as QMB.

6. Spenddown Period Ends

After the spenddown period ends, reinstate the SLMB-only coverage using the AC 053.

The begin date of the reinstated AC 053 coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial SLMB eligibility.

7. SLMB Enters Long-term Care

The enrollment of an SLMB who is admitted to long-term care and who becomes eligible for Medicaid in another classification and covered group is handled like an SLMB who meets a spenddown. Cancel the SLMB-only coverage effective the last day of the month before the month of admission to long-term care, reason "024". Reinstate the coverage with the begin date as the first day of the month of admission to long-term care.

M0320.208 QUALIFIED INDIVIDUALS (QI)

A. Policy

P.L. 105-33 (Balanced Budget Act of 1997) mandated Medicaid coverage of Qualified Individuals who would be Qualified Medicare Beneficiaries (QMBs) except that their income exceeds the QMB income limit. When implemented on January 1, 1998, the QI covered group consisted of two components, Group 1 and Group 2. Group 1 individuals receive Medicaid coverage for the payment of their Medicare Part B premium. Group 2 individuals receive Medicaid coverage for the portion of the Medicare Part B premium that is attributable to the cost of transferring coverage of home health services to Medicare Part B from Part A. The federal authority for Group 2 expired and Medicaid coverage for this component ended December 31, 2002. Effective January 1, 2003, the QI covered group consists only of the component formerly referred to as "Group 1." *QI funds are maintained in the MMIS for the current and previous year only.*

Like QMBs and SLMBs, eligible QIs are also placed on a medically needy spenddown if resources are within the medically needy limit.

1. Not An Entitlement

Medicaid coverage for this covered group is not an individual entitlement, which means that when the Department of Medical Assistance Services (DMAS) runs out of money for this covered group, no additional eligible individuals in this covered group will receive Medicaid benefits. DMAS will notify the DSS Central Office when the money for this covered group will run out.

Local departments of social services must continue to take and process applications for this covered group even after the funds run out. The MMIS will generate and send a notice to the recipient if the recipient will not receive the benefit because the funds have run out.

Applications for QI coverage for an upcoming year may not be taken until January 1 of that year.

2. Qualified Individual (QI)

A Qualified Individual (QI)

- is entitled to Medicare Part A hospital insurance benefits, but not entitled to Medicare Part A solely because he/she is a QDWI (enrolled in Part A under section 1818A of the Act);
- has resources that are within the resource limits for the Medicare Savings Programs (MSPs). See chapter *section M1110.003* for the current resource limits; and
- has income that is equal to or exceeds the SLMB limit (120% of the federal poverty limit) but is less than the QI limit (135%of the poverty limit).

B. Nonfinancial Eligibility

QIs must meet all the nonfinancial eligibility requirements in chapter M02.

1. Entitled to Medicare Part A

The QI must be entitled to or must be enrolled in Medicare Part A. The individual does not have to be aged, blind or disabled.

Enrollment in Part A of Medicare is verified by the individual's Medicare card, or by communication (such as SVES) with the Social Security Administration (SSA).

2. Individual Not Currently Enrolled In Medicare Part A

Individuals who are not currently enrolled in Medicare Part A must apply for and enroll in Medicare Part A at the local Social Security Administration (SSA) office, and must present verification of Medicare Part A enrollment to the local department of social services (DSS) in order to be eligible for Medicaid as QI.

If an individual appears to be eligible for Medicare but is not enrolled in Medicare, refer him/her to the SSA district office to apply for Medicare enrollment.

If an individual must pay a monthly premium for Medicare Part A, and cannot afford the premium, the SSA office will give the individual a bill for the premium when the individual is enrolled. The individual must present this bill and the Medicare Part A enrollment verification to the local DSS worker in order to be eligible for Medicaid as a QI.

NOTE: A disabled working individual who is enrolled or is eligible to enroll in Medicare Part A under Section 1818A of the Social Security Act **cannot** be enrolled as QI; he/she may be eligible as a Qualified Disabled and Working Individual (QDWI). See M0320.209 below for information on the QDWI covered group.

3. Verification Not Provided

If the applicant does not provide information documenting enrollment in Medicare Part A within the application processing time standard, he/she is not eligible for Medicaid as QI, but may be eligible in another covered group.

C. Financial Eligibility

1. Assistance Unit

The ABD assistance unit policy in chapter M05 applies to Qualified Individuals.

If the QI is living with his/her spouse who is aged, blind, or disabled, but does not have Medicare Part A, and both apply for Medicaid, two different financial calculations must be completed for the unit because of the different income limits used in the eligibility determinations. One is the medically indigent QI determination; the other is for the ABD spouse's CN, CNNMP or MN covered group.

2. Resources

The asset transfer rules in subchapter M1450 must be met by the QI.

The resource requirements for QMBs in chapter S11 and Appendix 2 to Chapter S11 must be met by the QI.

The resource limits for QI are the resource limits for the Medicare Savings Programs (MSPs). See *section M1110.003* for the current resource limits.

3. Income

The income requirements in chapter S08 must be met by the QI. The income limits for QIs are in M0810.002. A QI's countable income must exceed the SLMB limit and must be less than the QI limit.

By law, for QIs who have Title II benefits, the new income limits are effective the first day of the **second** month following the month in which the federal poverty limit is updated. For QIs who do NOT have Title II benefits, the new income limits are effective the date the updated federal poverty limit is published. Local DSS are notified each year of the new poverty limits via the broadcast system. Check that system to ascertain when the Title II COLA must be counted in determining QI income eligibility.

4. Income Within QI Limit

When the individual's countable income is equal to or more than 120% of the FPL and is less than 135% of FPL (the QI limit), the individual is eligible for Medicaid as a QI. Go to subsection D below.

5. Income Equals or Exceeds QI Limit

Spenddown does not apply to the medically indigent income limits. If the individual's income is equal to or exceeds the QI limit (135% of FPL), **he/she is not eligible as QI** and cannot spenddown to the QI limit.

D. QI Entitlement

Coverage under this group cannot begin earlier than January 1 of the calendar year.

QIs are eligible for retroactive coverage as a QI. Retroactive eligibility cannot begin earlier than January 1 of the current calendar year.

If all eligibility factors are met in the application month, eligibility for Medicaid as a QI begins the first day of the application month, **and ends December 31 of the calendar year**, if funds are still available for this covered group.

The Notice of Action on Medicaid must state the recipient's **begin and end dates** of Medicaid coverage.

E. Enrollment

1. Aid Category

QI = 056

2. Begin and End Dates

The begin date of coverage cannot be any earlier than January 1 of the calendar year. An edit is in place in the MMIS to prevent enrollment prior to January 1 of the current year. **Do not enter an end date of coverage.**

3. MMIS

The MMIS will:

- automatically cancel the QI recipient's coverage effective December 31 of each calendar year, and
- send a notice to the recipient to reapply for Medicaid coverage for the next calendar year.

F. QI Applications & Renewals

1. New Applicants

Applications for individuals who are not currently enrolled in Medicaid can be taken at any time. *If the application is processed in November or December, the coverage may be renewed for the following year without obtaining a separate renewal form. See M1520.200 C.11 for instructions on completing renewals for QIs.*

2. QI Enrollees

Coverage of individuals enrolled in the Qualified Individuals (QI) covered group (AC 056) is automatically cancelled effective December 31 of the current year. However, coverage for QIs can be renewed annually provided that there is no break in Medicaid eligibility. See M1520.200 C.11 for instructions on completing renewals for QIs.

G. Enrollee's Covered Group Changes To QI

1. Before November Cut-off

An enrolled recipient's AC cannot be changed to "056" using a "change" transaction in the MMIS. If, **before November cut-off**, a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because of an increase in income or resources, but is eligible as a QI, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part B premiums as a QI.

Cancel the recipient's full coverage effective the last day of the month, using cancel reason "007". Reinstate the recipient's coverage with the begin date as the first day of the month following the cancellation effective date. Specify the appropriate QI AC.

2. After November Cut-off

If, **after November cut-off**, a Medicaid recipient becomes ineligible for full-coverage Medicaid or QMB-only coverage because of an increase in income or resources, but is eligible as a QI, the agency must send an advance notice of proposed action to the recipient to cancel the recipient's Medicaid coverage effective December 31. The notice must specify that he must reapply for Medicaid if he/she wants Medicaid to pay his/her Medicare Part B premium. Cancel the recipient's full coverage effective December 31, using cancel reason "007".

H. Covered Service

The eligible QI will only receive Medicaid payment of his/her Medicare Part B premium through the Medicaid Buy-In Agreement with SSA. **The QI will not receive a Medicaid card.**

M0320.209 QDWI (QUALIFIED DISABLED & WORKING INDIVIDUALS)

A. Policy

42 CFR 435.121 - Coverage of Qualified Disabled & Working Individuals is mandated by the federal Medicaid law. Medicaid will only pay the Medicare Part A premium for individuals eligible as QDWI.

B. Nonfinancial Eligibility

The QDWI must meet all the nonfinancial eligibility requirements in chapter M02.

1. Definition Requirements

The individual must:

- be less than 65 years of age.
- be employed.
- have been entitled to Social Security disability benefits and Medicare Part A but lost entitlement solely because earnings exceeded the substantial gainful activity (SGA) amount.
- continue to have the disabling physical or mental impairment or be blind as defined by SSI and Medicaid but because he/she is working and earning income over the SGA limit does not meet the disability definition.
- be eligible to enroll or be enrolled in Medicare Part A (hospital insurance) under Section 1818A of the Social Security Act.
- not be eligible for Medicaid in any other classification or covered group.

The above definition requirements must be verified by the Social Security Administration (SSA). The individual must be enrolled in Medicare Part A under Section 1818-A of the Social Security Act. Enrollment in Part A of Medicare is verified by the individual's Medicare card, or by communication (such as SVES) with SSA.

NOTE: Blind individuals who lose SSA and Medicare because of earnings over SGA still meet the blind category for Medicaid purposes. Therefore, a blind individual whose countable

income is within CNNMP, medically needy, or QMB limits cannot be eligible as a qualified disabled and working individual.

2. Verification Not Provided

If the applicant does not provide information documenting enrollment in Medicare Part A within the application processing time standard, he/she is not eligible for Medicaid as QDWI, but may be eligible in another covered group.

C. Financial Eligibility

The assistance unit policy in chapter M05 applies to QDWIs.

1. Assistance Unit

If the QDWI individual is living with his/her spouse who is aged, blind, or disabled, but does not have Medicare Part A, and both apply for Medicaid, two different financial calculations must be completed for the unit because of the different income limits used in the eligibility determinations. One is the medically indigent QDWI determination; the other is for the ABD spouse's covered group.

2. Resources

The asset transfer rules in subchapter M1450 must be met by the medically indigent Medicare beneficiary.

The resource requirements in chapter S11 and Appendix 1 to Chapter S11 must be met by the QDWI Medicare beneficiary. Some of the real and personal property requirements are different for QDWIs. The different requirements are identified in Chapter S11, Appendix 1.

The resource limit for an individual is $4,000 (twice the SSI resource limit for an individual); the resource limit for a couple is $6,000 (twice the SSI resource limit for a couple).

3. Income

QDWIs must meet the income requirements in chapter S08. The income limits are in M0810.002. QDWIs do not receive Title II benefits.

4. Income Exceeds QDWI Limit

Spenddown does not apply to the medically indigent income limits. If the individual's income exceeds the QDWI limit, he/she is not eligible as QDWI and cannot spenddown to the QDWI limit. At application and redetermination, if the individual's resources are within the medically needy limit and the individual meets a medically needy covered group, place the individual on two 6-month spenddowns based on the MN income limit.

D. Entitlement

Entitlement to Medicaid as a QDWI begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month, including enrollment in Medicare Part A under Section 1818A of the Social Security Act. Retroactive entitlement, up to three months prior to application, is applicable if all QDWI eligibility criteria were met during the period.

If the individual is not enrolled in Medicare Part A under Section 1818A as of the month he/she meets the Medicaid eligibility requirements, the individual's entitlement to Medicaid cannot begin until the first day of the month in which his Medicare Part A enrollment under Section 1818A is effective.

The eligible QDWI will only receive Medicaid payment of his/her Medicare Part A premium through the Medicaid Buy-In Agreement with SSA. **The QDWI will not receive a Medicaid card.**

E. Enrollment

1. *Aid Category*

The *AC* for all QDWIs is "*0*55."

2. Recipient's *AC* Changes To QDWI

An enrolled recipient's *AC* cannot be changed to *AC* "*0*55" using a "change" transaction in the MMIS. If a Medicaid recipient becomes ineligible for full-coverage Medicaid, but is eligible as a QDWI, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare Part A premiums as a QDWI.

Cancel the recipient's full coverage effective the last day of the month, using cancel reason "007." Reinstate the recipient's coverage as QDWI with the begin date as the first day of the month following the cancellation effective date. *AC* is "*0*55."

3. QDWI's *AC* Changes To Full Coverage *AC*

When an enrolled QDWI becomes eligible in another classification and covered group which has full Medicaid coverage (except when he/she meets a spenddown); e.g., he/she is no longer able to work and starts to receive SSA and SSI disability benefits:

- cancel the QDWI coverage effective the last day of the month immediately prior to the month in which he/she became eligible in the full coverage classification and covered group, using cancel reason "*0*24;"

- reinstate the recipient's coverage with the begin date as the first day of the month in which he/she became eligible in the full coverage covered group, with the appropriate full coverage *AC*.

4. Spenddown Status

Eligible QDWIs who meet an MN covered group and who have resources that are within the lower MN resource limits are also placed on two 6-month medically needy spenddowns.

5. QDWI Meets Spenddown

When a QDWI meets a spenddown, cancel his *AC* "*0*55" coverage effective the date before spenddown was met using cancel reason "024." Reinstate coverage as medically needy beginning the day the spenddown was met and ending the last day of the spenddown budget period.

The *AC* is NOT dual-eligible:

- *0*18 for an aged MN individual NOT eligible as QMB;
- *0*38 for a blind MN individual NOT eligible as QMB;
- *0*58 for a disabled MN individual NOT eligible as QMB.

6. Spenddown Period Ends

After the spenddown period ends, reinstate the QDWI-only coverage using the *AC* "*0*55."

The begin date of the reinstated *AC* "*055*" coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial QDWI eligibility.

7. QDWI Enters Long-term Care

The enrollment of a QDWI who is admitted to long-term care and who becomes eligible for Medicaid in another classification and covered group is handled like a QDWI who meets a spenddown. Cancel the QDWI-only coverage effective the last day of the month before the admission to long-term care, reason "*0*24." Reinstate the coverage with the begin date as the first day of the month of admission to long-term care.

M0320.210 ABD WITH INCOME ≤ 80% FEDERAL POVERTY LIMIT (FPL)

A. Policy

Section 1902(m) of the Social Security Act allows a State to provide full Medicaid benefits to the categorically needy covered group of aged, blind and disabled individuals whose income is less than or equal to a percentage of the federal poverty limit (FPL).

The 2000 Appropriations Act mandated that effective July 1, 2001, the State Plan for Medical Assistance be amended to add the covered group of aged, blind and disabled individuals with income less than or equal to 80% FPL.

Eligibility in the ABD 80% FPL covered group is limited to those ABD individuals who do not meet the requirements for any other full benefit Medicaid covered group. ABD individuals who meet the requirements for the 300% SSI covered groups (see M0320.203 and 204) or are medically needy without a spenddown (see M0330) are to be enrolled in these groups and not in the ABD 80% FPL covered group. An eligible individual's resources must be within the SSI resource limits.

B. Nonfinancial Eligibility

An individual in this covered group must meet the nonfinancial requirements in chapter M02:

- aged, blind, or disabled definition in subchapter M0310;
- citizenship/alien status;
- Virginia residency;
- Social Security number provision/application requirements;
- assignment of rights to medical benefits requirements;
- application for other benefits; and
- institutional status.

C. Financial Eligibility

1. Asset Transfer

Asset transfer policy *only applies to individuals in long-term care*. *See* subchapter M1450.

2. Assistance Unit

The assistance unit policy and procedures in chapter M05 apply to ABD individuals with income less than or equal to 80% FPL. If not institutionalized, deem or count any resources and income from the individual's spouse with whom he lives. If institutionalized with a community spouse, go to subchapter M1480.

3. Resources

The resource limit is $2,000 for an individual and $3,000 for a couple.

The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply to this covered group.

All of the individual's resources must be verified and evaluated. All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements.

4. Income

The income limits are ≤ 80% of the FPL and are in section M0810.002. The income requirements in chapter S08 must be met.

5. Income Exceeds 80% FPL

Spenddown does not apply to this covered group. If the individual's income exceeds the 80% FPL limit, he is not eligible in this covered group. Determine the individual's eligibility in all other Medicaid covered groups.

D. Entitlement

1. Begin Date

If all eligibility factors are met in the application month, entitlement to full Medicaid coverage in this covered group begins the first day of the application month.

2. Retroactive Entitlement

ABD individuals in this covered group are entitled to retroactive coverage if they meet all the requirements in the retroactive period.

E. Enrollment

The ABD 80% group AC is:

- 029 for an aged enrollee;
- 039 for a blind enrollee; or
- 049 for a disabled enrollee.

M0320.211 MEDICAID WORKS

A. Policy

The Appropriations Act of 2006 authorized an amendment to the Virginia State Plan for Medical Assistance that allows disabled (including blind) individuals who are:

- at least age 16 and are under age 65, **and**
- who have countable income less than or equal to 80% of the FPL, (including SSI recipients) **and**
- who have countable resources less than or equal to $2,000 for an individual and 3,000 for a couple; **and**

- who are working or have a documented date for employment to begin in the future

to retain Medicaid coverage by cost-sharing through the payment of a premium as long as they remain employed and their earned income is less than or equal to 200% of the FPL. This type of cost-sharing arrangement is known as a **Medicaid** buy-in (MBI) program. MEDICAID WORKS is Virginia's MBI program.

B. *Relationship Between MEDICAID WORKS and 1619(b) Status*

The 1619(b) work incentive status available to SSI recipients allows the individual to earn a significantly higher income than the MEDICAID WORKS income limit. However, 1619(b) uses the same resource limit as SSI, while the resource limit for MEDICAID WORKS is significantly higher. An individual with SSI who meets the criteria for Medicaid coverage as a Qualified Severely Impaired Individual (1619(b)) may choose to participate in MEDICAID WORKS because of the higher resource limit. An individual with SSI must not be discouraged from enrolling in MEDICAID WORKS.

C. Nonfinancial Eligibility

An individual in this covered group must meet the nonfinancial requirements in chapter M02:

- blind or disabled definition in subchapter M0310;
- citizenship/alien status;
- Virginia residency;
- Social Security number provision/application requirements;
- assignment of rights to medical benefits requirements;
- application for other benefits; and
- institutional status.

The individual must also meet the following additional nonfinancial criteria:

- The individual must be competitively employed in an integrated setting. Work must occur in a work setting in the community or in a personal business alongside people who do not have disabilities. Work performed in a sheltered workshop or similar setting is **not** considered competitive employment in an integrated setting. Contact a Regional Medical Assistance Program Consultant if there is a question about whether the employment meets the criteria for MEDICAID WORKS.

- The individual must receive pay at the minimum wage or at the prevailing wage or "going rate" in the community, and the individual must provide documentation that payroll taxes are withheld. Self-employment must be documented according to the policy contained in S0820.210.

- The individual must establish a Work Incentive (WIN) Account at a bank or other financial institution, such as a checking or savings accounts. The individual must provide documentation for the case

- record designating the account(s) as a WIN Account. The account must either be a new account or an existing account with no other income but the wages earned while in MEDICAID WORKS. It cannot contain the individual's Social Security benefits.

- All individuals requesting enrollment in MEDICAID WORKS must also sign a MEDICAID WORKS Agreement, available on *SPARK* at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi. The agreement outlines the individual's responsibilities as an enrollee in the program.

- The individual must participate in cost sharing through the payment of a monthly premium to the Department of Medical Assistance Services. Note: Monthly premiums are not being charged at this time.

D. Financial Eligibility

1. Assistance Unit

a. Initial eligibility determination

In order to qualify for MEDICAID WORKS, the individual must meet the assistance unit policy and procedures in chapter M05 that apply to ABD individuals with income less than or equal to 80% FPL. Resources and income from the individual's spouse with whom he lives or, if under age 21, the individual's parents with whom he lives, must be deemed available.

b. Ongoing eligibility

Once the individual is enrolled in MEDICAID WORKS, **the individual is treated as an assistance unit of one.** Spousal and parental resources and income are disregarded for ongoing enrollee eligibility.

2. Resources

a. Initial eligibility determination

For the initial eligibility determination, the resource limit is $2,000 for an individual and $3,000 for a couple. Resources must be evaluated for all individuals, including SSI recipients, who wish to qualify for MEDICAID WORKS. The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply for the initial eligibility determination. The individual's countable, nonexempt resources must be verified. All countable resources, must be added together to determine if the individual's countable resources are within the limit.

b. Ongoing eligibility

Once the individual is enrolled in MEDICAID WORKS, the following resource policies apply:

1) For **earnings** accumulated **after** enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The 1619(b) threshold amount for *2009* is *$30,478*.

2) Resources accumulated while in MEDICAID WORKS and held in Internal Revenue Service (IRS)-approved retirement accounts, medical savings accounts, medical reimbursement accounts, education accounts, independence accounts, and other similar State-approved accounts are excluded. Examples of these accounts include Archer Medical Savings Accounts, 401(k) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, Thrift Savings Plans, and 503(b) plans. The account must be designated as a WIN Account in order to be excluded. **Resources accumulated while in MEDICAID WORKS and held in IRS-approved accounts that have been designated as WIN Accounts are also excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees**. The account must be exclusively used to hold resources accumulated while in MEDICAID WORKS (including interest) in order for the exclusion to continue.

3) For **all** other resources, the resource requirements in chapter S11 and Appendix 2 to chapter S11 apply. All of the individual's countable, nonexempt resources must be verified and evaluated.

All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements. The resource limit for resources not excluded in i or ii above is $2,000 for an individual.

3. Income

a. Initial eligibility determination

For the initial eligibility determination, the income limit is ≤ 80% of the FPL (see M0810.002). The income requirements in chapter S08 must be met. Individuals who receive SSI are considered to meet the income requirements and no evaluation of income is necessary for the initial eligibility determination (see M0320.201).

b. Ongoing eligibility

Once the individual is enrolled in MEDICAID WORKS, the following income policies apply:

1) The income limit for earned income is 200% of the FPL for one person (see M0810.002) as long as the funds are deposited in a WIN Account. The policy for determining countable earned income is contained in subchapter S0820.

If the individual is self-employed, net earnings from self-employment (NESE) must be demonstrated through documentation of Internal Revenue Service (IRS) filings, quarterly estimated taxes, business records, and/or business plans. The individual's signed allegation of self-employment is acceptable if no other evidence of NESE can be obtained. Follow the policy in S0820.220 for determining NESE.

2) The income limit for unearned income remains less than or equal to 80% of the FPL. The policy for determining countable unearned income is contained in subchapter S0830.

4. Income Exceeds 80% FPL at Eligibility Determination

Spenddown does not apply to the Medicaid Works covered group. Therefore, admission into MEDICAID WORKS is not available to individuals whose income exceeds 80% of the FPL. Evaluate the individual's eligibility in all other Medicaid covered groups.

E. Cost Sharing and Premium Payment

Cost sharing is required of all individuals enrolled in MEDICAID WORKS. Enrollees are responsible for copayments for services received (see M1850.100 B).

Premiums are assessed on a sliding scale based on the individual's income and are subject to change. Based on the sliding scale, some individuals may not owe a premium.

Note: premiums are not being charged at this time.

F. Good Cause

An individual may remain eligible for MEDICAD WORKS if one of the following good cause exceptions is met:

- If the individual is unable to maintain employment due to illness or unavoidable job loss, the individual may remain in MEDICAID WORKS for up to six months as long as any **required** premium payments continue to be made. The six-month period begins the first day of the month following the month in which the job loss occurred. The individual *should be asked to* provide documentation that he is unable to work from a medical or mental health practitioner or employer. *However, do not cancel the individual's eligibility under MEDICAID WORKS due to the lack of documentation if the individual indicates that he is still seeking employment.*

- DMAS may establish other good cause reasons. Requests for good cause other than the temporary loss of employment due to a documented illness or unavoidable job loss must be submitted to DMAS on the enrollee's behalf by the local department of social services.

G. Safety Net

Enrollees who are unable to sustain employment for longer than six months must be evaluated for continued coverage in all other Medicaid covered groups for which the individual meets the definition. Resources held in the WIN Account that are accumulated from the enrollee's earnings while in MEDICAID WORKS will be disregarded up to the 1619(b) threshold amount for this eligibility determination.

If found eligible and enrolled in another Medicaid covered group, the individual shall have a "safety-net" period of up to one year from MEDICAID WORKS termination and enrollment in another group to dispose of these excess resources before they are counted toward ongoing eligibility.

If the individual resumes working within the safety-net period, he may be re-enrolled in MEDICAID WORKS provided that all eligibility requirements are met, except that the resources in the WIN Account are disregarded up to the 1619(b) threshold amount. If the individual wishes to be re-enrolled in MEDICAID WORKS after the one-year safety net period, any resources retained in the WIN Account are countable.

Resources accumulated while in MEDICAID WORKS and retained in an IRS-approved account described in M0320.211 C.2.b.ii that has been designated as a WIN Account are excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees.

H. Benefit Package

Individuals enrolled in MEDICAID WORKS are entitled to the standard benefits available to full-benefit Medicaid enrollees (see Chapter M18).

***I.* Entitlement and Enrollment**

Entitlement for MEDICAID WORKS is dependent upon meeting the requirements listed above.

There is no retroactive coverage under MEDICAID WORKS. The application date in the MMIS is the date the individual signed the MEDICAID WORKS Agreement. Coverage shall begin on the first day of the month following the month in which all requirements are met. If the applicant has a future start date for employment, the effective date of eligibility shall be no earlier than the first day of employment. However, unless employment begins on the first day of the month, MEDICAID WORKS enrollment will begin on the first of the following month.

Complete the Medicaid Works fax cover sheet and fax it together with the following information to DMAS at 804-786-0973:

- a signed Medicaid Works Agreement,
- the Work Incentive Account (WIN) information (a bank account statement or verification from the bank that the account was opened), and
- one of the following verifications of employment:
  - a pay stub showing current employment or
  - an employment letter with start date or
  - self-employment document(s).

The AC for MEDICAID WORKS is 059. Use the following procedures to enroll the individual in MMIS:

New Application – Applicant Eligible as 80% FPL

1. For the month of application and any retroactive months in which the person is eligible in the 80% FPL covered group, enroll the individual in a closed period of coverage using aid category (AC) 039 (blind) or 049 (disabled), beginning the first day of the month in which eligibility exists. The cancel date is the last day of the month in which the MEDICAID WORKS Agreement was signed. Use Cancel Code 042.

2. Reinstate the individual's coverage in MEDICAID WORKS using AC 059 beginning the first day of the following month (the first day of the month following the month in which the MEDICAID WORKS Agreement is signed). Use the same application date (the actual date of the initial application) that was used for the month of application.

Current Enrollee

1. Cancel current coverage using Cancel Code 042.

2. Reinstate in AC 059 beginning the first day of the following month. **Use the date the MEDICAID WORKS Agreement was signed for the application date**.

Send a Notice of Action to the applicant/recipient advising him of his eligibility and acceptance into MEDICAID WORKS. Do not send the Advance Notice of Proposed Action when a recipient moves to MEDICAID WORKS, because his Medicaid coverage has not been reduced or terminated.

Eligibility for MEDICAID WORKS continues as long as the enrollee continues to:

- be employed,
- meet the definition of disability or blindness,
- meet the age limitation, and
- does not exceed the income and resource limits for MEDICAID WORKS.

The MEDICAID WORKS enrollee continues to meet the disability criteria as long as SSA has not completed a Continuing Disability Review and has not determined that the individual no longer has a disabling condition. The fact that the MEDICAID WORKS enrollee is earning over the SSA substantial gainful activity amount has no bearing on whether he meets the disability criteria. If the enrollee's disability status is unclear, contact a Regional Medical Assistance Program Consultant for assistance.

The individual's continuing eligibility must be determined at least every 12 months.

If the individual is no longer eligible for MEDICAID WORKS, the eligibility worker must determine whether the individual remains eligible in any other covered group. **The policy in M0320.211 F. above must be reviewed to determine whether the safety net rules apply**. If the individual is not eligible for Medicaid in any other covered group, coverage shall be cancelled effective the first of the month following the expiration of the 10-day advance notice

M0320.300 FAMILIES & CHILDREN CATEGORICALLY NEEDY

A. Introduction

An F&C individual must be a child under age 19 or must meet the adoption assistance, dependent child, foster care, parent or caretaker-relative of a dependent child living in the home, pregnant woman, or BCCPTA definition, *or must have applied for Plan First.*

The F&C CN covered groups are divided into the medically indigent (MI), CN and CNNMP classifications. First determine if the F&C individual meets an MI covered group. If the individual does not meet an MI covered group, then determine if the individual meets the requirements of an F&C CN or CNNMP covered group.

B. Procedure

The policy and procedures for determining whether an individual meets an F&C MI, CN or CNNMP covered group are contained in the following sections:

- M0320.301 MI Pregnant Women & Newborn Children;
- M0320.302 Plan First--Family Planning Services (FPS);
- M0320.303 MI Child Under Age 19 (FAMIS Plus);
- M0320.304 Low Income Families With Children (LIFC);
- M0320.305 IV-E Foster Care & IV-E Adoption Assistance;
- M0320.307 Individuals Under Age 21;
- M0320.308 Special Medical Needs Adoption Assistance;
- M0320.309 F&C In Medical Institution, Income $\leq$ 300% SSI;
- M0320.310 F&C Receiving Waiver Services (CBC);
- M0320.311 F&C Hospice;
- M0320.312 Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA).

M0320.301 MI PREGNANT WOMEN & NEWBORN CHILDREN

A. Policy

The federal Medicaid law requires the Medicaid State Plan to cover pregnant women and newborn children whose family income is within 133% of the federal poverty level (FPL). The law allows the State Plan to cover these pregnant women and newborns regardless of their resources; Virginia has chosen to waive the resource eligibility requirements for this covered group.

B. Nonfinancial Eligibility

1. Pregnant Woman

42 CFR 435.170 - The woman must meet the pregnant woman definition in M0310.124.

The MI pregnant woman must meet all the nonfinancial eligibility requirements in chapter M02.

a. Emergency services alien pregnant woman

If a pregnant woman is not eligible for full-benefit Medicaid because the woman does not meet the Medicaid alien status requirements for full-benefit Medicaid coverage, the woman may be enrolled in FAMIS MOMS if she (1) meets the FAMIS MOMS alien status requirements and all other FAMIS MOMS non-financial eligibility requirements, and (2) has income less than or equal to 200% FPL.

b. Does NOT apply to unqualified aliens

This policy does NOT apply to Unqualified aliens, including illegal and non-immigrant aliens, because they do not meet the alien status requirements for FAMIS MOMS. FAMIS MOMS does not allow emergency services only eligibility for unqualified aliens.

2. Newborn Child

42 CFR 435.117 - A child born to a woman who was eligible for Medicaid at the time the child was born (including a newborn child born to an alien eligible for Medicaid payment of emergency services only) is eligible as a newborn child under age 1 year.

a. Eligible To Age 1

A child no longer meets this covered group effective the end of the month in which the child reaches age 1, provided he was under age 1 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 1.

Any child born a Medicaid-eligible woman will continue to be eligible up to age 1. If the child's mother was covered by Medicaid as a categorically needy individual in a state other than Virginia at the time of the child's birth, verification of the mother's Medicaid coverage must be provided by the parent or authorized representative.

b. No Other Nonfinancial Eligibility Requirements

No other nonfinancial or financial eligibility requirements need to be met by the newborn child.

C. Financial Eligibility

1. Assistance Unit

Use the assistance unit policy in chapter M05 to determine the pregnant woman's financial eligibility. If a pregnant woman also applies for other family unit members living with her who do not meet the pregnant woman, newborn child or child under age 19 years covered group requirements, separate financial eligibility calculations must be completed for the unit. One is the MI pregnant woman determination; the other is based on the other members' covered group(s).

2. Asset Transfer

The asset transfer rules in subchapter M1450 apply to institutionalized MI individuals.

3. Resources

There is no resource limit.

4. Income

The income requirements in chapter M07 must be met by a pregnant woman. The income limits are 133% of the federal poverty level and are found in subchapter M710, Appendix 6.

5. Income Changes After Eligibility Established

a. Pregnant Woman

Once eligibility is established as a pregnant woman, changes in income do not affect her eligibility as long as she meets the pregnant definition and the other nonfinancial Medicaid eligibility requirements. This also includes situations where eligibility is established in the retroactive period.

For example, a married pregnant woman applies for Medicaid on October 10. She received a medical service in the retroactive period. Her expected delivery date is January 15. She and her husband have been unemployed since June 23. Her husband began earning $3,000 a month on October 9; she remains unemployed. Since they had no income during the retroactive period, she is found eligible for retroactive coverage effective July 1.

Because her available income (from her husband) changed after she established eligibility on July 1, the change in income does not affect her eligibility and she remains eligible for Medicaid in October and subsequent months until she no longer meets the pregnant woman definition or other nonfinancial requirements.

b. Newborn

Income changes do NOT affect the certain newborn's eligibility for the first year of the child's enrollment as a certain newborn.

The mother's failure to complete a renewal of her own eligibility and/or the eligibility of other children in the household does NOT affect the eligibility of the certain newborn.

6. Income Exceeds MI Limit

A pregnant woman whose income exceeds the MI income limit may be eligible for Virginia's Title XXI program, FAMIS MOMS. The income limit for FAMIS MOMS is *200%* FPL. See chapter M22 to determine FAMIS MOMS eligibility.

Spenddown does not apply to the medically indigent. If the pregnant woman's income exceeds the medically indigent limit, she is not eligible as medically indigent regardless of medical expenses. Eligibility as medically needy (MN) must then be determined in order for spenddown to apply, and all medically needy eligibility requirements must be met, including resource limits.

D. Entitlement

Eligible MI pregnant women are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group if pregnancy is verified as existing in the retroactive month(s).

The newborn's Medicaid coverage begins the date of the child's birth. A Medicaid application for the newborn child is not required until the month in which the child turns age 1.

Eligible medically indigent pregnant women and newborns are entitled to all Medicaid covered services as described in chapter M18.

After her eligibility is established as a medically indigent pregnant woman, the woman's Medicaid entitlement continues through her pregnancy and the 60-day period following the end of her pregnancy. Medicaid coverage ends the last day of the month in which the 60th day occurs.

E. Enrollment

The aid category (AC) for MI pregnant women is "091." The AC for newborns born to women who were enrolled in Medicaid as categorically needy or MI is "093."

M0320.302 PLAN FIRST - FAMILY PLANNING SERVICES (FPS)

A. Policy

Effective October 1, 2011, Plan First, Virginia's family planning services health program *covers individuals whose income is less than or equal to 200% FPL for their family size and who are not eligible for another full or limited-benefit Medicaid covered group, FAMIS or FAMIS MOMS. This optional covered group is available to individuals regardless of their age, gender, disability status, insured status or if they previously had a sterilization procedure.* ***While there are no age limits for enrollment in this group, an unemancipated child under age 18 should not be enrolled for family planning coverage without first obtaining the child's parent's or guardian's consent.***

Plan First covers only family planning services, including transportation to receive family planning services.

1. Application *Forms*

Eligibility for Plan First can be determined using any valid application form. An individual does not need to request Plan First for his eligibility to be determined. The Plan First and Application for Benefits forms allow individuals to specifically request a Plan First eligibility determination on the forms. If an individual indicates on the application or to the agency that he does not want his eligibility for Plan First determined, do not do so.

2. Determine Eligibility *in Other Medicaid Covered Groups, FAMIS or FAMIS MOMS* First

If the information contained in the application indicates **potential** eligibility in a full-benefit Medicaid covered group (e.g., the applicant has a child under 18 in the home *or alleges disability*), *in another limited benefit covered group (e.g., the individual has Medicare), or in FAMIS or FAMIS MOMS,* the worker must determine whether eligibility exists *in another covered group* before the individual(s) can be determined eligible for Plan First.

If additional information is needed to complete the eligibility determination in *another Medicaid* covered group**,** the applicant must be given the opportunity to provide the additional information needed. If the additional information is not provided by the deadline, determine the applicant's eligibility for Plan First only.

If the applicant is not eligible for Medicaid *in another covered group, FAMIS or FAMIS MOMS,* but is eligible for Plan First, enrollment in Plan First must be made directly in the MMIS.

B. Nonfinancial Requirements

Individuals in this covered group must meet the following Medicaid nonfinancial requirements in chapter M02.

DCSE services are available to all Medicaid recipients, but cooperation with DCSE is not a condition of eligibility for this covered group.

C. Financial Eligibility

1. Assistance Unit Use the assistance unit policy in chapter M05 to determine financial eligibility.

2. Resources There is no resource limit.

3. Income The income requirements in chapter M07 must be met for this covered group. The income limits are *200*% FPL and are found in subchapter M0710, Appendix 6.

4. Spenddown Spenddown does not apply to this covered group.

D. Entitlement and Enrollment

1. Begin Date Eligibility in the Plan First covered group begins the first day of the month in which the application is filed, if all eligibility factors are met in the month.

2. Retroactive Coverage *Individuals in this covered group are entitled to retroactive coverage if they meet all the requirements in the retroactive period. If eligible for retroactive coverage, however, coverage can begin no earlier than October 1, 2011.*

3. Enrollment The AC for Plan First enrollees is "080."

M0320.303 MI CHILD UNDER AGE 19 (FAMIS PLUS)

A. Policy Section 1902(a)(10)(A)(i)(VI) and 1902 (l)(1)(C) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children from birth to age 6 years whose countable income is less than or equal to 133% of the federal poverty limit (FPL). Section 1902(a)(10)(A)(i)(VII) and 1902 (l)(1)(D) of the Act - The federal Medicaid law requires the Medicaid State Plan to cover children who have attained age 6 years but are under age 19 years whose countable income is less than or equal to 100% of the FPL and allows states to cover children at higher income limits.

Virginia has elected to cover children from age 6 to age 19 with countable income less than or equal to 133% of the FPL. The federal law allows the State Plan to cover these children regardless of their families' resources; Virginia has chosen to waive the resource eligibility requirements for these children. Coverage under the MI Child Under Age 19 covered group is also referred to as FAMIS Plus.

B. Nonfinancial Eligibility The child must meet the nonfinancial eligibility requirements in chapter M02.

The child must be under age 19 years. The child's date of birth must be provided, but birth verification is not required. Any child under age 19 years can be eligible in this covered group regardless of the child's living arrangements or the child's mother's Medicaid eligibility.

A child no longer meets this covered group effective the end of the month in which the child reaches age 19 years, provided he was under age 19 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 19.

NOTE: a child who does not meet a Medicaid non-financial eligibility criterion AND who has excess income for Medicaid may be evaluated for FAMIS eligibility.

C. Financial Eligibility

1. Assistance Unit Use the assistance unit policy in chapter M05 to determine the child's financial eligibility.

2. Asset Transfer The asset transfer rules in subchapter M1450 apply to institutionalized MI individuals.

3. Resources There is no resource limit.

4. Income The income requirements in chapter M07 must be met by the child. The income limits are 133% of the FPL and are found in subchapter M0710, Appendix 6.

5. Income Changes Any changes in an MI child's income that occur after his eligibility has been established affect eligibility. Recalculate income and compare to the MI 133% FPL income limits.

6. Income Exceeds MI Limit A child under age 19 whose income exceeds the MI income limit may be eligible for Virginia's Title XXI program, Family Access to Medical Insurance Security (FAMIS). The income limit for FAMIS is 200% FPL. See chapter M21 to determine FAMIS eligibility.

Spenddown does not apply to the medically indigent. If the child's income exceeds the medically indigent limit, he/she is not eligible as medically indigent regardless of medical expenses. Eligibility as medically needy (MN) must then be determined in order for spenddown to apply, and all medically needy eligibility requirements must be met, including resource limits.

D. Entitlement Eligible MI children are entitled to full Medicaid coverage beginning the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth. Retroactive coverage is applicable to this covered group; however, the income limit for children age 6 – 19 cannot exceed 100% FPL for any period prior to September 1, 2002.

Eligible MI children are entitled to all Medicaid covered services as described in chapter M18.

E. Enrollment

The ACs for MI child*ren* are:

AC	Meaning:
090	• MI child under age 6; income greater than 100% FPL, but less than or equal to 133% FPL
091	• MI child under age 6; income less than or equal to 100% FPL
092	• MI child age 6-19; insured or uninsured with income less than or equal to 100% FPL; • MI child age 6-19; **insured** with income greater than 100% FPL and less than or equal to 133% FPL
094	• MI child age 6-19; **uninsured** with income greater than 100% FPL and less than or equal to 133% FPL

Do not change the AC when a child's health insurance is paid for by Medicaid through the HIPP program.

4. Income

The income requirements in chapter M07 must be met by the child. The income limits are 133% of the FPL and are found in subchapter M0710, Appendix 6.

5. Income Changes

Any changes in an MI child's income that occur after his eligibility has been established affect eligibility. Recalculate income and compare to the MI 133% FPL income limits.

6. Income Exceeds MI Limit

A child under age 19 whose income exceeds the MI income limit may be eligible for Virginia's Title XXI program, Family Access to Medical Insurance Security (FAMIS). The income limit for FAMIS is 200% FPL. See chapter M21 to determine FAMIS eligibility.

Spenddown does not apply to the medically indigent. If the child's income exceeds the medically indigent limit, he/she is not eligible as medically indigent regardless of medical expenses. Eligibility as medically needy (MN) must then be determined in order for spenddown to apply, and all medically needy eligibility requirements must be met, including resource limits.

D. Entitlement

Eligible MI children are entitled to full Medicaid coverage beginning the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth. Retroactive coverage is applicable to this covered group; however, the income limit for children age 6 – 19 cannot exceed 100% FPL for any period prior to September 1, 2002.

Eligible MI children are entitled to all Medicaid covered services as described in chapter M18.

E. Enrollment

The ACs for the MI child are:

AC	Meaning
090	MI child under age 6; income greater than 100% FPL, but less than or equal to 133% FPL
091	MI child under age 6; income less than or equal to 100% FPL
092	• MI child age 6-19; insured or uninsured with income less than or equal to 100% FPL; • MI child age 6-19; **insured** with income greater than 100% FPL and less than or equal to 133% FPL
*0*94	MI child age 6-19; **uninsured** with income greater than 100% FPL and less than or equal to 133% FPL

Do not change the AC when a child's health insurance is paid for by Medicaid through the HIPP program.

M0320.304 LOW INCOME FAMILIES WITH CHILDREN (LIFC)

A. Policy

Section 1931 of the Act - The federal Medicaid law requires the State Plan to cover dependent children under age 18 and parents or caretaker-relatives of dependent children who meet the financial eligibility requirements of the July 16, 1996 AFDC state plan. In addition, Medicaid covers dependent children and parents or caretaker-relatives of dependent children who participate in the Virginia Initiative for Employment not Welfare (VIEW) component of the Virginia Independence Program (VIP) and meet the requirements of the 1115 waiver. This covered group is called "Low Income Families With Children" (LIFC).

B. Nonfinancial Eligibility

The individual must meet all the nonfinancial eligibility requirements in chapter M02.

The child(ren) must meet the definition of a dependent child in M0310.111. The adult with whom the child lives must be the child's parent or must meet the definition of a caretaker-relative of a dependent child in M0310.107. A child or adult who lives in the household but who is not the dependent child's parent or caretaker-relative may be eligible as LIFC if he/she meets the definition of an EWB in M0310.113.

C. Financial Eligibility

1. Assistance Unit

The assistance unit policy in subchapter M0520 applies to the LIFC covered group. The assistance unit's financial eligibility is determined first. If the family unit has income that cannot be verified or that exceeds the amount for the individual's covered group, the family unit is divided into budget units, if appropriate.

If the LIFC individual is living with his/her spouse or child who is aged, blind, or disabled, two different financial calculations must be completed for the unit if the family unit does not meet the LIFC income limits, because of the different resource and income limits used in the F&C and ABD determinations.

2. EWB

An EWB meets the LIFC covered group only when the dependent child's family has income within the LIFC income limits and the family is eligible for Medicaid as LIFC.

When the LIFC household includes an individual who meets the EWB definition, the EWB's income eligibility is determined in a separate assistance unit. See M0520.103.

3. Resources

There is no resource test for the LIFC covered group.

4. Income

a. Non-VIEW Participants

The income requirements in chapter M07 must be met by the LIFC group. The income limits are in M0710.002.

b. VIEW Participants

The income requirements in chapter M07 must be met by VIEW participants. The method for determining income eligibility is different for VIEW participants and is found in M0710.730 D. The income limits are in M0710.002.

5. Income Exceeds CNNMP Limit

Spenddown does not apply to the CNNMP income limits. If the family/budget unit's (FU/BU's) income exceeds the F&C CNNMP income limit, the unit is not eligible as CNNMP LIFC and cannot spenddown to the CNNMP limit. If resources are within the medically needy limit, the unit may be placed on spenddown if at least one member meets an MN covered group, such as MN children under age 18.

D. Entitlement

Entitlement to Medicaid as an LIFC individual begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

E. Enrollment

The ACs for individuals in the LIFC covered group are:

- 081 for an LIFC individual in a family with one or no parent in the home;
- 083 for LIFC individuals in a two-parent household.

M0320.305 IV-E FOSTER CARE OR IV-E ADOPTION ASSISTANCE RECIPIENTS

A. Policy

42 CFR 435.145---The federal Medicaid law requires the State Plan to cover children who are eligible for foster care or adoption assistance payments under Title IV-E of the Social Security Act.

B. Children Who Receive SSI

Foster care or adoption assistance children who receive SSI meet the eligibility requirements for IV-E foster care or adoption assistance. They cannot receive both SSI and IV-E payments, so most of them elect to receive the higher SSI payment. These children are enrolled in Medicaid as SSI recipients.

C. Nonfinancial Eligibility *Requirements*

The child must be under age 21 years and must meet the IV-E foster care or IV-E adoption assistance definition in M0310.115 or M0310.102. *The child meets the age requirement until the end of the month in which the child turns age 21.*

The child must meet all the nonfinancial eligibility requirements in chapter M02. The IV-E eligibility determination meets the Medicaid requirements for Virginia residency and cooperation in pursuing support. Check the following nonfinancial requirements:

- citizenship or alien status (M0220);
- Social Security number (M0240);
- assignment of rights (M0250);
- application for other benefits (M0270);
- institutional status (M0280).

NOTE: IV-E eligible foster care or adoption assistance recipients meet the Medicaid institutional status requirements when they live in a public residential facility if the facility has less than 25 beds.

B. IV-E Foster Care

42 CFR 435.145---The federal Medicaid law requires the State Plan to cover children who are eligible for foster care maintenance payments under Title IV-E of the Social Security Act.

The child must meet the IV-E foster care definition in M0310.115 and must be receiving IV-E foster care maintenance payments. *A child of a IV-E foster care child is also considered to be a IV-E foster care child when the mother's IV-E payment includes an allocation for her child.*

The IV-E eligibility determination meets the Medicaid requirements for Virginia residency and cooperation in pursuing support.

NOTE: IV-E eligible foster care maintenance payment recipients meet the Medicaid institutional status requirements when they live in a public child care institution if the facility has less than 25 beds, or if they live in a publicly operated community residence that has no more than 16 beds. See section M0280.100 for definitions of public institutions.

C. IV-E Adoption Assistance

42 CFR 435.145--The federal Medicaid law requires the State Plan to cover children who are eligible for adoption assistance under Title IV-E of the Social Security Act and for whom a IV-E adoption assistance agreement between the LDSS and the adoptive parent(s) is in effect.

The child must meet the IV-E adoption assistance definition in M0310.102. The child does **not** have to receive a IV-E Adoption Assistance payment in order to meet the IV-E Adoption Assistance definition.

The IV-E Adoption Assistance eligibility determination meets the Medicaid requirements for Virginia residency and cooperation in pursuing support.

D. Financial Eligibility

A separate Medicaid financial eligibility determination is not made for IV-E eligible foster care or IV-E adoption assistance children, regardless of the state that makes the IV-E payment. Verify the child's IV-E *foster care* payment eligibility, *or the child's IV-E adoption assistance eligibility* via agency records.

E. Entitlement

1. IV-E Foster Care Child

Entitlement to Medicaid as a IV-E Foster Care child begins the first day of the month of commitment or entrustment if a Medicaid application is filed within 4 months of commitment or entrustment. Retroactive entitlement prior to the month of commitment or entrustment is not allowed.

If the Medicaid application is filed more than 4 months after entrustment or commitment, entitlement may be retroactive up to 3 months prior to application if the child met all Medicaid eligibility requirements in the retroactive months. However, Medicaid entitlement cannot go back to the month of entrustment or commitment when the application is filed more than 4 months after entrustment or commitment.

2. IV-E Adoption Assistance Child

Entitlement to Medicaid as a IV-E Adoption Assistance child begins the first day of the application month if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

H. Enrollment

The *aid category (AC)* for IV-E *foster care and adoption assistance* children is "*0*74."

M0320.307 INDIVIDUALS UNDER AGE 21

A. Policy

42 CFR 435.222 – The federal Medicaid law allows the State Plan to cover reasonable classifications of individuals under age 21 years who do not receive cash assistance but who meet the income requirements of the state's July 16, 1996 AFDC State Plan. *However, children under age 19 must first have eligibility determined in the FAMIS Plus covered group of children because the income limits are higher for that group. Individuals ages 19 and 20 should be evaluated in the Individuals Under Age 21 covered group when they are not eligible for Medicaid in any other full-benefit covered group.*

The reasonable classifications of individuals under age 21 are:

- *IV-E eligible foster care children who do NOT receive a IV-E maintenance payment,*
- *Non-IV-E foster care children,*
- *Department of Juvenile Justice (DJJ) children,*
- *Non-IV-E Adoption Assistance children,*
- *Children in intermediate care nursing facilities (ICF), and*
- *Children in intermediate care facilities for the mentally retarded (ICF-MR).*

B. Nonfinancial Eligibility *Requirements*

The individual must be under age 21 and meet the nonfinancial requirements in chapter M02.

C. *Reasonable Classifications*

The individual under age 21 must meet one of the following classifications:

***1.* Non IV-E Foster Care**

Children who meet the foster care definition in M0310.115 but do not receive a IV-E maintenance payment are "individuals in foster homes, private institutions or independent living arrangements for whom a public or private nonprofit child-placing agency is assuming full or partial financial responsibility." *This group also includes DJJ children.*

a. Children Living In Public Institutions

Non-IV-E foster care recipients meet the Medicaid institutional status requirements when they live in a public child care institution if the facility has less than 25 beds, or if they live in a publicly operated community residence that has no more than 16 beds. See section M0280.100 for definitions of public institutions.

When these children are placed in public residential institutions, the facility must not have capacity for more than 16 children (see M0280).

***b.* Child in Independent Living Arrangement**

A child in an independent living arrangement is eligible for Medicaid in this covered group if the child is *receiving services from* the local social services agency.

***2.* Non-IV-E Adoption Assistance**

Children under age 21 who meet the adoption assistance definition in M0310.102 for whom a Non-IV-E adoption assistance agreement between the local department of social services (LDSS) and the adoptive parent(s) is in effect are "individuals in adoptions subsidized in full or in part by a public agency." If the child receives a *Non-IV-E* adoption assistance payment, or if the child was adopted under an adoption assistance agreement *and is not eligible as a IV-E Adoption Assistance child*, then the child meets the "*Non-IV-E* adoption assistance" definition.

Non IV-E adoption assistance children who have "special medical needs" have additional requirements. See section M0320.308 for the Special Medical Needs Adoption Assistance requirements.

3. In ICF or ICF-MR

Children under age 21 who are patients *in either an ICF or ICF-MR meet the classification of "individuals in an ICF or ICF-MR" in the Individual Under Age 21* covered group.

D. Assistance Unit

1. *Non-IV-E* Foster Care Children (Includes DJJ)

The child is an assistance unit of one effective the date the child is removed from the home and placed in foster care. Each child in foster care is evaluated as a separate assistance unit, even if the child is living with his/her siblings in a foster care home.

A foster care *or DJJ* child continues to be a single person unit during a trial visit *in his own home*. A "trial visit" is no longer than *six* months for this section's purposes.

2. Adoptive Placement

While in adoptive placement, the child may continue to be treated as a foster care child. However, once the interlocutory or the final order of adoption is entered, the child must be treated as a Non-IV-E adoption assistance child; see 3. below.

3. *Non-IV-E Adoption Assistance-Interlocutory or Final Order Entered*

Financial eligibility is determined using the assistance unit procedures in *sub*chapter M0520, which require the inclusion of the child's adoptive parent(s) *and sibling(s). An adoption assistance child must have his/her eligibility determined by counting or deeming (as appropriate) his/her parent's and sibling's income.*

4. *Child in ICF or ICF-MR*

A child in an ICF or an ICF-MR is an institutionalized individual in a medical facility when he meets the definition of "institutionalized individual" in section M1410.010 B.2. When he meets the institutionalized individual definition, he is an assistance unit of one person.

E. Resources

There is no resource test for the *categorically needy non-money payment (CNNMP)* Individuals Under Age 21 covered group.

F. Income

1. Income Limits

For the Individuals Under Age 21 covered group, the income limit *is the F&C 100% income limit* found in chapter M07*10, Appendix 3.*

The foster care or adoption subsidy payment is excluded when determining the unit's income eligibility.

Foster care and Adoption Assistance children in residential facilities do not have a different income limit. For a foster care/adoption assistance child living outside the State of Virginia, the income limit for the *assistance* unit is the income limit for the Virginia locality which holds custody, pays the adoption subsidy, or signed the adoption assistance agreement.

***2.* Income Exceeds *F&C 100% Income* Limit**

For foster care (including DJJ) and adoption assistance children whose income exceeds the F&C 100% income limit, determine the child's Medicaid eligibility as a medically needy Individual Under Age 21 (see M0330.304).

For children who are institutionalized in an ICF or ICF-MR and whose income exceeds the *F&C 100% income limit, determine the child's Medicaid eligibility* in the 300% SSI covered group (see M0320.309).

G. Entitlement & Enrollment

1. Entitlement

Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

1. Enrollment

The aid category (AC) for individuals in the CNNMP covered group of Individuals Under Age 21 *is*:

- 076 for a non-IV-E Foster Care child;
- 075 for a Department of Juvenile Justice child;
- 072 for a Non-IV-E Adoption Assistance child;
- 082 for a child under age 21 in an ICF or ICF-MR.

M0320.308 SPECIAL MEDICAL NEEDS ADOPTION ASSISTANCE CHILDREN

A. Policy

42 CFR 435.227 - The federal Medicaid law allows the State Plan to cover an individual under age 21 years:

- for whom a non-IV-E adoption assistance agreement between the state and the adoptive parent(s) is in effect;
- who cannot be placed with adoptive parents without Medicaid because the child has special needs for medical or rehabilitative care; and
- who was enrolled in Medicaid under any covered group before the adoption assistance agreement was entered into OR who would have been eligible for Medicaid before the adoption assistance agreement was entered into if the eligibility requirements and standards of the IV-E foster care program were used, without employing the threshold title IV-A eligibility determination.

If the child was not enrolled in Medicaid or would not have been eligible for Medicaid prior to the adoption assistance agreement being entered into, the child is **not** eligible for Medicaid "Special Medical Needs" covered group.

The child's eligibility in another covered group must be evaluated. If the child is under age 19, evaluate his eligibility in the FAMIS Plus covered group of MI Child Under Age 19 (see M0320.303). If the child is over age 19 but under age 21, the child may be eligible as a Non-IV-E Adoption Assistance child in the CNNMP Individuals Under Age 21 covered group. See section M0320.307.

B. Nonfinancial Eligibility Requirements

The child must

- be under age 21,
- meet the "special medical needs" adoption assistance definition in M0310.102, and
- meet the nonfinancial requirements in chapter M02.

C. Financial Eligibility Requirements

1. Assistance Unit

The assistance unit consists of only the child if the child was eligible for Medicaid prior to the adoption assistance agreement being entered into. The adoptive parent(s)' income and resources are **not** counted or deemed; only the Special Medical Needs child's own income and resources are counted.

2. Asset Transfer

The asset transfer rules apply to Special Medical Needs children who are in long-term care. See subchapter M1450.

3. Resources

There is no resource test for the Special Medical Needs Adoption Assistance Children covered group.

4. Income

Adoption assistance children in residential facilities do not have a different income limit. The F&C 100% standard of need income limit for one person in the child's locality is used to determine eligibility in the Special Medical Needs covered group.

For a Virginia Special Medical Needs adoption assistance child living outside the State of Virginia, the income limit for the unit is the income limit for the Virginia locality that signed the adoption assistance agreement.

The adoption subsidy payment is excluded when determining the child's financial eligibility.

If the child's countable income exceeds the F&C 100% standard of need income limit, evaluate the child in the medically needy covered group of "special medical needs adoption assistance" in subchapter M0330.

D. Entitlement & Enrollment

Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

The AC for individuals in the CNNMP covered group of Special Medical Needs Adoption Assistance children is "072."

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M0320.309 F&C IN MEDICAL INSTITUTION, INCOME ≤ 300% SSI

A. Policy

42 CFR 435.236 - The State Plan includes the covered group of individuals who meet a families & children definition who are in medical institutions and who

- meet the Medicaid resource requirements; and
- have income that does not exceed 300% of the SSI individual payment limit (see M0810.002 A. 3.).

B. Nonfinancial Eligibility

An individual is eligible in this covered group if he/she meets the nonfinancial requirements in M1410.020.

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Must be institutionalized in a medical institution, not an IMD;

The individual must be a child under age 19, under age 21 who meets the adoption assistance or foster care definition or under age 21 in an ICF or ICF-MR, or must be a parent or caretaker-relative of a dependent child, or a pregnant woman as defined in M0310.

C. Financial Eligibility

When determining **income** to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. When determining **resources**, use F&C resource policy for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

1. Asset Transfer

The individual must meet the asset transfer policy in subchapter M1450.

2. Resources

a. Resource Eligibility - Married Individual

When determining resources for a married F&C institutionalized individual with a community spouse, use the resource policy in subchapter M1480. When determining resources for a married F&C institutionalized individual who has no community spouse, use the resource policy in subchapter M1460. **Evaluate countable resources using ABD resource policy in chapter S11.**

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible in a medically indigent covered group (which has more liberal resource methods and standards).

b. Resource Eligibility - Unmarried Individual

When determining resources for an unmarried F&C institutionalized individual, use the Medicaid F&C resource requirements in chapter **M06.** All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the F&C CNNMP resource limit of $1,000. Pay close attention to

- ownership of his/her former residence when the individual is in an institution. Determine if the former home is excluded in **M06.**

If the individual is a blind or disabled child, DO NOT DEEM any resources or income from the child's parent; count only actual resources the parent makes available to the child. If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically indigent (which has more liberal resource methods and standards).

3. **Income**

To determine if an individual has income within the 300% SSI income limit, **use gross income**, not countable income, and **use the ABD income policy and procedures in chapter S08 *and subchapter M1460*** **.** Determine what is income according to subchapter S0815, ABD What Is Not Income *and subchapter M1460, LTC Financial Eligibility*. DO NOT subtract the $20 general exclusion or any other income exclusions.

The individual is an assistance unit of 1 person. DO NOT deem any income from a spouse or parent.

Compare the **total gross income** to the 300% of SSI income limit *(see M810.002 A. 3.)*. If gross income is less than or equal to this limit, the individual is eligible for Medicaid in this covered group.

If the total gross income exceeds the 300% of SSI income limit, the individual is not eligible for Medicaid in the CNNMP covered group of F&C individuals in medical institutions.

D. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). If the individual has Medicare Part A, **re-calculate the individual's income** - subtract appropriate ABD income exclusions. Compare the countable income to the QMB limit.

1. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) – the individual has Medicare Part A and has countable income within the QMB income limit - the program designation is "62."

2. Not QMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) - the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - the *aid category (AC)* is "060."

E. Ineligible In This Covered Group

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. For unmarried individuals, redetermine resources using the F&C medically needy policy in chapter M06. Do not recalculate resources of a married individual.

Determine the individual's eligibility as QMB, SLMB, QDWI or QI if he/she has Medicare Part A.

M0320.310 F&C RECEIVING WAIVER SERVICES (CBC)

A. Policy

42 CFR 435.217 - The State Plan includes the covered group of individuals who meet a families & children definition who live in the community, who

- would be eligible for Medicaid if institutionalized;
- are screened and approved to receive Medicaid waiver services and have selected the option to receive Medicaid waiver services in lieu of nursing facility care;
- in the absence of the waiver services would require the level of care furnished in a hospital, nursing facility or ICF-MR; and
- have income that does not exceed 300% of the SSI individual payment limit (see M0810.002 A. 3.).

B. Nonfinancial Eligibility

An individual who receives Medicaid waiver services is eligible in this covered group if he/she meets the nonfinancial requirements in M1410.020:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Is not in a medical institution, may be in a residential institution that meets the institutional status requirements;
8. Meets an F&C definition in M0310.

Verify receipt of Medicaid waiver services; use the procedures in chapter M14.

Do not wait until the individual starts to receive the waiver services to determine his/her eligibility in this covered group. Determine his/her

eligibility in this covered group if he/she is screened and approved to receive Medicaid waiver services and has selected the option to receive Medicaid waiver services in lieu of nursing facility services. Presume that he/she will receive the services and go on to determine financial eligibility using the policy and procedures in C. below. If determined eligible, the individual is not entitled to Medicaid in this covered group unless the policy in item D. below is met. See item D. below for the entitlement and enrollment procedures.

C. Financial Eligibility

When determining **income** to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. When determining **resources**, use F&C resource policy for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

1. Asset Transfer

The individual must meet the asset transfer policy in *subchapter* M1450.

2. Resources

a. Resource Eligibility - Unmarried Individual

When determining resources for an unmarried F&C institutionalized individual, use the Medicaid F&C resource requirements in chapter **M06.** All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the F&C CNNMP resource limit of $1,000. Pay close attention to

- ownership of his/her former residence when the individual is in an institution. Determine if the former home is excluded in **M06.**

DO NOT DEEM any resources from a child's parent living in the home.

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group. He/she may be eligible as medically needy in a medically needy covered group.

c. Resource Eligibility - Married Individual

When determining resources for a married F&C institutionalized individual with a community spouse, use the resource policy in subchapter M1480. When determining resources for a married F&C institutionalized individual who has no community spouse, use the resource policy in subchapter M1460. **Evaluate countable resources using ABD resource policy in chapter S11.**

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically needy in a medically needy covered group.

3. Income

To determine if an individual has income within the 300% SSI income limit, **use gross income**, not countable income, and **use the ABD income policy and procedures in chapter S08 and subchapter M1460.** Determine what is income according to subchapter S0815, ABD What Is Not Income and subchapter M1460, LTC Financial Eligibility. DO NOT subtract the $20 general exclusion or any other income exclusions.

The F&C waiver services individual is an assistance unit of 1 person. DO NOT deem any income from a spouse or parent.

Compare the **total gross income** to the 300% of SSI income limit (see M0810.002 A.3). If gross income is less than or equal to this limit, the individual is eligible for Medicaid in the CNNMP covered group of F&C individuals receiving Medicaid waiver services.

If the total gross income **exceeds** the 300% of SSI income limit, the individual is **not** eligible for Medicaid in the CNNMP covered group of F&C individuals receiving Medicaid waiver services.

D. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). If the individual has Medicare Part A, re-calculate the individual's income - subtract the appropriate ABD income exclusions. Compare the countable income to the QMB limit.

1. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) – the individual has Medicare Part A and has countable income within the QMB income limit - the AC is "062."

2. Not QMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) – the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - the AC is "060."

E. Ineligible In This Covered Group

If the individual is not eligible for Medicaid in this covered group because of income, determine the individual's eligibility as medically needy spenddown. For unmarried individuals, redetermine resources using the F&C medically needy policy in chapter M06. Do not recalculate resources of a married individual.

Determine the individual's eligibility as QMB, SLMB, QDWI or QI if he/she has Medicare Part A.

M0320.311 F&C HOSPICE

A. Policy

SMM 3580-3584 - The State Plan includes the covered group of children under age 21, pregnant women and parents or caretaker-relatives of dependent children who are terminally ill and who elect hospice benefits. The hospice covered group is for individuals who are not eligible in any other full-benefit Medicaid covered group.

Individuals receiving hospice services in the F&C Hospice Covered group may also receive services under the Elderly and Disabled with Consumer Direction (EDCD) Waiver, if the services are authorized by DMAS (see M1440.101).

To be eligible in the hospice covered group, the individual must file an election statement with a particular hospice which must be in effect for 30 or more consecutive days. Eligibility in the Hospice covered group is ongoing as long as the individual continues to receive hospice care, subject to a renewal of eligibility at least once every 12 months. The eligibility worker must verify that the hospice agreement is current at the time of the annual renewal.

The 30-day requirement begins on the effective date of the hospice care election. Once the hospice election has been in effect for each of 30 consecutive days, the 300% of SSI income limit is used to determine Medicaid eligibility. If the individual's income is within the limit, eligibility begins the effective date of the hospice election.

In situations where the 30-day requirement has already been met, the individual does not have to meet it again when he/she elects hospice care. When there is no break in time between eligibility in a medical facility and the effective date of hospice election, the individual does not have to wait another 30 days for eligibility in the hospice covered group.

B. Nonfinancial Eligibility

A terminally ill individual who elects hospice services is eligible in this covered group if he/she meets the following requirements:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Is not in a medical institution, may be in a residential institution that meets the institutional status requirements;
8. Meets either the child, pregnant woman, or parent or caretaker-relative of a dependent child definition in subchapter M0310.

The individual must elect hospice care. Election of hospice care is verified either verbally or in writing from the hospice. If the verification is verbal, document case record.

C. Financial Eligibility

When determining **income** to compare to the 300% of SSI income limit, use the ABD income policy and procedures, regardless of the individual's definition or covered group. When determining **resources**, use F&C resource policy for unmarried F&C individuals; use ABD resource policy for married F&C individuals.

1. Asset Transfer

The individual in the hospice covered group must meet the asset transfer policy in subchapter M1450.

2. Resources

a. Resource Eligibility - Unmarried Individual

When determining resources for an unmarried F&C hospice individual, use the Medicaid F&C resource requirements in chapter **M06.** All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the F&C CNNMP resource limit of $1,000.

DO NOT DEEM any resources from a child's parent living in the home.

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group. He/she may be eligible as medically needy in a medically needy covered group.

c. Resource Eligibility - Married Individual

When determining resources for a married F&C hospice individual with a community spouse, use the resource policy in subchapter M1480. When determining resources for a married F&C hospice individual who has no community spouse, use the resource policy in subchapter M1460. **Evaluate countable resources using ABD resource policy in chapter S11.**

If current resources are within the limit, go on to determine income eligibility.

If current resources are NOT within the limit, the individual is NOT eligible in this covered group; he/she may be eligible as medically needy in a medically needy covered group.

3. Income

To determine if an individual has income within the 300% SSI income limit, **use gross income**, not countable income, and **use the ABD income policy and procedures in chapter S08.** Determine what is income according to subchapter S0815, ABD What Is Not Income. DO NOT subtract the $20 general exclusion or any other income exclusions.

The individual is an assistance unit of 1 person. DO NOT DEEM any income from the individual's spouse or parent.

Compare the total gross income to the 300% SSI income limit (see M0810.002 A. 3.). If countable income is equal to or less than this limit, the individual is eligible for Medicaid in the hospice covered group.

If the total gross income exceeds this limit, the individual is not eligible for Medicaid in the hospice covered group. Evaluate his/her eligibility as medically indigent or medically needy.

D. Entitlement & Enrollment

The hospice services recipient must elect hospice services and the election must be in effect for 30 days. The 30 day period begins on the effective date of the hospice election. Upon 30 days elapsing from the effective date of the hospice election, and the election is in effect for the entire 30 days, eligibility in the hospice covered group begins with the effective date of the hospice election if all other eligibility factors are met.

1. Entitlement

Eligible individuals in this group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Retroactive coverage is applicable to this covered group.

Eligible individuals in this group are classified as categorically needy non-money payment (CNNMP). If the individual has Medicare Part A, evaluate his/her eligibility as ABD hospice in M0320.205.

2. Enrollment

If the individual is eligible in any other full-coverage Medicaid covered group, he is enrolled under that aid category (AC) and not the Hospice AC (054). Enroll with AC *0*54 for an individual who meets an F&C definition but who is not eligible in any other full-coverage Medicaid covered group.

E. Post-eligibility Requirements (Patient Pay)

Individuals who receive hospice services in a nursing facility have a patient pay calculation (see subchapter M1470). *Individuals who receive hospice services outside of a nursing facility do not have a patient pay.*

Individuals who have elected hospice services and who also receive Medicaid Long-term Care services available under the EDCD Waiver must have a patient pay calculation for the EDCD services (see subchapter M1470).

***F.* Ineligible In This Covered Group**

There is no corresponding medically needy hospice covered group. Evaluate the individual in a medically indigent or medically needy covered group.

M0320.312 BREAST AND CERVICAL CANCER PREVENTION AND TREATMENT ACT (BCCPTA)

A. Policy

The Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) of 2000 (P.L. 106-354) provides for payment of medical services, including long-term care (LTC) (see Chapter M14) for certain women with breast and cervical cancer. Virginia chose to cover this group beginning July 1, 2001.

Women eligible for the BCCPTA program must be age 18 through 64. They must have been screened and certified as needing treatment for breast or cervical cancer (including pre-cancerous conditions) by a medical provider operating under the Center for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program (BCCEDP) and referred to LDSS for a Medicaid eligibility determination. These women must not have creditable health insurance coverage for treatment of breast or cervical cancer. *Virginia's BCCEDP program, Every Woman's Life, is administered by the Virginia Department of Health.*

Through an agreement between Virginia and the District of Columbia (D.C.), residents of northern Virginia (the cities of Alexandria, Fairfax, Falls Church, Manassas, Manassas Park and the counties of Arlington, Fairfax, Loudoun and Prince William) are allowed to be screened and diagnosed for breast or cervical cancer and pre-cancerous conditions through the DC Center for Disease Control and Prevention's "Project Wish" program. Women who are screened and certified as needing treatment for breast or cervical cancer through Project Wish may be eligible for Virginia Medicaid, provided they meet the requirements of the BCCPTA covered group. These women will receive a Virginia BCCPTA application form from the DC providers and will be instructed to submit the application directly to the local department of social services in their home locality.

Women diagnosed with cancer by a provider who is not operating under the BCCEDP are not eligible in this covered group.

B. Nonfinancial Eligibility

1. Required Nonfinancial Requirements

BCCPTA women must meet the following Medicaid nonfinancial requiremen in chapter M02:

- citizenship/alien status;
- Virginia residency;
- Social Security number provision/application requirements;
- assignment of rights to medical benefits requirements;
- application for other benefits; and
- institutional status.

In addition, BCCPTA women must not be eligible for Medicaid under the following mandatory categorically needy covered groups:

- LIFC;
- MI Pregnant Women;
- FAMIS Plus (MI Child Under Age 19);
- SSI recipients.

2. Creditable Health Insurance Coverage

BCCPTA women must not have creditable health insurance coverage. Creditable health insurance coverage includes:

- a group health plan;
- health insurance coverage under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;
- Medicare;
- Medicaid;
- armed forces insurance a medical care program of the Indian Health Service (IHS) or of a tribal organization;
- a state health risk pool.

There may be situations where a woman has creditable health insurance coverage as defined above, but the coverage does not include treatment of breast or cervical cancer due to a period of exclusion or exhaustion of lifetime benefits, *or the woman may have a high deductible. The woman is not eligible for Medicaid in the BCCCPTA covered group because she has creditable health insurance.*

C. Financial Eligibility

There are no Medicaid financial requirements for the BCCPTA covered group. The BCCEDP has income and resource requirements that are used to screen women for this program.

Women requesting Medicaid coverage of LTC services must provide verification of their resources and income and must meet all the LTC eligibility requirements in chapter M14.

D. Application Procedures

The application procedures for women who meet the BCCPTA non-financial requirements have been streamlined to facilitate the prompt enrollment and immediate access to services for women who are in need of treatment for breast or cervical cancer. In addition to the nonfinancial information required to evaluate eligibility in the BCCPTA covered group, the following information is needed for enrollment in Medicaid:

- name,
- address,
- sex and race,
- date of birth,
- country of origin and entry date, if an alien.

Women who meet the description of individuals in the LIFC, MI Pregnant Women, FAMIS Plus, or SSI recipients covered groups must complete the appropriate Medicaid application for the covered group and must have a Medicaid eligibility determination completed prior to determining their eligibility in the BCCPTA covered group. If not eligible in the LIFC, MI

Pregnant Women, FAMIS Plus, or SSI recipients covered groups, then determine their eligibility in the BCCPTA covered group.

1. Application Form

This covered group has a special application, BCCPTA Medicaid Application (form #032-03-384), that must be initiated by a BCCEDP provider, *including those affiliated with Project Wish operating in the District of Columbia.* The application includes the BCCEDP certification of the woman's need for treatment and the information needed to determine the nonfinancial eligibility in the BCCPTA covered group. Appendix 7 to subchapter M0120 contains a sample of the BCCPTA Medicaid Application form.

If eligibility in another Medicaid covered group must first be determined, the applicant must be given the appropriate Medicaid application.

2. Application Processing Time Frames

BCCPTA Medicaid applications filed by women who do not meet the description of an individual in the LIFC, MI Pregnant Women, FAMIS Plus, or SSI recipients covered groups must be processed within 10 working days of the agency's receipt of the signed application.

BCCPTA Medicaid applications filed by women who meet the description of an individual in the LIFC, MI Pregnant Women, FAMIS Plus, or SSI recipients covered groups must be processed as soon as possible, but no later than 45 calendar days of the agency's receipt of the signed application.

3. Notices

If the BCCPTA Medicaid application is the only application required and no additional information is required, the eligibility decision must be made immediately and applicant must be notified of the decision within 10 working days of the agency's receipt of the application.

If a decision cannot be made within 10 working days of receipt of the BCCPTA application, the worker must send a "Notice of Action on Medicaid", form #032-03-008, on the 10th day stating why action has not been taken, specifying what information is needed and a deadline for submitting the information.

E. Entitlement

1. Entitlement Begin Date

Eligibility under this covered group is met the beginning of the month the screening is completed if the woman later has a positive diagnosis as a result of the screening and is determined to be in need of treatment for her breast and/or cervical cancer.

Eligible BCCPTA women are entitled to full Medicaid coverage beginning the first day of the individual’s application month if all eligibility requirements are met in that month.

2. Retroactive Entitlement

Retroactive coverage is applicable to this covered group if the individual was screened by a medical provider operating under the BCCEDP and diagnosed as needing treatment for breast or cervical cancer in the retroactive month(s).

F. Enrollment The aid category for BCCPTA women is "066".

G. Benefit Package The BCCPTA group is a full-benefit covered group. All Medicaid-covered services are available to BCCPTA enrollees, including long-term care in a facility or in a community-based care waiver.

H. Renewal Annual renewal requirements are applicable to the BCCPTA covered group. At the time of the annual renewal, the recipient must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer. The BCCPTA Redetermination (form #032-03-653) is used for the renewal. See M1520.200 for renewal requirements.

CHAPTER M03
MEDICAID COVERED GROUPS
SUBCHAPTER 30

MEDICALLY NEEDY GROUPS

M0330 Changes

Changed With	Effective Date	Pages Changed
Update (UP) #2	08/24/09	pages 3, 6, 8, 16, 22
Update (UP) #1	07/01/09	pages 20, 21

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M0330.000 MEDICALLY NEEDY GROUPS

M0330.001 GENERAL POLICY PRINCIPLES

A. Introduction

All medically needy covered groups are optional; the federal Medicaid law does not require the state to cover the medically needy groups in its Medicaid state plan. However, if a state chooses to cover the medically needy, the state plan must cover all pregnant women, newborn children and individuals under age 18 who, except for resources and income, would be eligible for Medicaid as categorically needy. There are fewer MN covered groups than categorically needy covered groups.

Virginia chose to cover the medically needy. In addition to the required medically needy covered groups, Virginia chose to cover aged, blind, and disabled individuals and reasonable classifications of individuals under age 21.

1. MN Individual

The medically needy individual does not meet the financial requirements for a money payment, but has insufficient income and resources to meet his medical care needs. A medically needy individual is an individual who

- meets all the non-financial eligibility requirements in Chapter M02,
- meets one of the definitions in M0310 and an MN covered group,
- meets the appropriate MN resource and income requirements,
- is not an ineligible person listed in M0210.100, and
- does not meet a CN or CNNMP covered group.

2. Spenddown Feature

The major feature of the MN covered groups is a spenddown. An individual who meets the nonfinancial and MN resource eligibility requirements but whose income exceeds the MN income limit may a "spenddown" the excess income by deducting incurred medical expenses and become eligible for a limited period of full medically needy Medicaid coverage. An individual who has excess income becomes eligible when he/she has incurred medical expenses equal to the difference between his/her income and the MN income limit.

3. Different Benefit Package

Some medical services that are covered for the categorically needy covered groups are not available to the medically needy. ICF-MR services and IMD services are not covered for medically needy eligible recipients. However, the basic services such as inpatient and outpatient hospital, physicians, X-rays, prescription drugs, home health services and Medicare premiums, coinsurance and deductibles are covered for the medically needy. Long-term care nursing facility and waiver services are also covered for the medically needy.

B. Procedure

This subchapter explains in detail each of the MN covered groups and how to determine if an individual meets the requirements of an MN covered group. The following sections in this chapter contain the policy and procedures for determining whether an individual meets a Medicaid medically needy covered group:

- M0330.200 ABD Medically Needy Groups;
- M0330.201 Aged Individuals;
- M0330.202 Blind Individuals;
- M0330.203 Disabled Individuals;
- M0330.204 December 1973 Eligibles;
- M0330.300 Families & Children Medically Needy Groups;
- M0330.301 Pregnant Women;
- M0330.302 Newborn Children Under Age 1;
- M0330.303 Children Under Age 18;
- M0330.304 Individuals Under Age 21;
- M0330.305 Special Medical Needs Adoption Assistance.

M0330.200 ABD MEDICALLY NEEDY GROUPS

A. Introduction

To be eligible in an ABD (aged, blind or disabled) covered group, the individual must first meet the "Aged," "Blind" or "Disabled" definition in section M0310.100. If he/she does not meet the aged, blind or disabled definition, then go to Families & Children Medically Needy covered groups in section M0330.300 below.

B. Procedure

The policy and procedures for determining whether an individual meets an ABD MN covered group are contained in the following sections:

- M0330.201 Aged Individuals;
- M0330.202 Blind Individual;
- M0330.203 Disabled Individuals;
- M0330.204 December 1973 Eligibles.

1. Individual Not ABD Eligible Due To Home Property

If the individual is not eligible in an ABD covered group because of excess real property contiguous to the home, and he/she meets a medically needy Families & Children definition, determine if the individual meets an F&C MN covered group because the home property definition is more liberal for F&C covered groups.

2. Individual Ineligible Due To Excess Resources

If the individual is not eligible in an ABD covered group because of other excess resources and he/she has Medicare Part A, determine if the individual meets a medically indigent (MI) ABD covered group because the MI ABD resource requirements are more liberal than the MN requirements. If the individual is eligible as ABD MI, he/she will not be entitled to the full Medicaid benefit package; Medicaid will only pay the individual's Medicare premiums only, or the Medicare premiums, deductibles and coinsurance amounts. Other Medicaid covered services

such as prescription drugs and long-term care are not covered for the ABD MI.

M0330.201 AGED INDIVIDUALS

A. Nonfinancial Eligibility

42 CFR 435.330 - An individual is eligible in this covered group if he/she has attained age 65 years (M0310.105) and meets the following nonfinancial requirements in chapter M02:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Institutional status requirements;

B. Financial Eligibility

1. Asset Transfer

The individual must meet the asset transfer policy in subchapter M1450.

2. Assistance Unit

The assistance unit policy and procedures in chapter M05 apply to aged medically needy individuals. If married and not institutionalized, deem or count any resources and income from the individual's spouse with whom he/she lives. If married and institutionalized, go to subchapter M1480 for resource and income determination policy and procedures.

3. Resources

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. The resources policy in chapter S11 applies.

If the individual is married and institutionalized, use the resource policy in subchapter M1480.

a. Resources Within The Limit

If current resources are within the limit, go on to determine income eligibility.

b. Resources Exceed The Limit

If the individual is not eligible because of excess real property contiguous to the home, and he/she meets a medically needy Families & Children (F&C) definition, determine if the individual meets an F&C covered group since the F&C home property definition is more liberal for F&C.

If the individual is not eligible because of other excess resources and he/she has Medicare Part A, determine if the individual meets a medically indigent (MI) ABD covered group since the MI ABD resource requirements are more liberal than the MN requirements. See sections M0320.206, 207, *and 208* for the ABD MI covered groups.

If current resources are NOT within the limit, the individual is NOT eligible for Medicaid as medically needy because of excess resources.

4. Income

Determine gross income according to chapter S08. Subtract the $20 general exclusion and other exclusions.

Compare the total countable income to the MN income limit for the individual's locality group (see section S0810.002). If countable income is less than or equal to this limit, the individual is eligible for Medicaid in this medically needy covered group.

5. Income Exceeds MN Limit

An individual who has excess income becomes eligible in this MN covered group when he/she has incurred medical expenses equal to the difference between his/her income and the MN income limit (spenddown). See *chapter M13* for spenddown policy and procedures.

Additionally, if the individual has Medicare Part A, determine if the individual meets a medically indigent (MI) ABD covered group since the MI ABD income limits are higher than the MN limits. *See sections M0320.206, 207, and 208 for the ABD MI covered groups.*

C. Entitlement

Eligible individuals in this MN group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Individuals who become eligible after meeting a spenddown are entitled to full Medicaid coverage beginning the day the spenddown was met and ending the last day of the sixth month in the spenddown period. Retroactive coverage is applicable to this covered group.

D. Enrollment

Eligible individuals in this group are classified as medically needy (MN). If the individual has Medicare Part A, compare the individual's countable income to the QMB limit.

1. Program Designations

a. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) - the individual has Medicare Part A and has countable income within the QMB income limit - enroll the individual with program designation "**28**."

b. Not QMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) - the individual does NOT have Medicare Part A, OR has countable income

over the QMB income limit - enroll the individual with program designation "**18."**

2. Recipient's PD Changes To QMB-only

An enrolled recipient's PD cannot be changed to or from the QMB-only PDs using a "change" transaction in the MMIS. If a medically needy Medicaid recipient becomes ineligible for medically needy Medicaid but is eligible as a QMB, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare premiums, deductibles and coinsurance amounts as a QMB-only.

Cancel the MN coverage effective the end of the month. Reinstate the recipient's coverage in the QMB-only PD effective the first day of the month immediately following the cancellation date.

3. QMB Meets Spenddown

When an eligible QMB meets the spenddown, cancel the QMB-only coverage effective the day before the spenddown was met, using cancel reason "24". Reinstate the recipient's coverage with the begin date as the first date the spenddown was met. Program designation is aged MN dual-eligible QMB – "**28."**

If the end of the spenddown period has not yet occurred, coverage type is type 3. If the end of the spenddown period has passed, use type 4 coverage with the end date being the last day of the spenddown period.

4. Spenddown Period Ends

a. Not QMB Eligible

Spenddown coverage will automatically cancel in the MMIS after the end date of the coverage (spenddown) period. The individual must file a new application for Medicaid.

b. QMB Eligible

After the spenddown period ends, reinstate the QMB-only coverage using the appropriate QMB-only program designation. The begin date of the reinstated coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial QMB eligibility.

M0330.202 BLIND INDIVIDUALS

A. Nonfinancial Eligibility

42 CFR 435.330 - An individual is eligible in this covered group if he/she is blind according to the definition in M0310.106 and meets the following nonfinancial requirements in chapter M02:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;

5. Cooperation in pursuing support;
6. Application for other benefits;
7. Institutional status requirements;

B. Financial Eligibility

1. Asset Transfer

The individual must meet the asset transfer policy in subchapter M1450.

2. Assistance Unit

The assistance unit policy and procedures in chapter M05 apply to blind medically needy individuals. If not institutionalized, deem any resources and income from the individual's spouse with whom he/she lives, and his/her parent(s), if individual is under age 21, with whom he/she lives.

3. Resources

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. The resources policy in chapter S11 applies.

If the individual is married and institutionalized, use the resource policy in subchapter M1480.

a. Resources Within The Limit

If current resources are within the limit, go on to determine income eligibility.

b. Resources Exceed The Limit

If the individual is not eligible because of excess real property contiguous to the home, and he/she meets a medically needy Families & Children definition, determine if the individual meets an F&C MN covered group because the home property definition is more liberal for F&C covered groups.

If the individual is not eligible because of other excess resources and he/she has Medicare Part A, determine if the individual meets a medically indigent (MI) ABD covered group because the MI ABD resource requirements are more liberal than the MN requirements. See M0320.206 through 208 for the ABD MI covered groups.

If current resources are NOT within the limit, the individual is NOT eligible for Medicaid as medically needy because of excess resources.

4. Income

Determine gross income according to chapter S08. Subtract the $20 general exclusion and other exclusions. Note the special earned income exclusions for blind individuals.

Compare the total countable income to the MN income limit for the individual's locality group (see section S0810.002). If countable income is less than or equal to this limit, the individual is eligible for Medicaid in this medically needy covered group.

5. Income Exceeds MN Limit

An individual who has excess income becomes eligible in this MN covered group when he/she has incurred medical expenses equal to the difference between his/her income and the MN income limit (spenddown). See *chapter M13* for spenddown policy and procedures.

Additionally, if the individual has Medicare Part A, determine if the individual meets a medically indigent (MI) ABD covered group because the MI ABD income limits are higher than the MN limits. See sections M0320.206 through 208 for the ABD MI covered groups.

C. Entitlement

Eligible individuals in this MN group are entitled to full medically needy Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Individuals who become eligible after meeting a spenddown are entitled to full medically needy Medicaid coverage beginning the day the spenddown was met and ending the last day of the sixth month in the spenddown period. Retroactive coverage is applicable to this covered group.

D. Enrollment

Eligible individuals in this group are classified as medically needy (MN). If the individual has Medicare Part A, compare the individual's countable income to the QMB limit.

1. Program Designations

a. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) - the individual has Medicare Part A and has countable income within the QMB income limit - enroll the individual with program designation "**48**."

b. Not QMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) - the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - enroll the individual with program designation "**38.**"

2. Recipient's PD Changes To QMB-only

An enrolled recipient's PD cannot be changed to or from the QMB-only PDs using a "change" transaction in the MMIS. If a medically needy Medicaid recipient becomes ineligible for medically needy Medicaid but is eligible as a QMB, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare premiums, deductibles and coinsurance amounts as a QMB-only.

Cancel the MN coverage effective the end of the month. Reinstate the recipient's coverage in the QMB-only *AC* effective the first day of the month immediately following the cancellation date.

3. QMB Meets Spenddown

When an eligible QMB meets the spenddown, cancel the QMB-only coverage effective the day before the spenddown was met, using cancel reason "024". Reinstate the recipient's coverage with the begin date as the first date the spenddown was met, *end date is the last date of the spenddown period. AC* is blind MN dual-eligible QMB "048**."**

4. Spenddown Period Ends

a. Not QMB Eligible

Spenddown coverage will automatically cancel in the MMIS after the end date of the coverage (spenddown) period. The individual must file a new application for Medicaid.

b. QMB Eligible

After the spenddown period ends, reinstate the QMB-only coverage using the appropriate QMB-only *aid category*. The begin date of the reinstated coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial QMB eligibility.

M0330.203 DISABLED INDIVIDUALS

A. Nonfinancial Eligibility

42 CFR 435.330 - An individual is eligible in this covered group if he/she meets the disabled definition in M0310.112 and meets the following nonfinancial requirements in chapter M02:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Institutional status requirements;).

B. Financial Eligibility

1. Asset Transfer

The individual must meet the asset transfer policy in subchapter M1450.

2. Assistance Unit

The assistance unit policy and procedures in chapter M05 apply to disabled medically needy individuals. If not institutionalized, deem any

resources and income from the individual's spouse with whom he/she lives, and from the individual's parent(s), if individual is under age 21, with whom he/she lives.

3. Resources

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. The resources policy in chapter S11 applies.

If the individual is married and institutionalized, use the resource policy in *subchapter M1480.*

a. Resources Within The Limit

If current resources are within the limit, go on to determine income eligibility.

b. Resources Exceed The Limit

If the individual is not eligible because of excess real property contiguous to the home, and he/she meets a medically needy Families & Children definition, determine if the individual meets an F&C MN covered group because the home property definition is more liberal for F&C covered groups.

If the individual is not eligible because of other excess resources and he/she has Medicare Part A, determine if the individual meets a medically indigent (MI) ABD covered group because the MI ABD resource requirements are more liberal than the MN requirements. See sections M0320.206 through 208 for the ABD MI covered groups.

If current resources are NOT within the limit, the individual is NOT eligible for Medicaid as medically needy because of excess resources.

4. Income

Determine gross income according to chapter S08. Subtract the $20 general exclusion and other exclusions. Note the special earned income exclusions for disabled individuals.

Compare the total countable income to the MN income limit for the individual's locality group (see section S0810.002). If countable income is less than or equal to this limit, the individual is eligible for Medicaid in this medically needy covered group.

5. Income Exceeds MN Limit

An individual who has excess income becomes eligible in this MN covered group when he/she has incurred medical expenses equal to the difference between his/her income and the MN income limit (spenddown). See *chapter M13* for spenddown policy and procedures.

Additionally, if the individual has Medicare Part A, determine if the individual meets a medically indigent (MI) ABD covered group because

the MI ABD income limits are higher than the MN limits. See sections M0320.206 through 208 for the ABD MI covered groups.

C. Entitlement

Eligible individuals in this MN group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Individuals who become eligible after meeting a spenddown are entitled to full Medicaid coverage beginning the day the spenddown was met and ending the last day of the sixth month in the spenddown period. Retroactive coverage is applicable to this covered group.

D. Enrollment

Eligible individuals in this group are classified as medically needy (MN). If the individual has Medicare Part A, compare the individual's countable income to the QMB limit.

1. Program Designations

a. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) - the individual has Medicare Part A and has countable income within the QMB income limit - enroll the individual with program designation "**68**."

b. Not QMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) - the individual does NOT have Medicare Part A, OR has countable income over the QMB income limit - enroll the individual with program designation "**58."**

2. Recipient's PD Changes To QMB

An enrolled recipient's PD cannot be changed to or from the QMB-only PDs using a "change" transaction in the MMIS. If a medically needy Medicaid recipient becomes ineligible for medically needy Medicaid but is eligible as a QMB, the agency must send an advance notice of proposed action to the recipient because services are being reduced. The notice must specify that he will remain eligible only for payment of Medicare premiums, deductibles and coinsurance amounts as a QMB-only.

Cancel the MN coverage effective the end of the month. Reinstate the recipient's coverage in the QMB-only PD effective the first day of the month immediately following the cancellation date.

3. QMB Meets Spenddown

When an eligible QMB meets the spenddown, cancel the QMB-only coverage effective the day before the spenddown was met, using cancel reason "24". Reinstate the recipient's coverage with the begin date as the first date the spenddown was met. Program designation is the aged MN dual-eligible QMB "**68."**

If the end of the spenddown period has not yet occurred, coverage type is type 3. If the end of the spenddown period has passed, use type 4 coverage with the end date being the last day of the spenddown period.

4. Spenddown Period Ends

a. Not QMB Eligible

Spenddown coverage will automatically cancel in the MMIS after the end date of the coverage (spenddown) period. The individual must file a new application for Medicaid.

b. QMB Eligible

After the spenddown period ends, reinstate the QMB-only coverage using the appropriate QMB-only program designation. The begin date of the reinstated coverage is the first day of the month following the end of the spenddown period, and the application date is the date of the original application used to determine the initial QMB eligibility.

M0330.204 DECEMBER 1973 ELIGIBLES

A. Policy

42 CFR 435.340 - If the State Plan covers the medically needy, the Plan must provide protected medically needy coverage for blind and disabled individuals eligible in December 1973. This is an MN covered group of blind and disabled individuals who:

- were eligible as medically needy under the state plan in December 1973 on the basis of the blindness or disability criteria of the AB or APTD plan;
- for each consecutive month after December 1973 continue to meet the December 1973 blindness or disability criteria and the December 1973 financial eligibility requirements; and
- meet the **current** medically needy eligibility requirements except the blindness or disability criteria.

Continuing eligibility is determined on the basis of eligibility requirements in effect as of December, 1973 and current medically needy requirements.

B. December 1973 Eligibility Requirements

1. Nonfinancial

a. The individual must meet the nonfinancial eligibility requirements:

- Citizenship/alien status (M0220);
- Virginia residency (M0230);
- Social security number provision/application requirements (M0240);
- Cooperation in pursuing support (*M0250)*;
- Application for other benefits (M0270);
- Institutional status requirements (M0280).

b. It is not necessary to re-establish the blindness or disability requirement unless:

- the decision of the APTD Review Team or the Commission for the Visually Handicapped ophthalmologist was for a limited period, or

- the local department of social services has reason to believe the physical impairment or the visual handicap has been overcome or substantially improved.

If one of the above conditions exists, contact the Medicaid Disability Unit of the Department of Rehabilitative Services or the Department for the Visually Handicapped, as appropriate by the usual method to redetermine the individual's eligibility using the criteria followed by the former APTD Review Team or Commission for the Visually Handicapped in December, 1973.

2. Assistance Unit

The assistance unit consists of the blind or disabled individual, his or her spouse, and the blind or disabled individual's children under age 18 who live in the home. It also includes other specified individuals who are considered essential to his/her (or their) well-being (EWB).

3. Persons Essential To Well-Being (EWB)

Certain individuals are included in the blind or disabled individual's assistance unit if the following conditions are met:

a. the EWB person does not meet a Medicaid ABD or F&C definition.

b. the EWB person is living in the same household with the blind or disabled individual.

c. the EWB person is either

- a relative of specified degree (spouse, parent, grandparent, child, grandchild or sibling, except when the relative is age 16 years or older, is employable and out of school unless he is performing essential services which preclude his employment), or

- is performing a service for the individual that contributes to the security and physical, mental or social well-being of the individual and which otherwise would have to be purchased;

d. the EWB person is in need, i.e. has resources and income insufficient to meet his total allowable individual requirements, based on the resource and income limit for one person.

e. the EWB person wants his/her needs and resources and income considered in determining the blind or disabled individual's eligibility.

4. Resources

a. Resource Limits

Total resources (real and personal property) may not exceed $600 for a single person, $900 for two persons and $100 for each additional person in the family unit.

b. Home Property

Ownership of a dwelling occupied by the applicant as his home does not affect eligibility. A home is considered to be the house and lot or adjacent land, including a garden and outbuildings used in connection with the dwelling. It does not include land and outbuildings used for farming purposes.

c. Income-Producing Real Property

Ownership of income-producing real property, other than the home, such as may be used for farming or business, precludes eligibility if the equity therein of a family unit is $10,000 or more. Real property cannot be considered income-producing unless there is a reasonable annual income of approximately 10% of the market value of the property or gross income comparable to that received from similar property located in the community.

d. Other Real Property

Ownership of any other real property precludes eligibility unless the property cannot be sold, or sale would involve undue monetary sacrifice, or unless the market value of the property, if added to the personal property, does not exceed the allowable amount of personal property.

e. Personal Property

Personal property includes bank accounts, bonds, and other cash liquidable assets, and nonliquidable assets such as motor vehicles, stocks, cash value of life insurance.

When evaluating personal property, exclude

- life insurance policies with total face value of $5,000 or less for an individual,
- household equipment and furnishings,
- one motor vehicle,
- livestock providing food for family consumption
- farming or business equipment or livestock which are income-producing.

Life Insurance - When insurance (life, retirement, and other related types) has a total face value of over $5,000 for an individual, ascertain the cash value and count it as a resource. If, however, income benefits such as disability payments are currently available under the provisions

of a policy, the case surrender value of such policy does not necessarily have to be counted as a resource, if it is in the best interest of the client and the agency for the provisions of the policy to remain unchanged.

5. Income

a. Income Limits

The **annual** income limits were $1,900 for one person and $2,500 for two persons, and $400 for each additional person in the assistance unit. Monthly limits: $158.33 for 1 person; $208.33 for 2 persons; $33.33 monthly for each additional person ($241.66 for 3 persons; $274.99 for 4 persons, etc.).

b. Unearned Income

Social Security and Railroad Retirement benefits - For OAA and APTD-related persons who receive Social Security or Railroad Retirement benefits the first $4.00 monthly of such benefits for each recipient is excluded EXCEPT for the individual who is in a nursing facility and now receives $30.00 a month clothing and personal care allowance from SSI. Do not exclude $4.00 of the SSA or RR benefit received by an individual in a medical facility who now receives a $30 SSI check.

This exclusion is **not** applicable to the ineligible spouse who does not meet a Medicaid covered group.

c. Earned Income Exclusion for OAA and APTD-related Persons

The earned income exclusion for OAA and APTD-related individuals is the first $20 a month plus 1/2 the remainder up to a maximum of $35 per month.

C. Does Not Meet 1973 Requirements

If the individual no longer meets the December 1973 nonfinancial or financial eligibility requirements, the individual is not eligible in this MN covered group. Determine his/her eligibility in another covered group.

D. Meets 1973 Requirements

If the individual meets the December 1973 nonfinancial and financial eligibility requirements, the individual also meets the current medically needy resource and income requirements, except for life insurance. The current medically needy life insurance requirement is more restrictive than the 1973 requirement.

If the individual has life insurance, redetermine the life insurance countable value. Total all countable resources and compare the total to the current medically needy resource limit. If countable resources are within the current limit, the individual is eligible in this MN covered group.

E. Entitlement & Enrollment

Eligible individuals in this group are entitled to full Medicaid coverage.

Eligible individuals in this group are classified as medically needy (MN).

1. Dual-eligible As QMB

If the individual is also a Qualified Medicare Beneficiary (QMB) - the individual has Medicare Part A - his income is within the QMB income limit. Program designations:

- 48 for blind MN dual-eligible QMB;
- 68 for disabled MN dual-eligible QMB.

2. Not QMB

If the individual is NOT a Qualified Medicare Beneficiary (QMB) - the individual does NOT have Medicare Part A - the program designation is:

- 38 for blind MN not QMB;
- 58 for disabled MN not QMB.

M0330.300 FAMILIES & CHILDREN MEDICALLY NEEDY GROUPS

A. Introduction

An F&C medically needy individual must

- be a child under age 18, or
- meet the adoption assistance, foster care or pregnant woman definition in subchapter M0310.

B. Procedure

The policy and procedures for determining whether an individual meets an F&C MN covered group are contained in the following sections:

- M0330.301 Pregnant Women;
- M0330.302 Newborn Children Under Age 1;
- M0330.303 Children Under Age 18;
- M0320.304 Individuals Under Age 21;
- M0320.305 Special Medical Needs Adoption Assistance.

C. Individual Ineligible Due To Excess Resources or Income

If the individual is not eligible in an F&C covered group because of excess resources or income and he/she has Medicare Part A, determine if the individual meets a medically indigent (MI) ABD covered group because some of the MI ABD resource and income requirements are more liberal than the F&C MN resource requirements (motor vehicle, other real property occupied by dependent relative, unearned income exclusion, earned income exclusions).

If the individual is eligible as ABD MI, he/she will not be entitled to the full Medicaid benefit package; Medicaid will only pay the individual's Medicare premiums or the individual's Medicare premiums, deductibles and coinsurance amounts. Other Medicaid covered services such as prescription drugs and long-term care are not covered for the ABD MI.

M0330.301 PREGNANT WOMEN

A. Nonfinancial Eligibility

42 CFR 435.301(b)(1)(i)--If the state chooses to cover the medically needy, the State Plan must provide medically needy coverage to all pregnant women during the course of their pregnancy who, except for income and resources, would be eligible for Medicaid as categorically needy.

A pregnant woman's Medicaid eligibility is first determined in the MI pregnant women covered group which has no resource limit and has an income limit that is higher than the medically needy income limit. If a pregnant woman is not eligible as MI because her income is too high, then she may spenddown to the lower MN income limit IF her resources are within the MN resource limit.

A pregnant woman is eligible in this MN covered group if she meets the pregnant woman definition in M0310.119 and meets the following nonfinancial requirements in chapter M02:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
   NOTE: an MN pregnant woman must cooperate in pursuing support; see subchapter M0250);
6. Application for other benefits;
7. Institutional status requirements;

B. Financial Eligibility

1. Asset Transfer

The individual must meet the asset transfer policy in subchapter M1450.

2. Assistance Unit

The assistance unit policy and procedures in chapter M05 apply to medically needy pregnant women. If the pregnant woman is not institutionalized, consider the resources and income of a pregnant woman's spouse with whom she lives and, if the pregnant woman is under age 21, the pregnant woman's parent(s) with whom she lives. If a pregnant woman also applies for other assistance unit members living with her who do not meet an F&C medically needy covered group, separate financial eligibility determinations are done for the unit. One is the F&C medically needy determination for the pregnant woman. The other financial eligibility determination is based on the other individual's(s) classification and covered group(s).

3. Resources

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. The resources policy in chapter M06 applies.

If the individual is married and institutionalized, use the resource policy in subchapter M1480.

a. Resources Within The Limit

If current resources are within the limit, go on to determine income eligibility.

b. Resources Exceed The Limit

If *current resources exceed the limit, she is not eligible in this covered group.*

4. Income

Determine MN countable income according to chapter M07. Subtract the appropriate exclusions. Compare the total countable income to the MN income limit for the individual's locality group (see M0710, Appendix 5 for the MN income limits).

***5.* Income Exceeds MN Limit**

Because the MN pregnant woman's income exceeds the MI limit, it also exceeds the MN limit. She becomes eligible in this MN covered group when she has incurred medical expenses equal to the difference between her income and the MN income limit (spenddown). See chapter M13 for spenddown policy and procedures.

***6.* Income Changes**

Any changes in a medically needy pregnant woman's income that occur after her eligibility has been established, **do not** affect her eligibility as long as she meets the pregnant woman definition, the nonfinancial and MN resource eligibility requirements.

The spenddown liability must be recalculated when an income change is reported prior to eligibility being established.

C. Entitlement

Eligible individuals in this MN group are entitled to full Medicaid coverage beginning the first day the spenddown is met, and ending the last day of the month in which the 60th day occurs or the spenddown period ends, whichever comes first. Retroactive coverage is applicable to this covered group.

EXAMPLE:

A pregnant woman living in Group III applied for Medicaid on March 3. Her estimated date of conception is January 24, and her due date is October 20. Her income exceeds the MI limit for 2 persons. Her resources are within the medically needy resource limit and she is placed on a spenddown for the period March 1 through August 31. She meets the spenddown on May 11 and is enrolled in Medicaid as a medically needy pregnant woman through August 31.

She reapplies for Medicaid on September 5. Her income increased in August. Because her income increased after she established eligibility, but before the date her pregnancy ended, the increase in income does not affect her Medicaid eligibility. Her income that was verified in March is used to calculate her spenddown. She is placed on spenddown for the period September 1 through February 28, using the same spenddown amount from her previous spenddown and she establishes eligibility. Her child is born on October 10. Her Medicaid coverage as a pregnant woman is canceled effective December 31, the last day of the month in which the 60th day occurred after her pregnancy ended. She no longer meets the pregnant woman covered group requirements.

Note: The eligibility worker must evaluate the individual's eligibility in all other covered groups prior to taking action to cancel the coverage.

D. Enrollment

Eligible individuals in this group are classified as medically needy (MN), program designation "**97**."

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M0330.302 NEWBORN CHILDREN UNDER AGE 1

A. Policy

42 CFR 435.301 (b)(1)(iii) - If the state chooses to cover the MN, the State Plan must provide MN coverage to all newborn children born on or after October 1, 1984 to a woman who is eligible as MN and is receiving Medicaid on the date of the child's birth. Coverage must be provided to those newborn children whose mothers were eligible as MN but whose coverage was restricted to Medicaid payment for labor and delivery as an emergency service. The child remains eligible for one year.

B. Nonfinancial Eligibility

A child who meets this covered group:

- is under age of 1 year;
- was born to a mother who is found eligible for Medicaid as medically needy or meets spenddown effective on or before the date of the child's birth.

  If the child's mother was covered by Medicaid as a medically needy individual in a state other than Virginia at the time of the child's birth, verification of the mother's Medicaid coverage must be provided by the parent or authorized representative.

1. Continued Eligibility When Mother Becomes Ineligible

Any child born to an eligible pregnant woman will continue to be eligible in this covered group **up to age 1.**

EXAMPLE #*4*: A pregnant woman applied for Medicaid on October 24, *2008*. Her estimated date of conception is March 24, *2008*, and her due date is December 20, *2008*. Her income exceeds the MI limit for 2 persons. Her resources are within the medically needy resource limit and she is placed on a spenddown for the period October 1, *2008* through March 31, *2009*. She meets the spenddown on November 15, *2008*, and is enrolled in Medicaid as MN effective November 15, *2008* through March 31, *2009*.

Her child is born on November 30, *2008*, and is enrolled in Medicaid as an MN newborn. The mother's Medicaid coverage is canceled effective January 31, *2009*, the last day of the month in which the 60th day occurred after her pregnancy ended. The newborn's Medicaid coverage continues through November 30, *2009,* the end of the *month in which he turns one year old*. *The parent must be given the opportunity to file a Medicaid application prior to the cancellation of the newborn's coverage.*

2. Covered Group Eligibility Ends

The child no longer meets this covered group effective:

a. the end of the month in which the child reaches age 1 year; or

b. the end of the month in which the child no longer resides in Virginia.

B. Financial Eligibility

No other nonfinancial or financial eligibility requirements need to be met by the child.

C. Entitlement & Enrollment

Eligible newborns in this MN group are entitled to full Medicaid coverage beginning the date of the child's birth. Retroactive coverage is applicable to this covered group, but coverage cannot begin prior to the date of the child's birth.

Eligible children in this group are classified as medically needy (MN) and enrolled in aid category "099."

M0330.303 CHILDREN UNDER AGE 18

A. Nonfinancial Eligibility

42 CFR 435.301(b)(1)(ii) - If the state chooses to cover the medically needy, the State Plan must provide medically needy coverage to all children under 18 years of age who, except for income and resources, would be eligible for Medicaid as categorically needy.

A child under age 18's Medicaid eligibility is first determined in the categorically needy MI Child Under Age 19 covered group which has no resource limit and has an income limit that is higher than the medically needy income limit. If a child under age 18 is not eligible as MI because the child's countable income is too high, then the child may spenddown to the lower MN income limit **IF** the child's resources are within the MN resource limit.

A child is eligible in this MN covered group if he/she has not attained age 18 years and meets the nonfinancial requirements in chapter M02:

1. Citizenship/alien status;
2. Virginia residency;
3. Social security number provision/application requirements;
4. Assignment of rights to medical benefits requirements;
5. Cooperation in pursuing support;
6. Application for other benefits;
7. Institutional status requirements;

B. Financial Eligibility

1. Asset Transfer

The child must meet the asset transfer policy in subchapter M1450.

2. Assistance Unit

The assistance unit policy and procedures in chapter M05 apply to this covered group. If not institutionalized, count or deem any resources and income from the child's spouse and/or parent with whom he/she lives.

3. Resources

All of the individual's resources must be verified, evaluated, and counted together to determine if the individual meets the Medicaid resource requirements. The resources policy in chapter M06 applies.

If the child is married and institutionalized, use the resource policy in subchapter M1480.

a. Resources Within The Limit

If the child's resources are within the MN limit, go on to determine income eligibility.

b. Resources Exceed The Limit

If the child's resources are NOT within the limit, the child is NOT eligible for Medicaid because of excess resources.

4. Income

Determine MN countable income according to chapter M07. Subtract the appropriate exclusions. Compare the total countable income to the MN income limit for the child's locality group (see section M0710, Appendix 5 for the MN income limits).

5. Income Exceeds MN Limit

Because the MI children income limits are higher than the MN income limits, the child becomes eligible in the MN children under age 18 covered group when the child has incurred medical expenses equal to the difference between his/her income and the MN income limit (spenddown). See chapter M13 for spenddown policy and procedures.

C. Entitlement & Enrollment

Children who become eligible after meeting a spenddown are entitled to full medically needy Medicaid coverage beginning the day the spenddown was met. Retroactive coverage is applicable to this covered group.

Eligible children in this group are classified as medically needy (MN), *aid category* "**088**."

M0330.304 INDIVIDUALS UNDER AGE 21

A. Policy

42 CFR 435.308(b) - A state may choose to provide medically needy coverage to reasonable classifications of individuals under 21 years of age who *are* not eligible for coverage as categorically needy but who meet the medically needy resource and income requirements.

Virginia has chosen to cover the following reasonable classifications of individuals under age 21:

- *Non-IV-E Foster Care children*
- *Department of Juvenile Justice (DJJ) children,*
- *Non-IV-E Adoption Assistance children,*
- *Children in intermediate care nursing facilities (ICF), and*
- *Children in intermediate care facilities for the mentally retarded (ICF-MR).*

NOTE: the ICF-MR services are **not** covered for medically needy individuals, but other Medicaid covered services such as prescription drugs, physicians, inpatient and outpatient hospital services are covered for medically needy patients in ICF-MRs.

B. Nonfinancial Eligibility

The individual must be under age 21 and meet the nonfinancial requirements in chapter M02. *The child meets the age requirement until the end of the month in which the child turns age 21.*

C. *Reasonable Classifications*

The individual under age 21 must meet one of the following classifications:

1. Non IV-E Foster Care

Children who meet the foster care definition in M0310.115 but do not receive a IV-E maintenance payment are "individuals in foster homes, private institutions or independent living arrangements for whom a public or private nonprofit child-placing agency is assuming full or partial financial responsibility." *This group also includes DJJ children.*

a. Children Living In Public Institutions

Non-IV-E foster care children meet the Medicaid institutional status requirements when they live in a public child care institution if the facility has less than 25 beds, or if they live in a publicly operated community residence that has no more than 16 beds. See section M0280.100 for definitions of public institutions.

When these children are placed in public residential institutions, the facility must not have capacity for more than 16 children (see M0280).

b. Child in Independent Living Arrangement

A child in an independent living arrangement is eligible for Medicaid in this covered group if the child is receiving services from the local social services agency.

2. Non-IV-E Adoption Assistance

Children under age 21 who meet the adoption assistance definition in M0310.102 for whom a Non-IV-E adoption assistance agreement between the local department of social services (LDSS) and the adoptive parent(s) is in effect are "individuals in adoptions subsidized in full or in part by a public agency." If the child receives a *Non-IV-E* adoption assistance payment, or if the child was adopted under an adoption assistance agreement *and is not eligible as a IV-E Adoption Assistance child*, then the child meets the "*Non-IV-E* adoption assistance" definition.

Non IV-E adoption assistance children who have "special medical needs" have additional requirements. See section M0330.305 for the medically needy Special Medical Needs Adoption Assistance requirements.

3. In ICF or ICF-MR

Children under age 21 who are patients *in either an ICF or ICF-MR meet the classification of "individuals in an ICF or ICF-MR" in the Individual Under Age 21* covered group.

C. Assistance Unit

1. *Non-IV-E* Foster Care Children (Includes DJJ)

The child is an assistance unit of one effective the date the child is removed from the home and placed in foster care. Each child in foster care is evaluated as a separate assistance unit, even if the child is living with his/her siblings in a foster care home.

A foster care *or DJJ* child continues to be a single person unit during a trial visit *in his own home*. A "trial visit" is no longer than *six* months for this section's purposes.

2. Adoptive Placement

While in adoptive placement, the child may continue to be treated as a foster care child. However, once the interlocutory or the final order of adoption is entered, the child must be treated as a Non-IV-E adoption assistance child; see 3. below.

3. *Non-IV-E Adoption Assistance-Interlocutory or Final Order Entered*

Financial eligibility is determined using the assistance unit procedures in *sub*chapter M0520, which require the inclusion of the child's adoptive parent(s) *and sibling(s). An adoption assistance child must have his/her eligibility determined by counting or deeming (as appropriate) his/her parent's and sibling's income.*

4. *Child in ICF or ICF-MR*

A child in an ICF or an ICF-MR is an institutionalized individual in a medical facility when he meets the definition of "institutionalized individual" in section M1410.010 B.2. When he meets the institutionalized individual definition, he is an assistance unit of one person.

D. Resources

The resource limit and requirements are found in chapter M06.

If the resources exceed the limit, the child is not eligible for Medicaid. If the child is under age 19, determine the child's eligibility as *FAMIS Plus* because that classification has no resource limits.

***E.* Income**

The *MN* income requirements are found in *sub*chapter M07*10*.

1. Income Limits

For the MN Individuals Under Age 21 covered group, the income limit *is the medically needy income limit* found in chapter M07*10, Appendix 5*.

The foster care or adoption subsidy payment is excluded when determining the unit's income eligibility.

Foster care or adoption assistance children in residential facilities do not have a different income limit. For a foster care/adoption assistance child living outside the State of Virginia, the MN income limit for the unit is the income limit for the Virginia locality which holds custody, pays the adoption subsidy, or signed the adoption assistance agreement.

2. Income Exceeds MN Income Limit

If the unit's resources are within the medically needy limit, but the income exceeds the medically needy income limit, the unit is placed on a spenddown. All medical expenses of the unit members are used to meet the spenddown. Once the spenddown is met, only the child and family members who meet an MN covered group *and who applied for Medicaid* are enrolled in Medicaid.

***F.* Entitlement & Enrollment**

1. Entitlement

Entitlement to Medicaid begins the first day of the month in which the Medicaid application is filed, if all eligibility factors are met in that month. If the individual is eligible after meeting a spenddown, entitlement begins the date the spenddown was met and ends after the last day of the spenddown period.

Retroactive entitlement, up to three months prior to application, is applicable if all Medicaid eligibility criteria were met during the retroactive period.

2. Enrollment

The *aid category* for *medically needy* individuals in *the MN* covered group of *Individuals Under Age 21* are:

- *0*86 for an *MN* Non-IV-E foster care, *MN* Non-IV-E adoption assistance,
- *0*85 for an *MN* Juvenile Justice Department child;
- *0*98 for an *MN* child under age 21 in *an ICF* or ICF-MR.

M0330.305 SPECIAL MEDICAL NEEDS ADOPTION ASSISTANCE

A. Policy

42 CFR 435.308(b) - A state may choose to provide medically needy coverage to a child under age 21 years

- for whom a non-IV-E adoption assistance agreement between the state and the adoptive parent(s) is in effect;
- who cannot be placed with adoptive parents without Medicaid because the child has special needs for medical or rehabilitative care; and
- who was enrolled in Medicaid under any covered group before the adoption assistance agreement was entered into OR who would have been eligible for Medicaid before the adoption assistance agreement was entered into if the eligibility requirements and standards of the IV-E foster care program were used, without employing the threshold title IV-A eligibility determination.

If the child was not enrolled in Medicaid and would not have been eligible for Medicaid prior to the adoption assistance agreement being entered into, the child is **not** eligible for Medicaid in the MN covered group of "special medical needs adoption assistance children." *The child may be eligible in the MN Non-IV-E Adoption Assistance classification of Individuals Under Age 21 in section M0330.304.*

B. Nonfinancial Eligibility

The child must

- be under age 21,
- meet the "special medical needs" adoption assistance definition in M0310.102, and
- meet the nonfinancial requirements in chapter M02.

C. Financial Eligibility

1. Assistance Unit

The assistance unit consists of only the child if the child was eligible for Medicaid prior to the *special medical needs* adoption assistance agreement being entered into. The adoptive parent(s)' income and resources are **not** counted or deemed; only the *Special Medical Needs* adoption assistance child's own income and resources are counted.

A child in an ICF or an ICF-MR is an institutionalized individual in a medical facility when he meets the definition of "institutionalized individual" in section M1410.010 B.2. When he meets the institutionalized individual definition, he is an assistance unit of one person. The child's eligibility is determined in the CNNMP F&C 300% SSI covered group in M0320.309.

2. Asset Transfer

The asset transfer rules *apply to an institutionalized* child. *See subchapter* M1450.

3. Resources

The resource limits and requirements are found in chapter M06.

If the resources exceed the limit, the child is not eligible for Medicaid *as medically needy*. If the child is under age 19, determine the child's eligibility as F&C medically indigent because that classification has no resource limits.

4. Income

Adoption assistance children in residential facilities do not have a different income limit. The MN income limit for one person in the child's locality is used to determine the child's MN eligibility. For an adoption assistance child living outside the State of Virginia, the income limit for the child is the income limit for the Virginia locality which signed the adoption assistance agreement.

The adoption subsidy payment is excluded when determining the child's financial eligibility.

If the child's countable income exceeds the MN income limit, the child is placed on a spenddown. Only the child's medical expenses are used to meet the spenddown. Once the spenddown is met, the special medical needs adoption assistance child is enrolled in Medicaid.

D. Entitlement & Enrollment

Eligible individuals in this MN group are entitled to full Medicaid coverage beginning the first day of the individual's application month if all eligibility requirements are met in that month. Individuals who become eligible after meeting a spenddown are entitled to full Medicaid coverage beginning the day the spenddown was met and ending the last day of the sixth month in the spenddown period. Retroactive coverage is applicable to this covered group.

The *AC* for individuals in the MN covered group of special medical needs adoption assistance children is "086."

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CHAPTER M05
MEDICAID ASSISTANCE UNIT
SUBCHAPTER 10

GENERALS RULES AND PROCEDURES

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M0510.000 GENERAL RULES & PROCEDURES

M0510.001 ASSISTANCE UNIT GENERAL PRINCIPLES

A. Introduction

Medicaid is an assistance program which pays medical service providers for services rendered to eligible needy individuals. An individual's need is based on his financial eligibility--the amount of his resources and income.

Financial eligibility is determined in relation to specific resource and income limits. The income and resource limits are established in relation to the number of persons in the assistance unit. The assistance unit is the basis for the financial eligibility determination. Eligibility is based on the countable income and resources of the assistance unit members and of legally responsible relatives who are not included in the assistance unit and who live in the home. All of the resources and income which the individual has available to him, including resources and income "deemed" to be available to him, are counted.

B. Procedure

This subchapter contains the general policy and procedure for determining the individual's assistance unit for the financial eligibility determination.

- The Legal Base is contained in M0510.002;
- Definitions are contained in M0510.100;
- General Procedures are contained in M0510.200.

The detailed family/budget unit policy and procedures for individuals in an F&C covered group are contained in M0520. The detailed assistance unit policy and procedures for individuals in an ABD covered group are contained in M0530.

M0510.002 LEGAL BASE

A. Federal Law

The federal Medicaid law in Title XIX, section 1902(a)(17)(D), requires that a state plan for medical assistance include reasonable standards for determining eligibility for and the extent of medical assistance under the state plan. These standards must provide for reasonable evaluation of resources and income. The standards must:

- take into account only such income and resources as are available to the applicant or recipient;
- take into account only such income and resources as would not be disregarded under the Supplemental Security Income (SSI) program for aged, blind and disabled individuals, or the title IV-A program (AFDC program in effect on 7-16-96) for all other individuals;

- NOT take into account the financial responsibility of any individual for any applicant or recipient of assistance under the plan unless such applicant or recipient is such individual's spouse or such individual's child who is under age 21.

B. Federal Regulations

Federal regulations in 42 CFR 435.601 state that when determining Medicaid eligibility, the agency must apply the financial methodologies and requirements of the cash assistance program that is most closely categorically related to the individual's covered group, EXCEPT:

- when determining the financial responsibility of relatives, and
- when using more restrictive or more liberal resource methodologies than those of the cash assistance program, as specified in the state plan.

Federal regulations in 42 CFR 435.602 state that, except for a spouse of an individual or a parent for a child who is under age 21, the agency must not consider income and resources of any relative as available to an individual.

C. Virginia Medicaid Policy

When determining whose resources and income to count available to the individual applicant or recipient, Medicaid must take into account the resources and income of the individual's spouse or parent (if the individual is under age 21) with whom the individual lives. For the aged, blind and disabled (ABD) covered groups, Medicaid must use the SSI program methods for counting and "deeming" spouses' and parents' resources and income to an individual, except where they would result in "illegal" deeming of resources or income from a relative or person who is not legally responsible for the individual according to the federal Medicaid regulations. For the Families & Children (F&C) covered groups, Medicaid must use the 7-16-96 AFDC program methods for counting and "deeming" spouses' and parents' resources and income to an individual, except where they would result in "illegal" deeming of resources or income from a relative or person who is not legally responsible for the individual according to the federal Medicaid regulations.

Subchapter M0520 explains how to count the resources and income of a spouse or parent for the F&C covered groups. Subchapter M0530 explains how to count the resources and income of a spouse or parent for the ABD covered groups.

M0510.100 DEFINITIONS

A. Introduction

The terms used in this subchapter are defined below in this section.

B. Assistance Unit

The Medicaid assistance unit is the individual or family who applies for Medicaid and whose financial eligibility is determined. The assistance unit

for the Families & Children (F&C) covered groups is called the "family unit" or the "budget unit."

The assistance unit for an ABD individual is just the individual, unless the individual is married, living with his/her spouse and the spouse is also ABD. In this situation, the assistance unit is the married ABD couple.

C. Budget Unit

The budget unit (BU) is the term used for the assistance unit for F&C individuals in a family when specific circumstances exist. The BU is a sub-unit of the family unit (FU). It contains some, but not all, members of the family unit.

D. Family Unit

The family unit is the name for the assistance unit when determining eligibility for an F&C individual or family. The family unit consists of all individuals listed on the application form as living in the household and among whom legal responsibility for support exists.

Federal Medicaid law and regulations prohibit deeming resources or income from anyone other than a parent to a child under age 21 or from spouse to a spouse. An individual cannot be ineligible or have his spenddown liability increased because of counting income and resources of non-legally responsible individuals living in the household.

The family unit must be further divided into "budget units" when the family unit does not meet the resource or income limit, and

- the family unit contains a stepparent, an acknowledged father not married to the mother, a married Medicaid minor or a Medicaid minor parent in the home, or
- a child in the family unit has resources or income of his/her own.

The unit must include the legally responsible relative(s) with whom the individual lives (parent for child under age 21 and spouse for spouse) unless the spouse or the parent receives an SSI or IV-E foster care/adoption subsidy payment. Spouse refers to a person who would be defined as married to the individual under applicable state law. Parent refers to the natural or adoptive parent of the child.

E. Deeming

Deeming is the process of considering the income and resources of another person, who is not included in the assistance, family or budget unit, to be the income and resources of the individual who is applying for or receiving Medicaid. Deemed income and resources are counted available to the eligible individual whether or not they are actually made available to him/her.

The federal Medicaid regulations require that the income and resources of certain individuals other than the applicant be included (deemed available) when determining an individual's Medicaid eligibility. These individuals

are the individual's responsible relatives--the individual's parent when the individual is under age 21 and the individual's spouse, except when the parent or spouse receives SSI or IV-E assistance payments. Except for a spouse of an individual, or a parent for a child who is under age 21, the agency must not consider resources and income of any relative as available to an individual.

Resources and income deemed **to** an individual are not considered resources or income in subsequent deeming calculations of the individual's resources or income.

F. Deemor

A deemor is an individual whose income and resources are subject to deeming. Such individuals include ineligible parents and ineligible spouses. It does not matter whether these individuals have sufficient income or resources to deem, they are still considered to be deemors. The type of income such an individual receives (e.g., public income maintenance payments such as TANF, VA pension based on need, etc.) does not exclude him/her from this definition for an ABD determination. For F&C determinations, recipients of SSI or IV-E payments are NOT deemors.

G. Illegal Deeming

Illegal deeming is a procedure which results in counting or deeming resources or income to an individual from a person who is not the individual's spouse, or who is not the individual's parent if the individual is under age 21.

M0510.200 GENERAL PROCEDURES

A. Introduction

This section contains the general policy and procedure for determining the individual's assistance unit for the financial eligibility determination.

B. Institutionalized Individuals

When an individual is institutionalized in a medical facility or Medicaid waiver services, the individual is an assistance unit of one person. *Go to chapter M14 to determine eligibility for institutionalized individuals.*

C. Non Institutionalized Individuals

1. Child Under Age 19

a. Does Not Receive SSI

Determine the child's F&C MI eligibility first (if pregnant, use the 133% pregnant woman limits), even if child is also foster care or adoption assistance. If the child has excess income for MI, then determine the child's MN eligibility for spenddown. Use the F&C family/budget unit policy in M0520.

If the child is also blind or disabled and does NOT receive SSI, determine F&C MI eligibility first. Use the F&C family/budget unit policy in

M0520. If the child has excess income for MI, then determine the child's ABD MN eligibility for spenddown, using the ABD assistance unit policy in M0530.

b. Receives SSI

If the child receives SSI, determine the child's eligibility as an SSI recipient. If the child is not eligible for Medicaid as an SSI recipient, e.g., because of excess resources, determine the child's eligibility as F&C if the child is pregnant or under age 19. Use the F&C family/budget unit policy in M0520.

2. Individual Age 19 but Under 21

a. Receives SSI

If the child is age 19 or 20 and is not eligible for Medicaid as an SSI recipient, e.g., because of excess resources, determine his/her F&C eligibility IF he/she also meets an F&C covered group because the F&C real property requirements are different from the ABD requirements. Use the F&C family/budget unit policy in M0520.

If he/she does NOT meet an F&C covered group, he/she is not eligible for Medicaid.

b. Disabled or Blind Child

If the child is disabled or blind, first determine the child's ABD eligibility using the ABD assistance unit policy in M0530. If not eligible as ABD and the child meets an F&C covered group, use the F&C family/budget unit policy in M0520.

c. Pregnant Woman

If the individual is pregnant, determine F&C MI eligibility first. Use the family/budget unit policy in M0520. If the individual is not eligible as MI, she should meet the MN pregnant woman group. Use the F&C family/budget unit policy in M0520 when determining her MN eligibility.

3. Individual Age 21 and Older

a. Pregnant Woman

If the individual is pregnant, determine F&C MI eligibility first. Use the family/budget unit policy in M0520. If the individual is not eligible as MI, she should meet the MN pregnant woman group. Use the F&C family/budget unit policy in M0520 when determining her MN eligibility.

b. Other Individuals

If the individual is aged, disabled or blind, first determine the individual's ABD assistance unit in M0530. If the individual is not eligible as ABD and he/she meets an F&C covered group, use the F&C family/budget unit policy in M0520.

CHAPTER M05
MEDICAID ASSISTANCE UNIT
SUBCHAPTER 20

FAMILIES & CHILDREN (F&C) FAMILY/BUDGET UNIT

M0520 Changes

Changed With	Effective Date	Pages Changed
Update (UP) #4	07/01/10	pages 2, 2a

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M0520.000 FAMILIES & CHILDREN (F&C) FAMILY/BUDGET UNIT

M0520.001 OVERVIEW

A. Introduction

This subchapter contains the policy and procedures for determining the assistance unit for an individual or family who meets a Families & Children (F&C) covered group. For F&C financial eligibility determination purposes, the assistance unit is called the "family/budget" unit. A household is divided into one or more family units.

The family unit's financial eligibility is determined first. If the family unit has resources or income that cannot be verified or that exceeds the limit for the individual's covered group, the family unit is divided into "budget" units if certain requirements are met.

B. Policy

Medicaid law prohibits the consideration of resources and income of any person other than a spouse or parent in the final Medicaid eligibility determination. Resources and income CANNOT be counted

- from a stepparent to a stepchild;
- from a sibling to a sibling;
- from a child to a parent;
- from a spouse or parent living apart from the individual, unless it is a voluntary or court-ordered or DCSE-ordered contribution (exception for individuals in long-term care);
- from an alien sponsor to the alien.

The family unit will include any child(ren) under age 21 living in the home for whom a unit member is legally responsible regardless of whether or not the child(ren) meet(s) a covered group, unless the child is specifically excluded.

1. Member In One Unit

An applicant/recipient can be a member of only one family unit or one budget unit at a time.

2. May Exclude A Child

The applicant can choose to exclude any child(ren) from the family unit for any reason. If the parent wants to exclude a child who has been listed on the application, the request for exclusion must be in writing. None of the excluded child's needs are considered, and none of his income or resources are counted or deemed available to the unit. The advantages and disadvantages of the choice must be explained to the applicant or recipient.

3. Living Away From Home

A parent, or a child under age 21 who has not been emancipated, is considered living in the household for family unit composition purposes if the absence is temporary and the parent or child intends to return to the home when the purpose of the absence (such as employment, military service, education, rehabilitation, medical care, vacation, visit) is completed.

Children living in foster homes institutions are NOT temporarily absent from home. They are indefinitely absent from home and are NOT living with their parents or siblings for Medicaid purposes.

4. Psychiatric Residential Treatment Facilities

a. Children Living in a Psychiatric Residential Treatment Facility

Children placed in psychiatric residential treatment facilities are considered absent from their home if their stay in the facility has been **30** days or more. A child who is placed in a psychiatric residential treatment facility is considered NOT living with his parents for Medicaid eligibility purposes as of the first day of the month in which the 30th day of psychiatric residential placement occurs. Long-term care rules do not apply to these children.

b. Children's Mental Health Program Services Received After Discharge From Psychiatric Residential Treatment Facility

*Children who receive Medicaid-covered treatment in a psychiatric residential treatment facility **may** receive a special benefit package through the Children's Mental Health Program following discharge from the facility. Effective July 1, 2010, children who receive Children's Mental Health Program services after discharge from a psychiatric residential treatment facility continue to be eligible for Medicaid without the need for an eligibility review. When determining the Medicaid eligibility of these children, each child is considered an assistance unit of one (1) as long as the child continues to receive Children's Mental Health Program Services.*

See section M1520.100 E for documentation required for children who receive Children's Mental Health Program services in their own homes after discharge from the psychiatric residential treatment facility.

5. Medical Facilities

Children in medical institutions (facilities) are temporarily absent from home if their stay in the medical facility is less than 30 consecutive days. If the stay has been, or is expected to be, 30 or more consecutive days, go to section M1410.010 to determine if the child is institutionalized in long-term care. A child who is institutionalized in a medical facility or Medicaid waiver services is NOT considered living with his or her parents for Medicaid eligibility purposes.

C. Procedure

This section contains an overview of the F&C family unit and budget unit rules. The detailed policy and procedures are contained in the following sections:

- M0520.010 Definitions;
- M0520.100 Family Unit Rules;
- M0520.200 Budget Unit Rules;
- M0520.300 Deeming From Spouse;
- M0520.400 Deeming From Parent;
- M0520.500 Changes In Status;
- M0520.600 Pregnant Woman Budget Unit;
- M0520.700 Individual Under Age 21 Family Unit.

M0520.010 DEFINITIONS

A. Introduction

This section contains definitions of the terms used in the F&C family/budget unit policy and procedures.

B. Acknowledged Father

In Virginia, a man who is legally married to the mother of a child on the child's date of birth is considered to be the legal father of the child **UNLESS** another man has been determined by DCSE or a court to be the child's father. The man listed on the application form as the child's father is considered to be the child's acknowledged father when:

- the mother was not married to another man on the child's birth date, or

- the mother was married to another man on the child's birth date but DCSE or a court determined that the man listed on the application is the child's father,

unless documentation, such as the child's birth certificate, shows that another man is the child's father.

NOTE: Her declaration on the application of the child's father's name is sufficient unless there is evidence that contradicts the application. The mother's marital status at the time of the child's birth does not require verification; her declaration of her marital status is sufficient. See M0310.123 for the definition of a parent.

C. Household

For this subchapter's purposes, the "household" is everyone living in the residence and who is listed on the Application for Benefits as living in the residence.

D. Legal Emancipation

"Legal emancipation" from parents means that the parents and child have gone through court and a judge has declared that the parents have surrendered the right to the care, custody and earnings of the child and have renounced parental duties.

A married Medicaid minor is NOT emancipated unless a court has declared the married minor emancipated from his or her parent(s).

E. Legally Responsible Relative

A legally responsible relative is a person who is related to the individual applicant or recipient and who has a legal obligation under federal and state law to support the individual applicant/recipient.

Under federal Medicaid law and regulations, the only relatives who are legally responsible relatives are the following relative(s) with whom the individual applicant or recipient lives:

- the individual's spouse, and
- the individual 's parent if the individual is a child under age 21 years.

F. Medicaid Minor

A child under age 21 years is a Medicaid minor.

M0520.100 FAMILY UNIT RULES

A. Introduction

This section contains the rules that apply to the family unit within a household applying for Medicaid. The family unit consists of the individuals in the household among whom legal responsibility for support exists. A parent or non-parent caretaker can choose to exclude any child from the family unit by excluding the child from the Medicaid application (see M0520.001 B).

B. Family Unit Composition

When determining composition of the F&C family unit, start with the individual who applies for Medicaid and who meets an F&C covered group's requirements. These covered groups are:

- Pregnant women (MI and MN);
- Low income families with children (LIFC) (CNNMP);
- Newborn children (MI and MN);
- Children under age 19 (MI);

- Children under age 18 (MN);
- Individuals < 21 in foster care, adoption assistance, and ICF or an ICF-MR (CNNMP and MN).

Begin forming the family unit(s) by identifying a pregnant woman in the household, if any. If the household does not contain a pregnant woman, begin forming the family unit(s) by identifying the child(ren) who meets an F&C covered group.

1. Member In One Unit At A Time

An applicant/recipient*'s Medicaid eligibility can only be determined in* one F&C family unit at a time.

2. Include Responsible Relative(s)

The unit must include the legally responsible relative(s) with whom the individual lives (parent for child under age 21 and spouse for spouse), EXCEPT when:

- the child is in foster care and is placed in his/her home for a trial visit; or

- the spouse or the parent receives an SSI or IV-E foster care/adoption subsidy payment. Do not include SSI and IV-E Foster Care/Adoption Assistance recipients in the unit.

Include a TANF recipient who is a responsible relative in the unit but **do not count the TANF grant as income**. Non-TANF income is counted as income to the unit.

The unit must also include all individuals in the household for whom each individual in the unit is legally responsible except

- excluded individuals;
- SSI recipients, and
- IV-E recipients.

For example, a child age 10 lives with his mother and his 5 year-old sister who receives SSI; all are included on the application. The family unit consists of the 10 year old child and his mother who is legally responsible for him, but not his SSI recipient sister even though the mother is also legally responsible for her.

3. Child Under 21 Living Away From Home

A child under age 21 who is living away from home is considered living with his/her parent(s) in the household for family unit composition purposes if:

- the child is not emancipated, and

- the absence is temporary and the child intends to return to the parent's home when the purpose of the absence (such as education, rehabilitation, medical care, vacation, visit) is completed.

Children in medical institutions (facilities) are temporarily absent from home if their stay in the medical facility is less than 30 consecutive days. If the stay has been, or is expected to be, 30 or more consecutive days, go to section M1410.010 to determine if the child is institutionalized in long-term care. A child who is institutionalized in a medical facility or Medicaid waiver services is NOT considered living with his parents for Medicaid eligibility purposes.

Children placed in *psychiatric* residential treatment facilities are considered absent from their home if their stay in the *psychiatric* residential *treatment* facility has been 30 days or more. A child who is placed in a *psychiatric* residential facility is considered NOT living with his parents for Medicaid eligibility purposes as of the first day of the month in which the 30th day of *psychiatric* residential placement occurs. Long-term care rules do not apply to these children.

4. Pregnant Woman

An individual who meets the pregnant woman definition is counted as at least **two persons** when her eligibility is being determined in the MI Pregnant Woman or MN Pregnant Woman covered group. The unborn child (or children, if medical documentation verifies more than one fetus) must be included in the unit with the pregnant woman when determining her eligibility. A separate calculation is required for the other family unit members who do not meet a pregnant woman covered group. This calculation does NOT include the unborn child(ren) as part of the family unit and/or budget unit (BU).

When an individual is pregnant but her eligibility is determined in a covered group other than MI or MN Pregnant Woman, such as blind, disabled or Low Income Families with Children (LIFC), the pregnant woman is counted as just one person.

5. Cohabitant

A cohabitant is not the child(ren)'s parent and is not legally responsible for anyone in the family unit. Therefore, the cohabitant is not included in the family unit. Do not count a cohabitant's income or resources.

C. Examples

1. Household With Excluded Child

EXAMPLE #1: Household listed on application consists of applicant, her disabled spouse, her 15-year old son, and husband's 20-year old daughter. The 20-year old daughter is employed full-time. Medicaid is requested for applicant, her spouse, and her son. She specifies in writing that she wishes to exclude her husband's 20-year old daughter. The family unit consists of:

- the applicant
- her husband, and
- her 15-year old son.

The family unit's income is determined using the F&C income policy and procedures.

2. Household With Acknowledged Father

EXAMPLE #2: Household listed on the Medicaid application consists of pregnant woman applicant, her 5-year old son and her boyfriend, who is the acknowledged father of the 5-year old. They all request Medicaid.

The family unit for the Medicaid eligibility determination for the 5-year old child, and the acknowledged father consists of:

- the woman,
- the 5-year old child and
- the child's acknowledged father.

The family unit for the Medicaid eligibility determination for the pregnant woman consists of:

- the pregnant woman,
- her unborn child,
- the 5-year old child, and
- the child's acknowledged father.

The family unit's income is determined using the F&C income policy and procedures.

M0520.101 MULTIPLE FAMILY UNITS

A. Policy

Multiple family units exist in a household in the following situations:

1. Non-parent Caretaker

When the individual is applying for Medicaid as a non-parent caretaker of a dependent child, multiple family units exist.

2. EWB (Essential to the Well-Being)

When the individual is applying for Medicaid as an individual who is EWB to family with a dependent child, multiple family units exist.

3. Child--No Responsible Relative In Home

When the individual applying is a child under age 21 but has no responsible relative living in the household and is not a sibling of another child(ren) in the household, multiple family units exist.

4. Adult--No Responsible Relative In Home

When the individual applying is age 21 or older and is not legally responsible for the other applicant(s) in the household, multiple family units exist.

5. Foster Care Child

When the individual applying is a foster care child whose parent(s) live in the household and who is placed in his/her home for a trial visit (see M0520.701 below), multiple family units exist.

6. Siblings

Siblings under age 21 are included in the same family unit.

7. SSI Child

A child receiving SSI is always a separate family unit of one person.

B. Procedures

When an applicant applies for a child in the household, begin forming the family unit by identifying the child(ren) who applies and meets an F&C covered group. Divide the household into multiple family units when:

- the household contains an individual(s) who applies for Medicaid but who is not a legally responsible relative of the other individual(s) who has applied; or
- the household contains a foster care child under age 21 who is placed in the home for a trial visit.

Each family unit must contain only those individuals among whom legal responsibility for *financial* support exists.

M0520.102 NON-PARENT CARETAKER IN HOUSEHOLD

A. Policy

An individual who is not the parent of a dependent child who lives in the household, but who meets the definition of a caretaker-relative (subchapter M0310) is called a "non-parent caretaker." Only one **non-parent** caretaker in a household can meet the LIFC covered group. An individual cannot meet the caretaker-relative definition when the child's parent lives in the household.

A non-parent caretaker is in a family unit that is separate from the dependent child(ren) for whom the individual is a caretaker-relative.

B. Family Unit Composition

To determine the non-parent caretaker-relative's family unit, identify the non-parent caretaker-relative who requests Medicaid and meets the LIFC covered group. Include the caretaker-relative's spouse and/or the caretaker-relative's children under age 21 who live in the household in the family unit with the non-parent caretaker-relative. The dependent child(ren) is in a separate family unit.

C. Determine Income Eligibility

Add together all of the countable income received by the members of the non-parent caretaker-relative's family unit. Compare the total countable income to the LIFC 185% and F&C 90% income limits.

If the family unit's income is within the F&C 185% and the 90% limits, the non-parent caretaker-relative is eligible as LIFC. Also, the children under age 18 (or under age 19 if in school) and the spouse in the non-parent caretaker-relative's family unit are eligible regardless of her status as a non-parent caretaker-relative of another child, because her family unit meets the LIFC covered group.

If the family unit's income exceeds the LIFC income limits, determine if the family unit can be broken into BUs units to test the BUs' income against the LIFC limits. See M0520.200 below. If the family unit cannot be broken into BUs, the non-parent caretaker-relative is not eligible for Medicaid as LIFC because of excess income.

D. Examples--Non-Parent Caretaker-Relative Family Units

EXAMPLE #3: Household listed on application consists of applicant (aunt), her 10-year old niece, and her 8-year old nephew, who is not a sibling of the niece. She requests Medicaid for herself and the children.

The household consists of three family units:

1. the 8-year old nephew, who has no legally responsible relatives or siblings living in the household;

2. the *10-year old* niece, who has no legally responsible relatives or siblings living in the household; and

3. the aunt.

The financial eligibility for each family unit is determined using F&C financial policy and procedures and comparing the result to the limits for the covered group(s) for which eligibility is being determined. If each child's countable income is within the MI child income limits for an assistance unit of 1, each child is income eligible. If the aunt's countable income is within the F&C limits for the locality, the aunt is income eligible for the LIFC covered group.

EXAMPLE #4: Household listed on application consists of woman applicant (aunt), her husband (uncle), their 15-year old son, their 10-year-old niece, and their 8-year old nephew who is not a sibling of the niece. They all request Medicaid.

The household consists of three family units:

1. the 8-year old nephew, who has no legally responsible relatives or siblings living in the household;

2. the 10-year old niece, who has no legally responsible relatives or siblings living in the household; and

3. the aunt, uncle, and their son.

The financial eligibility for each family unit is determined using F&C financial policy and procedures and comparing the result to the limits for the covered group(s) for which eligibility is being determined. If the nephew's and niece's countable income is within the MI child income limits for an assistance unit of 1, each child is income eligible. If the aunt, uncle, and their son's countable income is within the F&C limits for the locality, the aunt, uncle, and their son are income eligible for the LIFC covered group. Their son is also income eligible for the MI child covered group.

M0520.103 EWB IN HOUSEHOLD

A. Policy

When the household includes an individual who applies for Medicaid who meets the definition of an EWB in subchapter M0310, and the person to whom the EWB provides essential services meets the nonfinancial and income requirements for Medicaid in the LIFC covered group, the EWB is in a separate family unit. An EWB does not exist if the family to whom he/she provides essential services is not eligible for Medicaid as LIFC.

The EWB's financial eligibility for Medicaid is determined by using the income of the EWB's family unit members only. The income of the individual to whom he/she is providing essential services is NOT counted because that individual is not legally responsible for the EWB, nor is the EWB legally responsible for the individual.

B. Family Unit Composition

To determine the EWB's family unit, start with the EWB who requests Medicaid and meets the LIFC covered group as an EWB. Include the EWB's spouse and/or the EWB's children under age 21 who live in the household. The dependent child(ren) and the caretaker for whom the EWB is providing essential services are in a separate family unit(s).

C. Determine Income Eligibility

Add together all of the countable income received by the members of the EWB's family unit. Compare the total countable income to the LIFC 185% and F&C 90% income limits.

If the EWB's family unit's income is within the F&C 185% and 90% limits, the EWB is eligible as LIFC, if the family to whom the EWB provides essential services is eligible as LIFC.

If the EWB's family unit's income exceeds the LIFC limit, determine if the family unit can be broken into BUs to test the BUs' income against the limits. See M0520.200 below. If the EWB's family unit cannot be broken into BUs, the EWB is not eligible for Medicaid as LIFC because of excess income.

D. Example--EWB In Household

EXAMPLE #5: Household listed on application consists of an applicant mother, her 6-year old son and her 20-year old niece. They all request Medicaid. Her niece takes care of her son while the mother works. The niece meets the definition of an EWB because she provides child care which enables the mother to work full time.

Because the niece is an EWB, the household contains multiple family units:

1. the 6-year old son and his mother; and

2. the EWB niece, who has no legally responsible relatives in the household.

The mother and son's family unit's income is determined using the F&C income policy and procedures. If their countable income is within the MI income limit for 2 persons, the son is eligible in the MI child covered group. If their countable income is **within** the LIFC income limit for 2 persons, the mother is eligible for Medicaid as LIFC, and her niece meets the LIFC covered group as an EWB. Because the niece has no income, she is eligible for Medicaid as an LIFC EWB.

If the mother's family unit income **exceeds** the LIFC limit, the mother is not eligible for Medicaid because of excess income. She cannot be placed on a spenddown because she does not meet a medically needy covered group. The niece is not eligible for Medicaid because the mother is not eligible as LIFC and the niece does not meet a Medicaid covered group.

M0520.200 BUDGET UNIT RULES

A. Policy

BUs are formed to assure that only the individual's resources and income and the resources and income of those persons legally responsible for the individual are used to determine the individual's Medicaid financial eligibility. If the individual's family unit has resources or income which cannot be verified or which exceed the limit for the individual's covered group, determine if the family unit can be broken into BU. Forming BUs based on resources is only applicable to the F&C MN covered groups. A family unit must be broken into BUs when:

1. a child in the family unit has his/her own income;

2. a child in the family unit has his/her own resources (applicable only for F&C MN covered groups);

3. the child's stepparent is in the family unit;

4. the child's parent with whom he/she lives is a Medicaid minor (under age 21) and they live with the minor parent's parent(s);

5. the child is married and living with his/her spouse and his/her parent(s);

6. the child(ren)'s acknowledged father lives in the household and is not married to the child(ren)'s mother.

All members of a family unit must be placed in a BU when the family unit can be divided into BUs. Although they will be included in a BU, persons found eligible at the family unit level do NOT have their eligibility redetermined at the BU level.

B. Budget Unit Rules The rules that apply to BU composition are:

1. Member In One Unit An applicant/recipient can be a member of only one F&C BU.

2. Children With Own Resources *(F&C MN Only)* or Income The child(ren) with his or her own resources or income is in a separate BU. Deem resources and income from parents. *Resources are deemed and/or counted only when determining eligibility for F&C MN covered groups.*

The parent(s) is/are included in the unit with child(ren) who has no resources or income.

If all of the children have resources or income, the parent(s) is/are in a separate BU. If there is more than one child with resources or income, the resources or income deemed from the parents are divided evenly among the children.

3. Medicaid Minor Caretaker Applicant When the Medicaid minor parent is not married and lives with his/her parent(s), he or she is included in a BU with his/her parent(s), NOT with his or her child(ren).

When the Medicaid minor parent is married and lives with his/her parent(s) and spouse, he or she is in a BU by himself/herself, NOT with his/her parent(s) and NOT with his or her child(ren) and spouse.

A married Medicaid minor parent is in a separate BU when living with his/her spouse and the minor's parent(s).

4. Married Medicaid Minor When the Medicaid minor is married and lives with his/her parent(s) and spouse, he or she is in a BU by himself/herself, NOT with his/her parent(s) and NOT with his or her child(ren) and spouse. A married Medicaid minor is in a separate BU when living with his/her spouse and the minor's parent(s).

5. Stepparent In Household *A stepparent is not included in a BU with his/her stepchild(ren).* A married parent **(except a Medicaid minor parent who lives with his/her parents)** is included in a BU with his/her spouse and their child(ren)-in-common. The parent's other child(ren) who are not the child(ren) of his/her spouse are in a separate BU.

6. Deeming From Parents When determining how much of the child's parent's income or *resources* are deemed available to the child's BU, any income or *resources* deemed to the parent from the parent's spouse who is not the child's parent, is NOT counted in the deeming calculation.

No income or resources deemed from the parent(s) of a minor child are deemed to the minor child's spouse or the minor's child.

7. Acknowledged Father An acknowledged father who lives in the household and is not married to the child(ren)'s mother is in a BU separate from the mother. Their child(ren)-in-common is NOT included in the BU with the father; the child(ren)-in-common is in a separate BU.

8. Spenddown Expenses

If a BU is ineligible because of excess income, only the unit's member's medical expenses will count toward the unit's spenddown, unless a BU member is legally liable to pay the medical expenses of another person in the household, whether or not that other person is in another Medicaid BU. If a BU member is legally liable for another person in the household, the other person's medical bills can count toward the BU member's spenddown.

A medical expense can only be used once to meet only one unit's spenddown. A child's medical expenses are first deducted from the child's unit. If the child's unit spenddown is not met, the child's medical expenses can be deducted from the parent's spenddown. If the child's unit's spenddown is met, then the child's medical expenses that were not used to meet the child's spenddown can be deducted from the parent's spenddown, if the medical expenses are not covered by Medicaid or other health insurance.

M0520.201 CHILD(REN) WITH RESOURCES AND/OR INCOME

A. Policy

The child(ren) with his or her own resources *(F&C MN covered groups only)* or income is in a separate BU. *Forming BUs based on resources is only applicable to F&C MN covered groups.* Deem income and resources from the parents *if the child is living with the parents;* and from the child's spouse if the child is married and living with the spouse.

B. *Forming Budget Units*

Place the child who has his/her own resources or income in a BU by himself.

EXAMPLE #6: Household listed on application consists of woman applicant, her disabled spouse, their 15-year old son, and their 20-year old daughter. *They all request Medicaid*.

The family unit consists of:

- the mother,
- her husband, and
- their two children under age 21.

The family unit's LIFC income is then determined using the F&C income policy and procedures.

Because the family unit's income exceeds the LIFC income limit for 4 persons and the son *receives unearned income from a trust fund, the* family unit is broken into BUs:

- BU *#1 = son*
- BU *#2 = mother, her husband, and their daughter*

The parent's BU's countable income is calculated to determine the parents' eligibility as LIFC and to determine how much income is deemed to the son's BU. *The parent's deemed income is added to the son's income to determine the son's BU's countable income for eligibility in the MI child covered group.*

M0520.202 MARRIED MEDICAID MINOR OR MEDICAID MINOR CARETAKER LIVING WITH PARENT

A. Policy

The Medicaid minor parent (caretaker) is included in a BU with his/her parent(s), NOT with his or her child(ren), unless the Medicaid minor caretaker has resources *(F&C MN covered groups only)* or income of his/her own, or is married and living with his/her spouse.

If the Medicaid minor parent (caretaker) has resources or income, or is married and living with a parent(s)and his/her spouse, place the Medicaid minor caretaker in a BU by himself/herself and deem the parents' resources and income (and the spouse's resources and income, when the Medicaid minor caretaker is married and living with his/her spouse) to the Medicaid minor caretaker.

B. Forming Budget Units

1. Medicaid Minor Caretaker

Place the Medicaid minor parent caretaker in a BU with his/her parents when the Medicaid minor parent:

- is not married, or is married but not living with his/her spouse, and
- has no resources or income of his/her own.

EXAMPLE #7: Household listed on application consists of woman applicant, her disabled spouse, their 17-year old daughter and her 2-year old son (woman's grandson). They all request Medicaid.

The family unit consists of :

- *the mother,*
- *her husband,*
- *their daughter, and*
- *the daughter's son.*

The family unit's income is determined using the F&C income policy and procedures. Because the family unit's income exceeds the LIFC and MI child's income limit for 4 persons and daughter is a Medicaid minor parent, the family unit is broken into BUs:

- BU #1 = 2-year old grandson
- BU #2 = the mother, her husband and the 17-year old Medicaid minor parent

The mother and her husband's countable income is calculated to determine their eligibility as LIFC and the Medicaid minor parent's eligibility as MI. Because the Medicaid minor parent has no income of her own, there is no income to deem to her son's BU.

2. Married Medicaid Minor

Place the married Medicaid minor in a BU by himself/herself when the Medicaid minor:

- is married and living with his/her spouse, *or*
- has resources or income of his/her own, *AND*
- lives with his/her parent(s).

Deem a portion of the married Medicaid minor's parent's resources and income to the married minor, and deem a portion of the married minor's spouse's resources and income to the married minor.

EXAMPLE #8: Household listed on application consists of the married Medicaid minor applicant age *17*, her spouse age 25 and her parents. They all request Medicaid.

The family unit consists of:

- *the married Medicaid minor,*
- *her husband, and*
- *her parents.*

The family unit's income is determined using the F&C income policy and procedures. The family unit's income exceeds the LIFC and the MI income limits for 4 persons.

Because the daughter is a married Medicaid minor *who lives wth her parents and her spouse,* the family unit is broken into BUs:

- BU #1 = the married Medicaid minor
- BU #2 = her husband
- BU #3 = her parents

The parent's BU's countable income is calculated to determine the parents' eligibility as LIFC and to determine the amount deemed to the married Medicaid minor. Her husband's countable income is calculated to determine the amount deemed to the married Medicaid minor. The income deemed from the married Medicaid minor's parents and the income deemed from her husband are added to the married Medicaid minor's income to determine her total countable income.

3. **Medicaid Minor Parent Caretaker Has Resources *(F&C MN Only)* or Income**

Place the Medicaid minor parent caretaker in a BU by himself/herself when the Medicaid minor caretaker has resources or income of his/her own.

EXAMPLE #9: Household listed on application consists of woman applicant, her spouse, their 17-year old daughter and the 17-year old's 2-year old son. They all apply for Medicaid.

The family unit consists of:

- *the mother,*
- *her husband,*
- *their daughter, and*
- *their daughter's 2-year old son.*

The family unit's income is determined using the F&C income policy and procedures. Because the family unit's income exceeds the LIFC and MI income limits for 4 persons, the mother and father are not eligible in the LIFC covered group, and the daughter and her child are not eligible as MI.

Because the Medicaid minor parent caretaker has unearned income from a trust fund, the family unit is broken into BUs:

- BU #1 = the 2-year old
- BU #2 = the Medicaid minor parent
- BU #3 = the mother and father of the minor parent

The mother and father's BU's countable income is calculated to determine their eligibility and to determine the amount of income to deem to their daughter.

The Medicaid minor parent's BU's countable income is first calculated to determine her income. Her income then is added to the amount of income deemed from her parents to determine her eligibility. A separate calculation must be done to determine the amount of the Medicaid minor parent's own income (not including income deemed from her parents) that must be deemed to her 2-year old.

The 2-year old's BU's countable income is the amount of income deemed from his mother since he has no other source of income.

M0520.203 STEPPARENT IN HOUSEHOLD

A. Policy

A stepparent is in a BU separate from his/her stepchild(ren). A married parent (except a minor married parent) is included in a BU with his/her spouse and their child(ren)-in-common. The parent's(s') other child(ren) who are not the child(ren) of his/her spouse are in a separate BU.

Deem resources and income from the parent to his/her child's BU. Do not deem any of the stepparent's resources or income to the parent's child.

B. *Forming Budget Units*

Place a married parent in a BU that is separate from the parent's child(ren); include the married parent's spouse (the child's stepparent) in the BU with the parent. Include the parent's and stepparent's child(ren)-in-common in the BU with the parent and stepparent.

EXAMPLE #10: Household listed on application consists of mother, her spouse, their 6-year old son, and her 8-year old son from another relationship. They all request Medicaid.

The family unit consists of:

- the mother,
- her 8-year old son,
- her spouse (stepparent to her son), and
- their 6-year old son.

The family unit's income is determined using the F&C income policy and procedures. The family unit's countable *income is within the MI income limit*, so the children are eligible as MI children. The family unit's income exceeds the *LIFC* 185% screen, so the unit is not eligible for LIFC Medicaid at the family unit level because of excess income.

BUs are allowed because there is a stepparent in the home:

- BU #1 = 8-year old child
- BU #2 = mother, stepparent, their 6-year old child

BU #2's income is calculated and screened at the LIFC 185% of need. Because the mother and her spouse's BU's income exceeds the LIFC 185% income screen, they are not eligible as LIFC and cannot be placed on a spenddown because they do not meet a medically needy covered group.

M0520.204 ACKNOWLEDGED FATHER IN HOUSEHOLD

A. Policy

An acknowledged father who lives in the household and is not married to the child(ren)'s mother is in a BU separate from the mother. Their child(ren)-in-common is NOT included in the BU with the father; the child(ren)-in-common is in a separate BU.

The mother's own children (who are not the acknowledged father's children) are included in a BU with the mother (unless the child(ren) has resources or income of his/her own).

B. *Forming Budget Units*

When an acknowledged father lives in the household and is not married to the child(ren)'s mother, place the child(ren) and *the acknowledged father* in separate BUs.

EXAMPLE #11: Household listed on application consists of mother, her boyfriend who is the acknowledged father of their 4-year old son, their 4-year old son and her 8-year old daughter. They all request Medicaid.

The family unit consists of:

- the mother,
- her 8-year old daughter,
- the acknowledged father, and
- their 4-year old son.

The family unit's gross income exceeds the income limits for the LIFC and MI child covered groups. Because there is an acknowledged father, BUs are formed:

BU #1 = mother, her 8-year old child
BU #2 = their 4-year old child
BU #3 = acknowledged father

M0520.300 DEEMING FROM SPOUSE

A. Policy

The spouse is included in the F&C spouse's budget unit UNLESS:

- the spouse is an SSI or IV-E recipient (do NOT deem any resources or income from an SSI or IV-E recipient spouse to the F&C spouse);

- the F&C spouse is a Medicaid minor parent and they are living with his/her parent(s);

- the F&C spouse's spouse is under age 21 and they are living with the spouse's parent(s).

B. SSI or IV-E Recipient Spouse

If eligibility is being determined in an F&C covered group that has a resource test, the income and resources owned **solely** by an SSI or IV-E recipient are not considered available to his/her spouse. The pro-rata share of resources owned **jointly** by the F&C spouse and his/her SSI or IV-E recipient spouse is counted available to the F&C spouse when they are living together.

When **not** living together, resources owned jointly with the SSI or IV-E recipient are available only if the SSI or IV-E recipient agrees to sell or liquidate the resource. If the SSI or IV-E recipient agrees, then only 1/2 of the resource's value is counted as available to the F&C spouse.

C. Married Medicaid Minor Living With Parents

Determine how much of the deemor spouse's resources *(F&C MN covered groups only) and income* to deem to the F&C spouse (Medicaid minor) using the following procedures:

1. Deem Resources

a. Determine Countable Resources

Determine the value of the deemor spouse's countable resources owned solely and jointly, according to policy in chapter M06.

b. Subtract Resource Deeming Standard

From the total of the deemor spouse's share of jointly held resources and resources held in his/her name only, subtract the $1,000 resource deeming standard.

c. Deem Remaining Resources

The remaining value, if any, is deemed available to the F&C spouse.

d. Deeming Does Not Reduce Resources

If any of the deemor spouse's resources that are over the resource limit are deemed, this does not make the spouse resource-eligible. Deeming resources does not reduce the deemor's countable resources.

2. Deem Income

To determine how much of the deemor spouse's income to deem to the F&C spouse, use the following procedures:

a. Determine Countable Income

Determine the deemor spouse's gross monthly countable unearned and earned income according to chapter M07.

b. Subtract Earned Income Exclusions

Subtract the applicable earned income exclusions listed in section M0720.500:

- Standard work exclusion of $90 (M0720.520), and
- Child/incapacitated adult care exclusion (M0720.540).

Do NOT subtract the $30 plus 1/3 or $30 earned income exclusions.

c. Subtract Deeming Standard

Subtract the deeming standard. The deeming standard is the F&C 100% income limit for the locality for

- the number of persons in the deemor spouse's BU, **plus**
- the number of deemor's child(ren) under age 21 in the household who are excluded from the Medicaid application (are not included in **any** Medicaid budget unit) and who are or can be claimed as dependents on the deemor's federal income tax return. If the deemor has not previously filed a return or states that he/she will claim a different number of dependents for the current year, use the number of dependents he/she intends to claim for the current year.

See M0710, Appendix 3, for the F&C 100% income limit.

NOTE: For the deeming calculation, a pregnant woman is only 1 person.

d. Subtract Support Payments Made

Subtract actual support paid to individuals NOT in the home, who are or could be claimed as dependents on the **deemor's** federal tax return.

Subtract actual alimony and/or child support payments made to individuals NOT in the home and not claimed as dependents on the **deemor's** federal income tax return.

e. Deem Remainder

Deem the remaining balance to the eligible F&C spouse (plus the spouse's F&C child(ren), if any, who is not in the spouse's BU) as unearned income.

NOTE: Deeming income does not reduce the deemor's countable income *for his Medicaid eligibility determination*.

D. Example--Married Minor Living With Parents

EXAMPLE #12: (Using 1999 figures)
A Medicaid minor pregnant woman lives with her husband, their 1-year old child, his 14-year old child from a previous marriage, and her parents. They apply for everyone except her parents. They live in Group I. Her husband earns $3,200 monthly. She has no income. She and her husband own a joint savings account with a balance of $1,600. Her father earns $2,000 monthly; her mother has no income.

1. Family Unit

The Medicaid minor pregnant woman's family unit consists of herself, her unborn child, her husband, their 1-year old child, his 14-year old child, and her parents (a family unit of 7).

$3,200	husband's earnings
+2,000	PG woman's father's earnings
5,200	total earnings
- 180	2 standard work exclusions ($90 x 2 = 180)
5,020	countable income
- 2,789	MI pregnant woman income limit for 7 persons
2,231	excess

The family unit's countable income exceeds the MI pregnant woman income limit for 7 persons, so the pregnant woman is not eligible for Medicaid as MI at the family unit level.

2. Budget Units

Because there is a Medicaid minor parent and a stepparent in the household, the family unit is divided into BUs:

- BU #1 = the minor PG woman *and unborn child (2);*
- BU #2 = her spouse, their 1-year old child (2);
- BU #3 = her spouse's 14-year old child (1);
- BU #4 = her parents (2).

Due to excess income at the BU level, a MN eligibility determination is required. Portions of her spouse's resources *(for F&C MN only)* and income are deemed to her BU according to the spouse deeming procedures.

BU #1 spouse deeming calculations:

a. Resource Deeming

$ 800	husband's ½ of joint savings
-1,000	resource deeming standard
0	excess (no resources deemed to F&C spouse)

b. Income Deeming

$3,200	husband's earnings
- 90	standard work exclusion
3,110	countable income
- 229	deeming standard for deemor's BU (2 persons in Group I)
2,881	excess
÷ 2	PG woman (spouse) and 14-year-old child
$1,440.50	deemed to each

The parents' deemed resources and income to the pregnant woman's BU are calculated according to M0520.400 below. The parents' deemed income is added to the spouse's deemed income to determine the minor PG woman's income eligibility.

M0520.400 DEEMING FROM PARENT

A. Policy

A parent's resources (F&C MN only) and income are considered available (either counted in the unit or deemed) to a child under age 21 living with a parent. The parent's resources and income are deemed to the child when the child is in a separate BU from the parent, unless

- the parent is an SSI recipient or has a 1619b status,
- the parent receives IV-E foster care or adoption assistance,
- the child is living away from home per M0520.001 B.3, or
- the child is a foster care child placed in the home for a trial visit of *6* months or less.

1. Deeming Standard

The deeming standard is the portion of the parent's countable resources or income that is not considered available to the child who is in a separate BU from the parent. The resource deeming standard is $1,000. The income deeming standard is the locality F&C 100% income limit for the deemor parent's BU plus any excluded children.

2. Single Parent or Parent and Stepparent with No Child in Common

When each child in the home has only one parent in the home and the parent is in a separate BU, subtract the whole deeming standard from the parent's countable resources and income.

Note: A stepparent is not a "parent" for deeming purposes.

3. Both Parents In Same BU- Married With Child in Common

a. No Stepchildren

When both parents (at least one child in common) are in the same BU and there are no stepchildren, subtract the whole deeming standard from the parents' resources and income.

b. Stepchildren

When both parents (at least one child in common) are in the same BU and they have at least one child in common in the home who is included in the family unit, subtract one-half of the deeming standard for the parents' BU from deemor parent's resources and income.

When both parents are in the same BU and all their children-in-common are excluded from the family unit, subtract the whole deeming standard for the parents' BU from the deemor parent's resources and income.

4. Both Parents In Different BUs

When both parents (at least one child in common) are in separate BUs, subtract the whole deeming standard from the deemor parent's countable resources and income.

B. Deeming Resources (F&C MN Only)

To determine how much of the deemor parent's resources to deem to the child, use the following procedures:

1. Determine Countable Resources

Determine the value of countable resources owned solely by the parent and the value of countable resources owned jointly with the parent's spouse or another person, according to policy in chapter M06. All resources that are in the deemor parent's name only plus the deemor's share of jointly held resources are counted.

2. Subtract Resource Deeming Standard

a. Single Parent or Parent and Stepparent with No Child in Common

Subtract the whole resource deeming standard of $1,000 from the deemor's total countable resources (those in the deemor's name only plus the deemor's share of jointly held resources).

Separate deeming calculations for each deemor parent must be done to ensure stepparent resources are not deemed.

b. Both Parents In Same BU With Child in Common

1) Subtract the whole deeming standard of $1,000 from the parents' countable resources when there are children in common and no stepchildren in the home.

When both parents are deeming only to children in common, their resources are combined and only one deeming calculation is done.

2) Subtract one-half of the resource deeming standard ($500) from each deemor parent's countable resources, when there are children in common **and** stepchildren in the home, *and at least one child-in-common in the home is included in the family unit*.

Separate deeming calculations for each deemor parent must be done to ensure stepparent resources are not deemed.

c. Both Parents In Different BUs

When both parents are in the home but in different budget units, subtract the whole resource deeming standard of $1,000 from the deemor's total countable resources (those in the deemor's name only plus the deemor's share of jointly held resources).

Separate deeming calculations must be completed for each deemor parent.

3. Deem Resources Remainder

The remaining value, if any, is deemed available to the non-excluded F&C child(ren) who are not in the parent's BU. If the parent has more than one non-excluded child in the household who is not in the parent's BU, divide the remaining resource value by the number of non-excluded children who are not in the parent's BU.

NOTE: Deeming resources does not reduce countable resources for the deemor's eligibility determination.

4. Example--Resource Deeming From Parent

EXAMPLE #13: A woman lives with her husband, their 5-year old child, her 11- year old and 12-year old children from a previous marriage, and his 14-year old child from a previous marriage. They apply for everyone in the family. They live in Group I. Due to excess income, a medically needy eligibility determination must be done.

The family's resources consist of a savings account of $1,050 owned jointly by the woman and her spouse, one car owned by the husband with an equity value of $1,000 and a second car (owned jointly by the woman and her spouse) with an equity value of $50. Each child owns a U.S. savings bond valued at $100.

The Medicaid family unit is broken into budget units to determine resource eligibility.

- budget unit #1 = her husband's 14-year old child;
- budget unit #2 = their 5 year old child;
- budget unit #3 = her 11 year old child;
- budget unit #4 = her 12 year old child;
- budget unit #5 = the woman, her husband.

Each parent has a child who is not the child of his/her spouse; therefore, separate deeming calculations are used.

a. Mom's Resource Deeming Calculation

The mother's resources are deemed available to each of her children who are not in her BU (including her child-in-common with her husband):

$ 525	½ savings account
+ 25	her ½ equity in the second car (not excluded)
550	countable resources
- 500	½ resource deeming standard (parents in same BU, child in common)
50	deemable resources
÷ 3	number of her children not in her BU
$16.67	deemed to each of her children not in her BU

b. Dad's Resource Deeming Calculation

The Dad's resources are deemed available to each of his children who are not in his BU (including his child-in-common with his wife):

$ 525	½ savings account
+ 25	his ½ equity in the second car (not excluded)
550	countable resources
- 500	½ resource deeming standard (parents in same BU, child in common)
50	deemable resources
÷ 2	number of his children not in his BU
$ 25	deemed to each of his children not in his BU

c. Budget Units #3 and #4

$ 100.00	child's savings bond
+ 16.67	deemed from Mom
$ 116.67	child's countable resources

Each child has total resources of $116.67. Each child's resources are less than the MN resource limit; each is resource-eligible and is placed on an MN spenddown.

d. Budget Unit #1

$ 100.00	child's savings bond
+ 25.00	deemed from Dad
$ 125.00	child's countable resources

The child has total resources of $125. Dad's child's resources are less than the MN resource limit, so the child is resource-eligible and is placed on an MN spenddown.

e. Budget Unit #2

$100.00	child's savings bond
+ 16.67	deemed from Mom
+ 25.00	deemed from Dad
$141.67	child's countable resources

Their child's countable resources are less than the MN resource limit, so their child is resource-eligible and is placed on an MN spenddown.

C. Deeming Income

To determine how much of the deemor parent's income to deem to the F&C child(ren), use the following procedures:

1. Determine Countable Income

Determine the deemor parent's gross monthly countable unearned and earned income according to chapter M07.

2. Subtract Earned Income Exclusions

Subtract the applicable earned income exclusions listed in section M0720.500:

- standard work exclusion of $90 (M0720.520), and
- child/incapacitated adult care exclusion(M0720.540).

Do NOT subtract the $30 plus 1/3 or $30 earned income exclusions.

3. Subtract Income Deeming Standard

a. Single Parent or Parent and Stepparent with No Child in Common

Subtract the whole income deeming standard. The income deeming standard is the F&C 100% income limit for the locality (see M710, Appendix 3) for

- the number of persons in the deemor's BU, **plus**
- the number of children under age 21 in the household who are excluded from the Medicaid application (not included in **any** Medicaid assistance unit) and who are or can be claimed as dependents on the deemor's federal income tax return. If the deemor has not previously filed a tax return or states that he/she will claim a different number of dependents for the current year, use the number of dependents he/she intends to claim for the current year. Do not count children who receive SSI when determining the income deeming standard.

A deeming calculation must be done for each deemor parent.

NOTE: For the deeming calculation, a pregnant woman is only 1 person.

b. Both Parents In Same BU and Child-in-Common

1) Subtract the whole income deeming standard from the parents' income when there *is a* child(ren)-in-common and no stepchildren in the home.

When both parents are deeming only to child(ren)-in-common, only one deeming calculation is done.

2) Subtract one-half of the income deeming standard from the parent's countable income when there are children in common **and** stepchildren in the home, *and at least one child-in-common in the home was included in the family unit*.

Separate deeming calculations for each deemor parent must be done to ensure stepparent income is not deemed.

*3) When both parents are in the same BU and ALL their children-in-common are **excluded** from the family unit, subtract the whole income deeming standard for the parents' BU from the deemor parent's income.*

Separate deeming calculations for each deemor parent must be done to ensure stepparent income is not deemed.

c. Both Parents In Different BUs

Subtract the whole income deeming standard from the deemor parent's countable income.

Separate deeming calculations must be done for each deemor parent.

4. Subtract Support Payments Made

Subtract actual alimony and/or child support payments made to individuals not in the home, *regardless of whether or not the individuals are* claimed as dependents on the deemor's federal income tax return.

5. Deem Remainder

Deem the remaining income as unearned income to the non-excluded F&C child(ren) in the household who are not in the parent's BU. If the parent has more than one non-excluded F&C child in the household who is not in the parent's BU, divide the remaining income by the number of non-excluded children who are not in the parent's BU (plus the parent's minor spouse, if any, who is not in the parent's BU).

NOTE: Deeming income does not reduce the deemor's countable income for the deemor's eligibility determination.

6. Example—Income Deeming From Parent; Stepchildren In Home

EXAMPLE #14: (Using July 2002 figures)
An application is filed for a woman *who* lives with her husband, their 5-year-old child, her 11-year-old and 12-year-old children from a previous marriage, and his 14-year-old child from a previous marriage. They live in Group I. Her husband earns $2,200 monthly. She earns $800 monthly. Her children each receive $150 monthly child support. They have no resources. The Medicaid family unit's countable income exceeds the income limits for all appropriate covered groups.

The Medicaid family unit is broken into budget units because there are stepparents in the home and some of the children have their own income.

- budget unit #1 = Dad's 14-year old child
- budget unit #2 = Mom's 11-year old child
- budget unit #3 = Mom's 12-year old child
- budget unit #4 = Mom, Dad, and their child

Each parent has a child who is not the child of his/her spouse; therefore, separate deeming calculations are used.

a. Mom's Income Deeming Calculation

Mom's countable income is deemed to each of her children who are not in her BU.

$ 800.00	Mom's earnings
- 90.00	standard work exclusion
710.00	countable income
- 156.63	½ deeming standard for 3 in Group I ($313.25)
553.37	deemable income
÷ 2	number of her children not in her BU
$ 276.69	deemed to each child

b. Dad's Income Deeming Calculation

Dad's countable income is deemed to his child.

$2,200.00	Dad's earnings
- 90.00	standard work exclusion
2,110.00	countable income
- 156.63	½ deeming standard for 3 in Group I ($313.25)
$1,953.37	deemable income

c. BU #1

$1,953.37 countable income (deemed from Dad) exceeds MI child limit for BU of 1 and child is placed on a MN spenddown.

d. BUs #2 and #3

$ 276.69	deemed unearned income from Mom
+ 150.00	child's own income
- 50.00	child support disregard
376.69	countable income is within MI child limit for both BUs of 1

e. BU #4

$2,200	husband's earnings
+ 800	woman's earnings
- 180	standard work exclusions ($90 x 2 = 180)
2,820	countable earned income exceeds LIFC income limit

7. Example—Income Deeming From Parent; All Children-in-Common Excluded

EXAMPLE #14a: (Using July 2005 figures)

A woman lives with her husband, their 5-year old child, her 11-year old and 12 year-old children from a previous marriage, and his 14-year old child from a previous marriage. They exclude their child, and apply for themselves and the other 3 children. They live in Group III. Her husband earns $2,200 monthly. She earns $800 monthly. Her children each receive $150 monthly child support. They have no resources. The Medicaid family unit's countable income exceeds the income limits for all appropriate covered groups.

The Medicaid family unit is broken into budget units because there are stepparents in the home and Mom's two children have their own income.

- *budget unit #1 = Dad's 14-year old child*
- *budget unit #2 = Mom's 11-year old child*
- *budget unit #3 = Mom's 12-year old child*
- *budget unit #4 = Mom and Dad*

Their excluded child is not included in the parents' BU, but is counted when determining the deeming standard. Each parent has a child who is not the child of his/her spouse; therefore, separate deeming calculations are used.

a. Mom's Income Deeming Calculation

Mom's countable income is deemed to each of her children who are not in her BU.

$ 800.00	*Mom's earnings*
- 90.00	*standard work exclusion*
710.00	*countable income*
- 437.58	*whole deeming standard for 3 in Group III*
272.42	*deemable income*
÷ 2	*number of her children not in her BU*
$136.21	*deemed to each child*

b. Dad's Income Deeming Calculation

Dad's countable income is deemed to his child.

$2,200.00	*Dad's earnings*
- 90.00	*standard work exclusion*
2,110.00	*countable income*
- 437.58	*whole deeming standard for 3 in Group III*
$1,672.42	*deemable income*

c. BU #1

$1,672.42 countable income (deemed from Dad) exceeds MI child limit for BU of 1 and child is placed on a MN spenddown.

d. BUs #2 and #3

$ 136.21 deemed income from Mom
+ 150.00 child's own income
- 50.00 child support disregard
236.21 countable income is within MI 133% FPL limit for1 person

Mom's children are eligible for Medicaid as MI children under age 19.

e. BU #4

$2,200 Dad's earnings
+ 800 Mom's earnings
- 180 standard work exclusions ($90 x 2 = 180)
2,820 countable income exceeds LIFC income limit for 2

Mom and Dad are not eligible for Medicaid because their income exceeds the LIFC income limit and they do not meet any other covered group.

M0520.500 CHANGES IN STATUS

A. Policy

When the household composition changes, or the circumstances of the household members change, the F&C family and budget unit may change, and the requirements to deem a spouse's or parent's resources *(F&C MN only)* and income may change.

B. Procedure

See M0520.501 for Family/Budget Unit Changes.
See M0520.502 for Deeming Changes.

M0520.501 FAMILY/BUDGET UNIT CHANGES

A. Introduction

Some changes in the household composition which require changes in the family unit or budget units are listed and described in this section.

B. Spouses Separate or Divorce

If a married F&C individual and his/her spouse separate or divorce and no longer live together, the spouse is not included in the F&C individual's family or budget unit beginning the month after the month in which the separation or the divorce occurred. If a married F&C individual and his/her spouse divorce but they remain living in the same household, the divorced father is considered an acknowledged father beginning the month after the month in which the divorce occurred.

C. Individual Begins Living With A Spouse

For applicants, if an F&C individual or deemor begins living with a spouse, the spouse is included in the family or budget unit beginning with the month in which they begin living together.

For recipients, if an F&C individual or deemor begins living with a spouse, the spouse is included in the family or budget unit beginning with the month after the month they begin living together.

D. Parent and Child Begin Living in Same Household

For applicants, if an F&C child begins living with a parent in the same household (e.g., a child comes from aunt's home to live in mother's home), the child and parent are included in the family unit for purposes of determining eligibility beginning the month in which they begin living together.

For recipients, if an F&C child begins living with a parent in the same household (e.g., a child comes from aunt's home to live in mother's home), the child and parent are included in the family unit for purposes of determining eligibility beginning the month **after** the month they begin living together.

NOTE: A newborn child is considered living with the parent(s) as of the date the child is born, unless the child is entrusted into foster care on that date.

E. Spouse or Parent Dies

If a spouse or parent dies, the spouse or parent is deleted from the family or budget unit effective with the month following the month of death.

F. Individual Becomes Institutionalized

If an F&C individual becomes institutionalized, either in a medical facility or in Medicaid CBC waiver services, the individual is a separate family unit effective with the first month in which the individual is institutionalized.

G. Individual Leaves Home

If an F&C individual leaves the household, the individual is deleted from the family or budget unit beginning with the month following the month in which he left the household.

NOTE: If a spouse, parent or child was temporarily absent from the household, this rule applies effective with the month after the month the spouse's, parent's or child's absence is no longer considered temporary.

H. Child Attains Age 21

Effective the month following the month in which a child attains age 21, the child is removed from the family or budget unit. An individual attains age 21 on the day preceding the anniversary of his/her birth.

M0520.502 DEEMING CHANGES

A. Introduction

Some changes in the circumstances of the household members which require changes in the deeming procedures are listed and described in this section.

B. Spouses Separate or Divorce

If a married F&C individual and his/her spouse separate or divorce and no longer live together, or their marriage ends in divorce but they remain living in the same household, the spouse's resources *(F&C MN only)* and income are not deemed to the F&C spouse's family or budget unit beginning the month after the month in which the separation or the divorce occurred. The divorced father who lives in the household with his child(ren) and ex-wife is treated like an acknowledged father.

NOTE: If an application is filed in the month of separation or divorce, deeming applies that month even if the application is filed on or after the date of separation or divorce.

C. Individual Begins Living With A Spouse

If an F&C individual begins living with a spouse, deeming of the spouse's resources *(F&C MN only)* and income to the F&C spouse's BU begins effective with the month after the month they begin living together.

D. Spouse Or Parent Dies

If a spouse or parent dies, deeming stops for purposes of determining eligibility effective with the month following the month of death. If the child lives with two parents and one dies, deeming continues from the surviving parent to determine eligibility.

E. Individual Becomes Institutionalized

If an F&C individual becomes institutionalized, either in a medical facility or in Medicaid CBC waiver services, deeming stops for purposes of determining eligibility effective with the first month in which the individual is institutionalized.

F. Individual Leaves Home

If a spouse, parent or child no longer live in the same household, deeming of that spouse's or parent's resources *(F&C MN only)* and income stops effective the month after the month the spouse, parent or child leaves the household for purposes of determining eligibility, except for a foster care child. When a child is removed from the home and placed in foster care, the child becomes an FU of 1 person effective the date of commitment or entrustment or non-custodial foster care agreement. The child is deleted from the family's FU effective the end of the month during which the child was placed in foster care.

NOTE: If a spouse, parent or child was temporarily absent from the household, this rule applies effective with the month after the month the spouse's, parent's or child's absence is no longer considered temporary.

G. Parent and Child Begin Living in Same Household

If an F&C child begins living with a parent in the same household (e.g., a newborn child comes home from a hospital), the parent's income is deemed to the child's budget unit for purposes of determining eligibility beginning the month after the month they begin living together.

H. Child Attains Age 21

Deeming stops effective the month following the month in which a child attains age 21. An individual attains age 21 on the day preceding the anniversary of his/her birth. Eligibility is determined using only the individual's own income after the child attains age 21. The individual's income for the current month and subsequent months must include any income in the form of cash provided by the parents.

M0520.600 PREGNANT WOMAN BUDGET UNIT

A. Policy

A pregnant woman's family or budget unit always consists of at least 2 persons--herself and the unborn child, or children when it is medically verified that there is more than one fetus.

The other members of the household who are included in the pregnant woman's family or budget unit depend on whether the pregnant woman is under age 21 years, is married and is living with her parent(s) or spouse.

B. Budget Unit

The budget unit includes her spouse who lives with her unless the spouse receives SSI, or she and/or her spouse are Medicaid minors living with her or his parent(s).

The budget unit also includes her child(ren) under age 21 living in the home unless:

- the child(ren) has his or her (their) own income (child is separate budget unit);
- she specifically excludes the child(ren);
- the child(ren)'s acknowledged father is living in the home and is not married to the pregnant woman;
- she is a Medicaid minor and lives with her parent(s);
- she is a married Medicaid minor and lives with her spouse and parent(s); or
- she is married and living with her spouse who is not the father of the child(ren). If she is married, living with her spouse who is not the father of her child(ren), and she does not exclude her child(ren) under

age 21 living in the home, the child(ren) is a separate BU and the pregnant woman's own income and resources deemed available to the child.

M0520.601 UNMARRIED PG WOMAN OVER AGE 21 BUDGET UNIT

A. Policy

An unmarried pregnant woman's family or budget unit always consists of at least 2 persons--herself and the unborn child, or children when it is medically verified that there is more than one fetus. It includes her minor child(ren) under age 21 who live with her unless

- the child has his/her own resource *(F&C MN only)* or income,
- the child's acknowledged father lives in the home, or
- she excludes the child.

B. Example--Unmarried PG Woman Over Age 21

EXAMPLE #15: ***(Using 2/15/00 figures)*** Group II locality. An unmarried pregnant woman age 25 applies for Medicaid for herself and her 10-year old child. She lives with her parents, her 20 year old brother and her 10-year old child. They have no resources. She earns $1,200 per month and her 10-year old child receives $200 monthly child support from his father. Her family unit consists of herself *(pregnant woman counts as two persons for her eligibility)* and her 10-year old, 3 persons. *The 10-year child's family unit consists of the 10-year old and his mother, 2 persons.*

$1,200	PG woman's earnings
- 90	standard work exclusion
1,110	countable earnings
$ 200	monthly child support
- 50	support disregard
150	countable unearned
+1,110	countable earned
1,260	countable monthly income

The pregnant woman's family unit's income is less than the MI pregnant woman's income limit so she is eligible as an MI pregnant woman.

M0520.602 MARRIED PG WOMAN BUDGET UNIT

A. Policy

A married pregnant woman's BU includes her spouse with whom she lives, unless

- she is under age 21 and they live with her parent(s),
- her spouse is under age 21 and they live with his parent(s),
- she has a minor child(ren) living in the household who is not her spouse's child, or
- her spouse has a minor child(ren) living in the household who is not the PG woman's child.

1. PG Woman Is Medicaid Minor Living With Her Parents

When the married PG woman is a Medicaid minor (under age 21 years old) and they live with her parent(s), the BU consists of the Medicaid minor pregnant woman and her unborn child (or children if medically verified). Her spouse and their child(ren) are in a separate BU.

2. PG Woman's Spouse Is Medicaid Minor Living With Spouse's Parents

When the married PG woman's spouse is a Medicaid minor and they live with her spouse's parent(s), the BU consists of the pregnant woman, the unborn child(ren) and their child(ren)-in-common, if any. Her Medicaid minor spouse is in a separate BU and her spouse's parents are in a separate BU.

3. PG Woman And/Or Spouse Have Other Children

When the married PG woman and/or her spouse are age 21 or older, or are under age 21 but do not live with either's parent(s), and have other children in the household who are not their children-in-common, the BU consists of the pregnant woman, her unborn child(ren) and her spouse. Her child(ren) is in a separate BU and his child(ren) is in a separate BU.

B. Example—Married PG Woman Over Age 21, Other Children In Household

EXAMPLE #16: A Medicaid application is filed for a pregnant woman and everyone in her family. She lives with her husband who is not aged, blind, or disabled, her 10-year old child by a former marriage, and his 15-year old child from a former marriage. They have no resources. The family unit's income exceeds the MI pregnant woman income limit for 5 persons, the MI child income limit for 4 persons, and the LIFC 185% standard of need for 4 persons, so BUs are formed because there is a stepparent in the household. Three BUs exist:

- BU #1 = the pregnant woman, her unborn child, and her husband (3);
- BU #2 = her husband's 15-year old child (1);
- BU #3 = her 10-year old child (1).

C. Example—Married PG Woman Under Age 21, Living With Spouse's Parents

EXAMPLE #17: *A Medicaid application is filed for a minor pregnant* woman age 19 and everyone in her family. She lives with her husband who is age 19, her 2-year old child by a former relationship, and his parents (6 persons). They have no resources. The *pregnant woman's* family unit's income exceeds the *MI pregnant woman* income limit for 6 persons, so budget units are formed because there are a stepparent and a minor spouse in the household. *Four* budget units exist:

- #1 = the pregnant woman and her unborn child (2);
- #2 = her 2-year old child (1);
- #3 = her husband (1);
- #4 = his parents (2).

M0520.603 UNMARRIED MINOR PG WOMAN BUDGET UNIT

A. Policy

When the Medicaid minor (under age 21 years old) pregnant woman is not married, the budget unit consists of the Medicaid minor pregnant woman and her unborn child (or children if medically verified) and the minor pregnant woman's child(ren) who live with her, unless

- she lives with her parent(s), or
- her child(ren) has resources or income of his/her own.

If the unmarried Medicaid minor pregnant woman lives with her parent(s), the budget unit consists of the Medicaid minor pregnant woman and her unborn child (or children if medically verified) and the Medicaid minor pregnant woman's parent(s). Her child(ren) are in a separate budget unit.

1. Her Stepparent In Household

If the Medicaid minor pregnant woman's parent is married and the spouse lives in the household, the Medicaid minor pregnant woman's parent is NOT included in the budget unit with her. A portion of her parent's own resources and income is deemed to the Medicaid minor pregnant woman.

2. Siblings In Household

If the Medicaid minor pregnant woman has a minor (under age 21) sibling(s) in the household who is listed on the application form, that sibling is included in *the* unit with her parent(s) unless

- the sibling(s) has his/her own resources or income, or
- a stepparent or acknowledged father lives in the home.

If the sibling(s) has resources or income, the parent(s) must be advised of the opportunity to exclude that sibling from the family unit.

3. Medicaid Minor PG Woman Is Also Medicaid Minor Caretaker

If the Medicaid minor pregnant woman lives with her parents and also has a child(ren) of her own living with her for whom Medicaid is requested, she is also a Medicaid minor caretaker. Her child(ren) is in a separate budget unit. The pregnant woman is in a separate budget unit with her parent(s) and minor siblings who live at home, if the Medicaid minor PG woman and her siblings have no income or resources of their own. If the

Medicaid minor PG woman has resources or income of her own, she is in a separate BU and a portion of the pregnant woman's own income and resources is deemed available to her child(ren).

B. Example—Unmarried Medicaid Minor PG Woman

EXAMPLE #18: A Medicaid minor pregnant woman lives with her 2-year old child, her parents, and her 16 year old brother. *A Medicaid application is filed for the* Medicaid minor PG woman and the PG woman's child. The *pregnant woman's* family unit consists of the Medicaid minor pregnant woman, her unborn child, her 2 year old child, her parents and her brother. They have no resources. She has income from part-time work. Her parents earn $2,100 monthly. *Her* family unit's income exceeds the MI *pregnant woman* income limit for 6 persons, so the family unit is broken into budget units because the Medicaid minor PG woman has her own income and she is a minor parent living with her parents. Three budget units exist:

- budget unit #1 = the Medicaid minor PG woman (2);
- budget unit #2 = her 2 year old child (1);
- budget unit #3 = the parents, her 16 year-old brother (3).

M0520.700 INDIVIDUAL UNDER AGE 21 FAMILY UNIT

A. Policy

The family unit of an individual who meets the covered group of "individuals under age 21 who are in foster care, adoption assistance or in ICF/ICF-MR care" is determined using the family unit rules in M0520.100 above when the individual lives with a parent or spouse. If the individual does not live with a parent or spouse, the individual is in a family unit by himself.

If the individual under age 21 is living away from home, see M0520.001 B.3. to determine if the individual is considered living with his/her parents.

B. Procedure

The following sections contain the policy and procedures to use when determining the family/budget unit of an individual under age 21:

- M0520.701 Foster Care Child Family Unit;
- M0520.702 Non IV-E Adoption Assistance Family Unit;
- M0520.703 Special Medical Needs Adoption Assistance Child
- M0520.704 Child In ICF or ICF-MR.

M0520.701 FOSTER CARE CHILD FAMILY UNIT

A. Policy

A foster care child who is not living with his/her parents is a family unit of one person. A child in foster care who is not living with his or her parent(s) is evaluated as a separate family unit, even if the child is living with his or her own siblings in foster care. When a child is removed from his/her home and placed in foster care, the child becomes a family unit of 1 person effective the date of the commitment or entrustment to, or non-custodial agreement with the agency.

1. Child Living With Parents

If the foster child is living with his or her parents and/or siblings NOT on a trial visit basis, the foster care child is included in the family unit with his/her parents and siblings.

If the child's family unit has resources (F&C MN only) or income which exceeds the limit for the child's covered group, determine if the family unit can be broken into BUs. The foster care child is included in a BU with his/her parents UNLESS:

- the child has his/her own resources (F&C MN only);
- the child has his/her own income;
- the child's stepparent is in the family unit;
- the child's parent with whom he/she lives is a minor (under age 21) and they live with the minor parent's parent(s);

- the child(ren)'s acknowledged father lives in the household and is not married to the child(ren)'s mother.

2. Child Placed In Own Home For Trial Visit

A foster care child who is placed in the home with his/her parents and siblings **for a trial visit** is a separate family unit of 1 person. The parent(s)' resources and income are NOT deemed available to the foster care child. Verify the trial visit with the agency's Child Welfare Services staff.

The trial visit is no longer than *6* months for this section's purposes. A child will continue to be a single person BU during a trial visit and only the child's income and resources will be counted in determining the child's Medicaid eligibility.

3. Foster Care Payment Is Excluded

The foster care payment is excluded when determining the family unit's financial eligibility.

B. Examples

1. Trial Visit

EXAMPLE #19: The agency services staff places the foster care child, age 10, with his family for a trial visit. The child does not receive a foster care payment from the agency. The household consists of the foster care child, his mother and father, his 13-year old sister, and his 22-year old brother. The household consists of 2 family units:

- family unit #1 = foster care child (1);
- family unit #2 = foster care child's parents, 13-year old sister (3).

2. Home Placement, Not Trial Visit

EXAMPLE #20: The agency services staff places the foster care child, age 10, with his family. This is NOT a trial visit, but the agency retains custody of the child. The child does not receive a foster care payment from the agency. The household consists of the foster care child, his mother and father, his 13-year old sister, and his 22-year old brother. The household consists of one family unit: the foster care child, his parents and his 13-year old sister (4).

M0520.702 NON IV-E ADOPTION ASSISTANCE CHILD FAMILY UNIT

A. Policy

A non IV-E adoption assistance child who is not living with his/her parents is a family unit of one person.

1. Child Living With Parent(s)

A non IV-E adoption assistance child who is living with his or her parent(s) is evaluated as a separate family unit from placement until the interlocutory or final order of adoption, whichever comes first. The adoptive parents' resources and income are NOT deemed available to the adoption

assistance child until the interlocutory or final order of adoption, whichever comes first, is entered.

After the interlocutory or final order of adoption, whichever comes first, a non IV-E adoption assistance child who is living with his or her parent(s) is included in a the family unit with his/her parent(s). If the family unit has resources *(F&C MN only)* or income which exceeds the limit for the child's covered group, determine if the family unit can be broken into BUs. The non IV-E adoption assistance child is included in a BU with his/her parents UNLESS:

- the child has his/her own resources *(F&C MN only)*;
- the child has his/her own income;
- the child's stepparent is in the family unit.

2. Exclude Adoption Subsidy Payment

The adoption subsidy payment is excluded when determining the unit's financial eligibility.

B. Example –Child Placed With Adoptive Parents

EXAMPLE #21: Mary B. is a 19-year old *non IV-E foster care child* who is in the custody of the local social services agency. On August 5, 1997, she is placed with Mr. and Mrs. G who plan to adopt her. The adoption assistance agreement was signed on August 5, 1997. There is no interlocutory order and the final order will not be signed until February 1998. Mr. and Mrs. G have two children, Tom who is age 17 and Jane who is age 15. Mary receives $575 per month SSA benefits from her deceased father's work record. Mr. G earns $3,000 per month gross earnings. Mrs. G has no income of her own. Mary's continued Medicaid eligibility is determined:

Mary's family unit consists of Mary by herself because she does not live with any responsible relative. The final order of adoption will not be signed until February 1998. Beginning with the month following the month in which the final adoption order is signed. Mary will be in a family unit with her adoptive parents and siblings.

C. Example—Child Living With Adoptive Parents

EXAMPLE #22: John is a 20-year old *non IV-E adoption assistance child* who is in the custody of the local social services agency until August 5, 1997, when the final order of adoption was signed by the judge. His adoptive parents are Mr. and Mrs. T. The adoption assistance agreement was signed on September 15, 1996. Mr. and Mrs. T have two other children, George who is age 17 and Julie who is age 15. John receives $250 per month adoption subsidy. Mr. T earns $3,000 per month gross earnings. Mrs. T has no income of her own. John's continued Medicaid eligibility for September 1997 and subsequent months is determined:

John's family unit consists of himself, his adoptive parents and his two siblings, a family unit of 5 persons.

M0520.703 SPECIAL MEDICAL NEEDS ADOPTION ASSISTANCE CHILD FAMILY UNIT

A. Policy

A non IV-E special medical needs adoption assistance child who is living with his or her parent(s) is evaluated as a separate family unit. **The adoptive parents' income is NOT deemed available to the special medical needs adoption assistance child at any time.**

B. Exclude Adoption Subsidy Payment

The adoption subsidy payment is excluded when determining the child's financial eligibility.

M0520.704 CHILD IN ICF OR ICF-MR FAMILY UNIT

A. Policy

When an individual under age 21 is in an intermediate care facility (ICF) (nursing facility) or ICF-MR (intermediate care facility for the mentally retarded) for 30 consecutive days or more, the child is institutionalized and is considered separated from his/her parents.

Child in medical institutions (facilities) are temporarily absent from home if their stay in the medical facility is less than 30 consecutive days. If the stay has been, or is expected to be, 30 or more consecutive days, go to section M1410.010 to determine if the child is institutionalized in long- term care. A child who is institutionalized in a medical facility or Medicaid waiver services is NOT considered living with his or her parents for Medicaid eligibility purposes.

The child is a family unit of one person, regardless of the child's covered group. The parents' resources and income are **not** deemed available to the child. If the parents give the child any money, that money is counted as income according to the F&C income rules in chapter M07.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES
MEDICAID PROGRAM

MEDICAID F&C RESOURCE/INCOME DEEMING WORKSHEET

CASE NAME: _____ CASE NUMBER: _____

DEEMOR'S NAME: _____ DATE: _____

RESOURCE DEEMING

Reminders:

Deem resources when evaluating LIFC or MN eligibility. Count only the pro-rata share when appropriate.

Deemor's Countable Resources:

Cash $_____

Checking Account(s) _____

Savings Account(s) _____

Other Liquid Resources _____

Vehicles - excess value
(1 is totally excluded in MN) _____

Real Property _____

Other Non-Liquid Resources _____

TOTAL COUNTABLE RESOURCES =
$_____

Minus Resource Deeming Standard -

___ $1,000 or

___ $500 (Use when parents are in the same BU and have a child in common, and at least one parent is deeming to a child who is not the spouse's child.)

DEEMABLE RESOURCES $_____

INCOME DEEMING

Step 1

Deemor's Gross Earned Income $ _____ (1)
(Parent 1 or Applicant's Spouse)

Minus Standard Work Exclusion 90.00 (2)

Sub-total _____ (3)

Minus Other Exclusions _____ 4)

Sub-total _____ 5)

Add Unearned Income _____ 6)

Countable Income $ _____ (7)
(Parent 1 or Applicant's Spouse)

Deemor's Gross Earned Income $ _____ (8)
(Parent 2)

Minus Standard Work Exclusion 90.00 (9)

Sub-total _____ (10)

Minus Other Exclusions _____ (11)

Sub-total $ _____ (12)

Add Unearned Income _____ (13)

Parent 2 Countable Income _____ (14)

TOTAL COUNTABLE INCOME _____ (15)
(Line 7 + Line 14)

Step 2

Determine the Income Deeming Standard. The deeming standard is the F&C 100% Monthly Income Limit for the number of persons in the deemor's BU plus the number of deemor's excluded children in the home who are or could be claimed as tax dependents on the deemor's federal tax income return. Total # of people _____.

_____Whole income deeming standard, or

_____One-half income deeming standard
(Use when parents are in the same BU and have a child in common, and at least one parent is deeming to a child who is not the spouse's child.)

Income Deeming Standard _____(16)

Step 3

Total Countable Income (line 15) $ _____(17)

Minus Income Deeming Standard (line 16) _____(18)

Minus alimony/support paid by the deemor(s) to individuals not in the home _____(19)

DEEMABLE INCOME $ _____(20)

DETERMINING AMOUNT OF RESOURCES AND INCOME DEEMED TO EACH PERSON

Divide the DEEMABLE RESOURCES and DEEMABLE INCOME amounts by the **number of persons** for whom the parent is legally responsible who are **in BU's outside** the parent(s) BU.

DEEMABLE RESOURCES $_____divided by _____ = $_____Resources deemed to each person

DEEMABLE INCOME $_____divided by _____ = $_____Income deemed to each person

CHAPTER M05
MEDICAID ASSISTANCE UNIT
SUBCHAPTER 30

ABD ASSISTANCE UNIT

M0530 Changes

Changed With	Effective Date	Pages Changed
Update (UP) #5	7/1/11	page 14
TN #95	3/1/11	page 1 Appendix 1, page 1
TN #93	1/1/10	pages 11, 19 Appendix 1, page 1

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M0530.000 ABD ASSISTANCE UNIT

M0530.001 OVERVIEW

A. Introduction

This subchapter contains the policy and procedures for determining the assistance unit for a non institutionalized individual who meets an aged, blind or disabled (ABD) covered group. Do not use this subchapter for an institutionalized individual; use subchapter M1460 to determine an institutionalized individual's financial eligibility.

The number of persons in the assistance unit and the individual's covered group determine which resource and income limits apply. The deeming policy and procedures in this subchapter explain how to determine how much of a legally responsible relative's resources and income is deemed to the ABD individual.

Appendix 1 to this chapter lists the deeming allocations used when deeming income of a legally responsible relative.

B. Assistance Unit Composition

When determining composition of the ABD assistance unit, identify the individual who applies for Medicaid, who meets the aged, blind or disabled definition in M0310 and who meets an ABD covered group's requirements.

1. Responsible Relatives

a. Spouse

The unit must include the individual's spouse with whom the individual lives when the spouse applies for Medicaid and meets the aged, blind or disabled definition in M0310, regardless of whether the spouse receives an SSI or IV-E foster care/adoption subsidy payment.

b. Parent of Blind/Disabled Child Under Age 21

The parent(s) with whom the blind or disabled child under age 21 lives is legally responsible to support the child. However, the parent is not included in the child's assistance unit. The parent's resources and income are deemed available to the child.

2. SSI Recipients

The policy in this subchapter applies when determining the **resource** eligibility of individual SSI recipients or of couples when both spouses receive SSI and one or both owns an interest in real property contiguous to the home or undivided interest in heir property, or a former residence.

If the SSI recipient is ineligible for Medicaid in the SSI Medicaid covered group due to excess resources, first determine the individual's eligibility in an F&C covered group, if possible, using the F&C assistance unit and financial eligibility rules. If the individual is not eligible in one of the F&C covered groups, then determine his eligibility as an ABD individual.

This subchapter does **not** apply to the **income eligibility** determination of an SSI recipient because an SSI recipient meets the Medicaid income eligibility requirements just by the fact that he/she receives an SSI payment.

3. Living With Family and Children

If the ABD individual lives with his/her spouse and/or dependent child(ren) who request Medicaid in a families and children covered group, the policy in this subchapter applies only to the ABD individual. Use the assistance unit policy in M0520 and the financial requirements in chapters M06 and M07 for the family members who meet an F&C covered group.

4. Living Arrangement

An ABD individual's, couple's or child's living arrangement on the first day of the month is used to determine the individual's status for the entire month. If they are living together (or child is living with parent) on the first of the month, they are living together for the entire month except when separation due to institutionalization occurs within the month. If they are living apart on the first of the month, they are considered separated for the entire month.

When an individual is admitted to an Adult Care residence (ACR) or other residential facility, he is considered separated and living apart from his spouse (or parent if the individual is under age 21) as of the first of the month following the admission month.

5. Institutionalization

When an individual is institutionalized in a medical facility, he is considered separated and living apart from his spouse (or parent if the individual is under age 21) as of the first day of the month in which he is admitted to a nursing facility or to Medicaid-approved community-based care waiver services. He is considered separated as of the first of the month during which he has been hospitalized in an acute care or rehabilitation hospital for 30 consecutive days.

If an individual is institutionalized, do not use this subchapter. Use the policy and procedures in chapter M14 to determine an institutionalized individual's eligibility.

6. Deeming From Married Parent

When determining how much of the child's parent's income is deemed available to the child's unit, any income of the parent's spouse who is not the child's parent is not counted.

C. Pregnant Blind or Disabled Woman

If the blind or disabled individual also meets the pregnant woman definition, first determine the woman's eligibility in the MI Pregnant Woman covered group using the F&C assistance unit and financial eligibility rules. If she is not eligible as an MI pregnant woman, then determine her eligibility as an ABD individual.

D. Spenddown Expenses

If an ABD assistance unit is ineligible because of excess income, the assistance unit's member(s)'s medical expenses will count toward the spenddown. If an individual in the unit is legally liable for another person in the household who is not in the assistance unit, the other person's medical bills can count toward the unit's spenddown. If the ABD individual's spouse's or parent's income is deemed to the individual, the spouse's or parent's medical expenses are also deducted from the ABD individual's spenddown.

A medical expense can only be used once to meet only one unit's spenddown. A child's medical expenses are first deducted from the child's unit. If the child's unit spenddown is not met, the child's medical expenses

can be deducted from the parent's spenddown. If the child's unit's spenddown is met, then the child's medical expenses that were not used to meet the child's spenddown can be deducted from the parent's spenddown, if the medical expenses are not covered by Medicaid or other health insurance.

M0530.002 DEFINITIONS

A. Introduction

This section contains the definitions of terms used in this subchapter that are applicable to ABD individuals' assistance units and financial eligibility determinations.

B. Child

For ABD assistance unit composition purposes, a child is someone who is not married, is not the head of a household, and is either under age 18 or is under age 22 and a student. For ABD **deeming** purposes, a child is an individual under age 21.

1. Blind/Disabled (BD) Child For Deeming Purposes

A blind/disabled (BD) child who is subject to deeming is a natural or adopted child under age 21, who lives in a household with one or both parents and who meets the blind or disabled definition in M0310. Deeming to the BD child no longer applies beginning the month following the month the child attains age 21. An individual attains a particular age on the day preceding the anniversary of his/her birth. Deeming applies in the month of attainment of age 21 regardless of whether an application is filed before or after the day of attainment.

For purposes of ABD deeming, a blind or disabled (BD) child who does NOT apply for Medicaid is still a BD child for deeming purposes and NO allocation is deducted for a BD child when calculating the NABD spouse's or parent's deemable income.

2. Non Blind/Disabled (NBD) Child For Deeming Purposes

A non blind/disabled (NBD) child, for deeming purposes, means the natural or adopted child of an Medicaid-eligible individual or the individual's spouse, or the natural or adopted child of a parent or the parent's spouse, who

- lives in the same household with the ABD individual or BD child,
- is **not** blind or disabled, and
- is under age 18, or under age **21** and a **student** regularly attending a school, college, or university, or a course of vocational training to prepare him for gainful employment.

3. NBD Child Documentation Requirements

If the parent does not provide the following documentation for an NBD child in the household, do NOT deduct an NBD child allocation for that NBD child from the parent's income when calculating deemable income:

a. Age

Accept the allegation of an NBD child's age, absent evidence to the contrary.

b. Relationship

Accept an individual's statement that a parent-child relationship exists in both initial application and redeterminations. If there is reason to question the allegation, verify relationship.

c. School Attendance

If an NBD child is alleged to have no earnings, accept the allegation of student status. If an NBD child under age 21 alleges student status and earnings, verify school attendance and document the file according to the instructions in M0530.002, item I, below. Do not redetermine student status unless a change in school attendance is alleged.

C. Parent

For ABD deeming procedures, "parent" means the BD child's natural or adoptive parent who lives with the BD child. Deeming applies from a parent to a child when they live together in the same household.

A stepparent is not considered a parent for ABD deeming purposes. Even if a natural or adoptive parent is deceased or is divorced from the stepparent, and the child is living with the stepparent, the stepparent is **not** a parent of the BD child for deeming purposes.

D. Aged, Blind or Disabled (ABD) Spouse

For ABD deeming procedures, "ABD spouse" means the ABD individual's spouse who meets the aged, blind or disabled definition in M0310, and who applies for Medicaid.

E. Non Aged, Blind or Disabled (NABD) Spouse

For ABD deeming procedures, "NABD spouse" means the ABD individual's spouse who

- does not meet the aged, blind or disabled definition in M0310, or
- who does not apply for Medicaid.

Deeming applies from a spouse to a spouse when they live together in the same household.

F. Allocation

An allocation is an amount deducted from income subject to deeming which is considered to be set aside for the support of certain individuals other than the ABD individual or BD child. The types and amounts of these allocations are described in this subchapter. Changes in allocations (e.g., due to birth or death, entering or leaving a household, no longer meeting the definition of a child) are effective with the month following the month of change.

1. NBD Child Allocation

An allocation from an Parent's or spouse's income is given for each NBD child living in the same household. The amount of the allocation is equal to the difference between the SSI payment limit for two persons and the SSI payment limit for one person.

The allocation amount increases automatically whenever the SSI payment limit increases. *See Appendix 1 to this subchapter for current amount.*

The allocation for an NBD newborn child is effective the month following the month of birth. An NBD child allocation is given for a child who is away at school if the child is under age 21 and considered to be temporarily absent from the household. Allocations from a spouse's or a parent's income for an NBD child in the household end the month after the month the child attains age 18 or, if a student, age 21.

Each NBD child's allocation is reduced by the amount of his or her own income, including child support payments from an absent parent. (Note, however, that NBD children **do not** receive the one-third child support exclusion).

2. Parent Living Allowance

A living allowance is deducted from a parent's own income when deeming parental income to a BD child. The amount of the living allowance depends upon whether one or both parents are living in the household. The living allowance for one parent living with the child in the household *is* the SSI payment limit for one person. The living allowance for both parents living with the child in the household *is* the SSI payment limit for a couple.

The living allowance increases automatically whenever the SSI payment limit increases. *See Appendix 1 to this subchapter for current amounts.*

G. Household

A household is common living quarters and facilities under such domestic arrangements and circumstances as to create a single economic unit or establishment. For the purposes of deeming, the household comprises

- the ABD individual, the spouse and any children of the couple or either member of the couple; or
- the BD child, the parent(s), and other children of the parent(s).

Deeming only applies in household situations. Unless temporarily absent, only those individuals residing in the household are a part of the household for deeming purposes. An individual is not a member of the household for deeming purposes if he/she is absent from home for a

period which is not a temporary absence as defined below in item I. (for example, military service or confinement in a public institution).

If a child is born in an institution (e.g., a hospital) the child is not a member of a household until the **month after the month** the child goes home. A child born at home is a member of the household the month of birth.

NOTE: Deeming does not apply when an ABD individual and NABD spouse are living in an institution even when they are sharing a room. Deeming **does** apply in noninstitutional care situations (e.g., adult foster care) if the ABD individual is placed with a deemor spouse or parent.

H. Student Child

A student child is an individual who

- is neither married nor head of a household,
- is under age 21 years, and
- regularly attends school or college or training designed to prepare him/her for a paying job.

1. Regular Attendance

Regular attendance means that the individual takes one or more courses of study and attends classes

- in a college or university for at least 8 hours a week under a semester or quarter system;
- in grades 7-12 for at least 12 hours a week;
- in a course of training designed to prepare him/her for a paying job for at least 15 hours a week if the course involves shop practice or 12 hours a week if the course does not involve shop practice. This type of training includes anti-poverty programs such as the Job Corps and government-supported courses in self-improvement; or
- for less than the amount of time indicated above for reasons beyond the student's control, such as illness, if the circumstances justify the reduced credit load or attendance.

NOTE: Attendance at an elementary school does not satisfy the student child requirement.

2. Homebound Students

An individual may be a student when he/she has to stay home because of a disability, and

- studies a course or courses given by a school (grades 7-12), college, university or government agency, or
- a home visitor or tutor from school directs the study or training.

3. Periods of Nonattend-ance

a. Vacation

An individual remains a student when classes are out if he/she actually attends classes regularly just before the time classes are out and:

- tells the agency that he/she intends to resume attending regularly when school reopens; or
- actually does resume attending regularly when school reopens.

b. Recommendation of Teacher or Counselor

A student's counselor or teacher may believe the student needs to stay out of class for a short time during the course or between courses to enable him/her to continue study or training. Consider the individual to be a student regularly attending school, college, or training to prepare him/her for a paying job if he/she is in a course:

- designed to prepare disabled people for work; or
- to prepare the individual for a job that is specially set up for people who cannot work at ordinary jobs.

c. Last Month of School

An individual is a student regularly attending school for the month in which he/she completes or stops the course of study or training.

4. Development

Develop school attendance for a child between the ages of 18-21 who is not blind or disabled and could be included in the parent-to-child and spouse-to-spouse deeming calculations.

a. Basic Information

Obtain the following information:

- Name and address of the school or institution furnishing the training:
- Name and telephone number of the person to contact for verification, if necessary; and
- Information on the course or courses of study, dates of enrollment, number of hours of attendance, other activities of the child.

b. School Enrollment

Verify enrollment by:

- examining a school record such as an ID card, tuition receipt, or other comparable evidence; or

- contacting the school or agency, but only if the individual does not have the evidence.

Document the file with enrollment information. If you contact the school or agency, accept either a written statement from the contact or an oral statement recorded in the file.

c. Student's Allegation of Number of Hours of Attendance

Accept the student's allegation without requesting school certification of attendance, if the allegation of attendance meets the regular attendance requirements above. If the student alleges a reduced credit load or attendance due to circumstances beyond his or her control, obtain an explanation from the student and place it in the file.

d. Special Education

If a student indicates he/she is enrolled in special education for the disabled which does not satisfy the standard academic or vocational training requirements, develop to determine whether the course contains training to prepare him/her for a paying job.

e. Vocational or Technical Training

Absent evidence to the contrary, accept the school or agency's allegation that the course includes some formalized instruction.

I. Temporary Absence

For the purposes of deeming, a temporary absence exists when an individual (ABD individual or BD child, NABD spouse or parent, or NBD child) leaves the household but intends to, and does, return in the same month or the following month. If the absence is temporary, deeming continues to apply.

1. Child Subject To Parental Control

A child who is away at school but returns home on some weekends, holidays, or vacations and **is** subject to parental control is considered temporarily absent from the parents' household, regardless of the duration of the absence. If a child is away at school and is **not** subject to parental control, he/she is **not** living in the parents' household.

2. Operating Procedures

A child who is away at school is one who is participating in an educational or vocational training program. The rule above only applies to a child who is away at an educational or vocational training facility.

When a child resides at a facility and the facility is not an educational or vocational training facility, the rule above does not apply. When a child resides in a facility and leaves the facility for brief visits to the parents' home, do not deem the parents' income and resources for any month if the absence from the facility is temporary. An individual is considered

temporarily absent from a facility for deeming purposes if the absence is not intended to and does not exceed a full calendar month.

Certain evidence may indicate that a child away at school is not subject to parental control. Such evidence includes an existing agreement, a court order, or the signed statements of the parents and the school authorities. In the absence of such evidence, assume that a child is subject to parental control. Parental control is the authority of the parent(s) to make decisions on the child's behalf, whether or not the control is actually exercised.

M0530.010 EXCLUDED RESOURCES

A. Policy

Assets which are not resources to an ABD individual are not resources to an NABD spouse or NBD child (See S1120).

In addition to assets which are not resources, there are certain resources which are excluded from the resources of an individual whose resources are deemed to an applicant/recipient. These exclusions from resources used in the resource deeming calculation correspond to exclusions of an ABD individual's own resources.

B. Related Policies

1. Resource Determination

To determine the NABD spouse's or parent's resources, see chapter S11. See S1120 for assets that are not, or may not be, resources. See S1130 for the list of resource exclusions. See S1140 for countable resources. See S0830.605 concerning Home Energy Assistance funds and Support and Maintenance Assistance funds that are retained beyond the month of receipt.

2. Pension Funds

a. Excluded Pension Funds

Pension funds owned by the NABD spouse or parent are excluded from deeming. Pension funds are defined as funds held in an individual retirement account (IRA) as described by the Internal Revenue Service (IRS) code, or funds held in work-related pension plans (including such plans for self-employed individuals, sometimes referred to as Keough plans). However, amounts distributed from a pension fund to the NABD spouse or parent will count as income that can be deemed to the ABD spouse or BD child.

b. Countable Pension Funds

IRA's, Keough plans, 401-K plans, and similar pension funds owned by the applicant/recipient and/or his/her ABD spouse or parent are **countable resources**, and amounts distributed from the funds are countable income, since these types of pension funds may be withdrawn by the owner.

c. Development Procedures

1) If an NABD spouse or parent alleges having money in a pension fund, accept the allegation.

2) Develop interest income from excluded pension funds per M0830.500.

3) If an NABD spouse or parent withdraws monies he or she had contributed to a pension fund, treat the withdrawal as a conversion of a resource.

3. Other Resource Exclusions

All resource exclusions that apply to an ABD individual's resources apply to the combined resources of an ABD individual and an NABD spouse or parent who lives with him or her.

4. Burial Fund Exclusion

For treatment of the burial fund exclusion, see M1130.410.

5. Burial Space Exclusion

For treatment of the burial space exclusion, see M1130.400.

M0530.020 EXCLUDED INCOME

A. Policy

Receipts which are not income to an ABD individual are not income to an NABD spouse or NBD child (See S0815).

In addition to items which are not income, there are certain items which are excluded from the income of an individual whose income is deemed to an applicant/recipient. Furthermore, an NBD child's allocation is not reduced by any of these excluded items. These exclusions from income used in the deeming calculation correspond to exclusions of an ABD individual's own income AND include some additional exclusions. For example, one-third of child support payments from an absent parent is excluded for a BD child, but is NOT excluded from an NBD child's income in the deeming calculation.

B. Excluded Income

The following types of income are excluded when determining countable income of an NABD spouse or parent subject to deeming. These types of income are also excluded from the income of an NBD child in a household for purposes of reducing the NBD child allocations:

1. Income Excluded In S08

Income excluded by policy in chapter S08 is also excluded from the income of an NABD spouse or parent.

2. Grant, Scholarship or Fellowship

Exclude any portion of any grant, scholarship, or fellowship which is used to pay the cost of tuition and fees at an educational institution or costs of vocational technical training designed to prepare the individual for gainful employment.

3. *SNAP*

Exclude the bonus value of *Supplemental Nutrition Assistance Program (SNAP) benefits* (*formerly* Food Stamps) and the value of USDA donated foods.

4. Support Paid

Exclude any portion of the NABD individual's income paid to the Division of Child Support Enforcement (DCSE), court, ex-spouse, or child(ren) as court-ordered or DCSE-ordered support.

a. Ask whether any of the income received by the NABD spouse or parent is used to make any support payments. If such payments are alleged:

- Document the allegation that such support payments are made;
- Request a copy of the court order or State agreement which shows the amount of the payments and the beginning and ending dates of the payments. Exclude the amount specified in the court order or State agreement, or the actual payment, **whichever is less**. A deemor's own records may be used to document the amount of support payments made.

b. Deduct the amount of the support payment from the income of the NABD spouse or parent **before** determining the amount of income to be deemed. Deduct the amount of such payments from the income of an NBD child (if the child **pays** support payments) before reducing the NBD child's allocation.

- Deduct the support amount first from the NABD spouse=s, parent=s or NBD child=s unearned income.
- Use any remaining balance of the support obligation to reduce the NABD spouse's, parent's or NBD child's earned income.

5. Student Earnings

Exclude income earned by an NBD child in the home who is a student (unless the child actually makes the income available to the family).

If an NBD child is a student (M0530.002 I.), the child's earned income up to $400 a month but not more than $1,620 per year does **not** reduce the allocation for the NBD child.

a. If an NBD child has earnings, verify that the NBD child is a student (see M0530.002 I.). If a child's student status ends, stop applying the student earned income exclusion beginning with the month after the month in which the student status ended.

b. Verify the NBD child's wages. Verify the wages even if alleged to be $65 or less per month.

c. Allocate the student earned income exclusion beginning with January, or the first month the NBD child has earnings or the month in which

the ABD individual becomes eligible for Medicaid, whichever is later in a calendar year. See S0820.510 for additional information on this exclusion.

d. The exclusion may be applied during a period of nonattendance at school if the requirements in M0530.002 I. are met.

6. Blind Work Expenses

Expenses of an NABD spouse, parent or NBD child who is blind and working are used to reduce earned income before it is deemed or before using the earnings to reduce the NBD child allocation. See S0820.535 for instructions on applying this exclusion.

7. Impairment Related Work Expenses

The impairment-related work expenses (IRWE) incurred and paid by a deemor who meets the Medicaid disability definition will be deducted from the deemor's earned income prior to considering the income available for deeming. See S0820.540 for instructions on determining the amount of IRWE.

8. In-Home Supportive Services Payments

Payments made by programs funded under title XX of the Social Security Act or other State funding sources for in-home supportive services necessary to enable an individual who needs these services to live in his or her home are "in-home supportive services payments." The payments are made either to the individual to pay for the services or to the person performing the services. The Veterans Administration also pays an allowance for medically qualified veterans, widows, or widowers in need of the aid and attendance of another person. This aid and attendance payment is included in the pension or compensation payment to the veteran or widow(er).

In-home supportive services (chore, attendant, homemaker) payments are medical or social services and are not income when paid directly to an ABD individual to pay for the services (S0815.050). However, the payment **is income** to the individual who is providing the care or services.

Payments provided under title XX or other Federal, State, or local governmental programs to an ABD individual and **paid** by the individual to his/her NABD spouse or NBD child living in the same household in return for in-home supportive (chore, attendant, homemaker) services, are excluded from the NABD spouse's, parent's or NBD child's income for deeming purposes. Such payments, made directly to the NABD spouse or parent or NBD child to provide the services to the ABD individual, are also excluded from income for deeming purposes.

NOTE: If an NABD spouse or parent receives in-home supportive services payments for services provided to anyone other than his/her ABD spouse or BD child, the payments are included as income subject to deeming.

M0530.100 UNMARRIED INDIVIDUAL (AGE 21 OR OLDER)

A. Policy

An unmarried ABD individual's assistance unit consists of one person--the individual. The individual's child(ren) living with him or her are NOT included in the ABD individual's assistance unit, nor is any of the individual's resources or income allocated for the child(ren) when determining countable resources and countable income.

B. Assistance Unit

Resources Determination - unit of one.

Income Determination - unit of one.

M0530.200 MARRIED INDIVIDUAL LIVING WITH SPOUSE

A. Introduction

A married individual living with his/her spouse is always an ABD couple assistance unit (2 persons) for the **resource** eligibility determination. For the **income** eligibility determination, a married individual living with his/her spouse is an ABD couple assistance unit (2 persons) when the NABD spouse has deemable income, or an assistance unit of 1 person when the NABD spouse has no deemable income.

An aged, blind, or disabled individual or couple found guilty of Medicaid fraud by a court is ineligible for Medicaid benefits for a period of twelve months from conviction. If only one member of an aged, blind, or disabled couple is found guilty, the innocent spouse's eligibility is not affected. The assistance unit remains the same. The guilty spouse is ineligible for twelve months *(see M1700.200)*.

B. Procedure

For an ABD couple, see M0530.201.

For an ABD individual with an NABD spouse, see M0530.202 and 203 below.

M0530.201 ABD COUPLE ASSISTANCE UNIT

A. Policy

This section contains the policy and procedures for determining an ABD couple's assistance unit.

When a married couple is living together and each individual in the couple meets the Aged, Blind or Disabled definition in M0310, AND each

individual applies for Medicaid, their financial eligibility is determined as an ABD couple--an assistance unit of two persons (see M0530.201 below). If one spouse receives SSI, this spouse must be included in the unit with the spouse who does not receive SSI. The resources and income (other than the SSI payment) of the SSI recipient spouse must be considered available along with those of the spouse who does not receive SSI.

EXCEPTION: When

- a member of the ABD couple is a Medicaid minor spouse (under age 21),
- the ABD couple lives with the minor spouse's parent(s), and
- the parent's(s') deemed resources or income makes the ABD couple ineligible,

recalculate each spouse's resource and income eligibility as a separate assistance unit (1 person in each). Deem the parent's(s') resources and income to the Medicaid minor spouse. Do NOT deem the spouses' resources and income to each other.

B. Resource Determination

Determine the couple's countable resources according to chapter S11. NOTE: Some resources' values are calculated differently for the ABD medically indigent groups. If a spouse also has Medicare Part A, determine a resource's value using both the MN and MI methods.

1. Compare To Couple's Resource Limit

Total the couple's countable resources and compare to the resource limit appropriate to each individual's covered group. *The ABD resource limits are contained in M1110.003.*
.

2. Resources Meet Limit

If the couple's resources are less than or equal to the resource limit, the couple meets the resource requirements for the covered group whose resource limit was met.

3. Resources Exceed Limit

If the couple's resources exceed the resource limit, the couple is not eligible for Medicaid in that covered group. If the couple's resources exceed both resource limits, the couple is not eligible for Medicaid in any ABD covered group. Deny Medicaid because of excess resources. If the wife is pregnant, determine her eligibility as a pregnant woman.

EXCEPTION: When

- a member of the ABD couple is a Medicaid minor spouse (under age 21),
- the ABD couple lives with the minor spouse's parent(s), and

- the parent's(s') deemed resources makes the ABD couple ineligible,

recalculate each spouse's resource eligibility as a separate assistance unit (1 person in each). Deem the parent's(s') resources to the Medicaid minor spouse. Do NOT deem the spouses' resources to each other. If a spouse is resource-eligible after this recalculation, determine the spouse's income eligibility as an ABD individual (assistance unit of 1 person); see M0530.100.

C. Income Determination

Determine the couple's countable income according to chapter S08. Total the couple's countable income.

NOTE: In calculating an ABD couple's countable income, **do not** allocate or deduct any amount for a child.

1. Compare To Income Limit

Compare the couple's total countable income to the income limit for two persons appropriate to each individual's covered group. See M0810.002 for the income limits.

2. Income Meets Limit

If the couple's income is less than or equal to the income limit, the couple meets the income requirements for the covered group whose income limit was met. See chapter M15 for Medicaid entitlement policy.

3. Income Exceeds Limit

If the couple's income exceeds the income limit, the couple is not eligible for Medicaid in that covered group. If the couple's resources meet the MN requirements and the MN resource limit, the couple may become eligible for a limited period of MN coverage if they meet a spenddown. See *chapter* M13 for spenddown policy. If the wife is pregnant, determine her eligibility as a pregnant woman.

D. Examples

1. ABD Couple--One Spouse Receives SSI

EXAMPLE #2: (*Using 1999 figures)*
A husband and wife, each 67 years old, live together in a Group II locality. The wife receives SSA of *$391* and SSI of $109 per month. The husband receives *$455* SSA and $100 VA pension per month. Both have Medicare Part A and both apply for Medicaid. The husband and wife are an ABD assistance unit of two for Medicaid resource eligibility purposes. Their countable resources are within the Medicaid resource limit for 2 persons. The wife is income-eligible because she receives SSI. The husband's income eligibility is based on an assistance unit of two. All of the husband's income is counted; only the wife's SSA benefit is counted because SSI payments are excluded. The husband's income eligibility is calculated:

$*455* husband=s SSA
+100 husband=s VA pension
+391 wife=s SSA
946 couple=s unearned income
- 20 general income exclusion
$926 couple=s countable income

$ 926 couple=s countable income
- 922 QMB income limit for 2
4 excess

$ 926 couple=s countable income
x 6 months
$5,556 6 months income
- 1,850 Group II income limit for 2
$3,706 excess

The couple's income is compared to the MI limit for two persons, since the husband has Medicare Part A, and to the medically needy income limit for two persons in Group II. Because the couple's income exceeds the QMB limit for 2 persons, the husband is not eligible for QMB Medicaid. The couple's countable income exceeds the medically needy limit for two; only the husband is placed on spenddown. The wife is eligible as a categorically needy SSI recipient.

2. ABD Couple With NBD Child

EXAMPLE #3: ***(Using 1999 figures)***
Mr. and Mrs D live in a Group I locality with their 18 year-old daughter. Mr. D is 67 years old. Mrs. D is 58 years old and disabled, but she works part-time. Her impairment-related work expenses (IRWE) are $50 per month. Mr. D receives SSA of $475 per month and $100 gross earnings per month. Mrs. D receives $150 SSA and $300 gross earnings per month. Their daughter has no income. Mr. and Mrs. D both have Medicare Part A and both apply for Medicaid. They are an assistance unit of two for Medicaid resource eligibility purposes. Their countable resources are within the Medicaid resource limit for 2 persons. Their income eligibility is calculated (NOTE: no allocation is subtracted for their NBD child because they are an ABD couple):

$475 Mr. D's SSA
+150 Mrs. D's SSA
625 couple's unearned income
- 20 general income exclusion
$605 couple's countable unearned income

$300 Mrs. D's gross earned income
- 50 Mrs. D's IRWE exclusion
250 Mrs. D's net earnings
+100 Mr. D's gross earned income
350 couple's gross earnings
- 65 exclusion
285
) 2 2 remainder earnings exclusion
142.50 couple's countable earned income
+605.00 couple's countable unearned income
$747.50 couple's countable monthly income
- *922*.00 QMB income limit for 2
0 excess

$747.50 couple's countable monthly income
x 6 months
4485 6-month income
-1700 Group I limit for 2
$2785 excess

Because the couple's income is less than the QMB limit for 2 persons, they are eligible for QMB Medicaid. Their income exceeds the medically needy limit for two and they are placed on a spenddown.

M0530.202 DEEMING RESOURCES FROM NABD SPOUSE

A. Policy

When a married couple is living together BUT

- only one spouse applies for Medicaid, or
- only one spouse meets the Aged, Blind or Disabled definition in M0310,

the individual spouse's resource eligibility is determined as a couple--an ABD assistance unit of 2 persons, and the NABD spouse's resources are counted available to the ABD individual.

The resources of one spouse are considered available to the other whether or not they are actually made available. Resource eligibility exists if the value of the couple's combined resources does not exceed the resource limit for two persons. **The resources of an SSI recipient spouse must be counted available even if SSI recipient spouse does not apply for Medicaid.**

Verify and document the NABD spouse's resources as required for an ABD individual.

***B.* Excluded Resources**

When determining the NABD spouse's resources, do not include the resources listed in section M0530.010 above.

***C.* Countable Resources**

Total countable resources are the combination of the resources of the ABD individual and the NABD spouse after all applicable resource exclusions are applied.

Total countable resources are compared to the resource limit for a couple. If the amount of the resources does not exceed the limit, the applicant/recipient meets the resource eligibility requirement. If countable resources exceed the limit, the applicant/recipient is ineligible because of excess resources.

***D.* Example--No Resources Excluded**

EXAMPLE #4: Mr. and Mrs. Daley live together. Mr. Daley, who is age 65, applies for Medicaid on February 4, 1997. His wife is under age 65 and neither blind nor disabled, nor does she meet any Medicaid

covered group. Mr. Daley has no resources of his own. However, Mrs. Daley has $1,900 in a savings account and owns a vacant lot valued at $500 which does not produce income.

The couple's countable resources are as follows:

$1,900 - Mrs. Daley's savings account
+ 500 - Mrs. Daley's lot
$2,400 - couple's combined resources
- 0 - applicable exclusions
$2,400 - couple's countable resources
- 3,000 - couple's resource limit
0 excess

Mr. Daley meets the resource eligibility requirements.

***E*. Example--Some Resources Excluded**

EXAMPLE #5: Mr. and Mrs. Sands live together. Mr. Sands, who is disabled, applies for Medicaid on October 2, 1997. Mrs. Sands does not meet a Medicaid covered group. She works for a company with a pension plan and states she has accumulated $5,000 in her pension fund which she can withdraw at any time. Mr. and Mrs. Sands jointly own two grave sites worth $500 each and have a joint bank account with a balance of $ 1,000.

The couple's resources are as follows:

Excluded Resources:
$5,000 - pension fund
+ 1,000 - grave sites
$6,000 - excluded resources

Countable Resources:
$1,000 - joint bank account

$1,000 - couple's countable resources
- 3,000 - couple's resource limit
0 excess

Mr. Sands meets the resource eligibility requirements.

***F*. Example--Some Resources Excluded--Individual is Ineligible**

EXAMPLE #6: Mr. Smith, who is 69 years old, applies for Medicaid on October 15, 1997. He lives with his wife who is age 62, neither blind nor disabled, nor does she meet a Medicaid covered group. They have the following resources: a joint checking account of $250; United States savings bonds (in both their names) worth $400, and two automobiles--one with a current market and equity value of $6,000, and the other with a current market value and equity value of $3,000. In addition, Mrs. Smith owns a plot of land which produces no income and has an equity value of $2,000. Mr. Smith owns a life insurance policy on his own life with a face value of $5,000 and a cash surrender value (CSV) of $897. Mrs.

Smith owns a life insurance policy on her life with a face value of $1,000 and a CSV of $900.

Excluded Resources:
$6,000 - one automobile
+ 900 - CSV of life insurance of Mrs. Smith with face value not over $1,500
$ 6,900 - excluded resources.

Countable Resources:

$ 250 - joint checking account
400 - savings bonds
3,000 - second automobile
2,000 - Mrs. Smith's real estate
+ 897 - CSV of Mr. Smith's life insurance (face value > $1,500)
$6,547 - couple's countable resources
-3,000 - couple's resource limit
$3,547 - excess resources

Mr. Smith is ineligible because of excess resources.

M0530.203 DEEMING INCOME FROM NABD SPOUSE

A. Policy

When a married couple is living together BUT

- only one spouse applies for Medicaid, or
- only one spouse meets the Aged, Blind or Disabled definition in M0310,

the individual's income eligibility is determined as an individual--an ABD assistance unit of one person--if the NABD spouse has no deemable income. If the NABD spouse has deemable income, the individual=s income eligibility is determined as an ABD couple. The NABD spouse=s income is deemed available to the ABD individual applicant UNLESS the NABD spouse receives SSI or other income based on need.

The income of the NABD spouse, after applying the applicable deeming procedures in this section, is considered to be the ABD individual's own unearned income, and is called deemed income. This deemed income is added to the individual's own earned and unearned income in order to determine the individual's income eligibility.

B. Do Not Deem If Spouse Receives Benefits Based On Individual Need

If the NABD spouse receives assistance or a benefit paid by a government agency which is based on economic need, none of the NABD spouse's income is deemed available to the applicant/recipient. Government benefits based on need include SSI, TANF, Veterans Administration pensions, General Relief payments, etc., but do not include *SNAP*,

fuel assistance, or any benefit based on the entire household's needs. If the NABD spouse does not receive a government benefit which is based on need, the spouse's income is deemed available.

The government benefits based on need are those payments made under:

1. **TANF** — Title IV-A of the Social Security Act, Temporary Assistance to Needy Families with Children (TANF);
2. **SSI and AG** — Title XVI of the Social Security Act (Supplemental Security Income (SSI), including Virginia's Auxiliary Grants program payments (state-administered mandatory supplements);
3. **Refugee Assistance** — The Refugee Act of 1980 (those payments based on need);
4. **Disaster Relief** — The Disaster Relief Act of 1974;
5. **BIA Assistance** — General assistance programs of the Bureau of Indian Affairs;
6. **State or Local Assistance** — State or local government assistance programs based on need; and
7. **VA Assistance Based On Need** — U.S. Veterans Administration programs (those payments based on need).

C. Excluded Income

When determining the NABD spouse's income, do not include the income listed in section M0530.020 above.

D. Deeming Process

When an NABD spouse lives in the same household as the ABD individual, these deeming rules are applied in the following order:

- Determine the NABD spouse's earned and unearned income in the month;
- Deduct an allocation for each NBD child in the household (item E below);
- Compare the remainder to the deeming standard (item F below).

First, determine the NABD spouse's countable earned and unearned income in the month.

E. Subtract NBD Child Allocation

Deduct an allocation for each NBD child who lives in the household is deducted. **Exception:** no allocation is given for any children who are receiving public assistance maintenance payments, such as TANF.

1. NBD Child Allocation

The allocation for each NBD child is the difference between the SSI payment limit for two persons and the SSI payment limit for one person.

The allocation amount automatically increases whenever the SSI limits increase. *See Appendix 1 to this subchapter for current amount.*

2. Reduce NBD Child Allocation

Each NBD child's allocation is reduced by the amount of his or her own income. The items listed in section M0530.020 above are not included as income to the NBD child for purposes of reducing the allocation.

If any NBD children in the household have income, verify the NBD child's income. However, when the alleged income exceeds the amount of the NBD child allocation amount (i.e., no NBD child allocation will apply for that NBD child), document the allegation in the file but do not verify the income. Document an allegation in the file when any NBD child living in the household has no income. Do not redevelop the NBD child's income unless a change is alleged or there is a reason to believe a change has occurred.

3. Subtract NBD Child Allocation Amount

Subtract the allocations for NBD children first from the NABD spouse's **unearned** income. If the NABD spouse does not have enough unearned income to cover the allocations, the allocation balance is subtracted from the NABD spouse's **earned** income.

F. Compare Remainder To Deeming Standard

Compare the NABD spouse's remaining income to the deeming standard (the difference between the SSI payment limit for two persons and the SSI payment limit for one person). *See Appendix 1 to this subchapter for current amount.*

G. Result (To Deem or Not To Deem...)

1. Less Than or Equal To Deeming Standard

If the NABD spouse's remaining income is equal to or less than the deeming standard, there is no income to deem to the ABD individual. In this situation, the ABD individual's own countable income is determined and subtracted from the appropriate income limit for one person to determine eligibility. See S0810.002 for the income limits.

2. More Than Deeming Standard

If the remaining income of the NABD spouse is more than the deeming standard, the ABD individual and the NABD spouse are treated as a couple, using the procedures in H "Couple Calculation" below.

NOTE: The $20 general exclusion has not been deducted from the ABD individual's income at this point.

H. Couple Calculation

The ABD individual and the NABD spouse are treated as a couple using the following procedures:

1. Combine Income

Combine the amount of the NABD spouse's unearned income remaining after NBD child allocation(s) with the ABD individual's own unearned income. Combine the amount of the NABD spouse's earned income remaining after NBD child allocation(s) with the ABD individual's earned income.

2. Subtract Exclusions

Subtract the appropriate income exclusions *from the remaining income*:

- the first $20 of the couple's unearned income (if less than $20 of unearned income in a month, any remaining portion of the $20 exclusion is applied to the couple's earned income in the month),
- $65 of the couple's earned income in a month, and one-half of remaining earned income in a month.

The result is the couple's monthly countable income. When determining MN eligibility, multiply the couple's monthly countable income by 6.

3. Compare To Income Limit

Compare the couple's countable income to the income limit for two persons appropriate to the ABD individual's covered group. See M0810.002 for the income limits.

4. Income Meets Limit

If the couple's countable income is less than or equal to the income limit, the ABD individual meets the income requirements for the covered group whose income limit was met. See chapter M15 for Medicaid entitlement policy.

5. Income Exceeds Limit

If the couple's countable income exceeds the income limit, the ABD individual is not eligible for Medicaid in that covered group. If the couple's resources meet the MN requirements and the MN resource limit, the ABD individual may become eligible for a limited period of MN coverage if he/she meets a spenddown. See *chapter M13* for spenddown policy.

I. Examples

The examples below illustrate application of the spouse-to-spouse deeming rules in the ABD income eligibility calculation.

1. No Deemed Income After NBD Child Allocation

EXAMPLE #7: *(Using January 2000 figures)*
Ms. Wilson, an aged individual, applied for Medicaid. She lives with her NABD spouse Mr. Wilson and their 20 year old NBD child, Mike, in Group II. Their resources are within the resource limit. Mr. Wilson receives a $80 monthly benefit (unearned income) per month. He has no earned income. Mike receives $20 monthly unearned income. Ms. Wilson's income is *$800* monthly SSA. She has Medicare Part A. Her assistance unit is one person with income deemed from her NABD spouse. The deeming calculation is:

$257	NBD child allocation amount
- 20	Mike' income
237	NBD child allocation

$ 80 Mr. Wilson's unearned income
- *237* NBD child allocation
- *157* remainder NBD child allocation
+ 0 Mr. Wilson's earned income
$ 0 NBD spouse's total income after allocation

Since Mr. Wilson has no remaining income, and $0 is less than the *$257* deeming standard, no income is deemed to Mrs. Wilson. Instead, only her own countable income is compared to the MN, QMB, SLMB *and QI* income limits for one person to determine whether she is eligible. Mrs. Wilson's own countable income is *$780*, which exceeds the MN and the QMB income limit for one person. However, it is within the SLMB income limit. She is eligible for SLMB coverage beginning *January 1, 2000.* She is also placed on a spenddown of *$3,180* (*$780* x 6 months = *4,680 -1500 = $3180*) for the period *January 1* through *June 30*.

2. Spouse Has Earned and Unearned Income After Allocation

EXAMPLE #8: ***(Using January 2000 figures)***
Mr. Jack Ingalls, a disabled individual, applies for Medicaid. He lives with his NABD spouse and NBD 19 year old child, Cathy, in a Group I locality. Mr. And Mrs. Ingalls' resources are within the resource limit. Mr. Ingalls receives $100 unearned income monthly; he does not have Medicare Part A. Cathy has no income. Mrs. Ingalls has earned income of $450 a month and unearned income of $285 a month. Mr. Ingalls' assistance unit is one person with income deemed from his NABD spouse. The deeming calculation is:

$285 Mrs. Ingalls' unearned income
-257 NBD child allocation
28 remainder unearned income
+450 Mrs. Ingalls' earned income
$478 NBD spouse's total income after allocation

Mrs. Ingalls' total income is more than the *$257* deeming standard. Therefore, Mrs. Ingalls' income is deemed to Mr. Ingalls by combining Mrs. Ingalls' income after allocation with Mr. Ingalls' income to determine his MN eligibility:

$285 Mrs. Ingalls' unearned income
-257 NBD child allocation
28 remainder unearned income
+100 Mr. Ingalls' unearned income
128 combined unearned income
- 20 general income exclusion
108 couple's countable unearned income

$450 Mrs. Ingalls' earned income
+ 0 Mr. Ingalls' earned income
450 couple's earned income
- 65 earned income exclusion
385

385
÷ 2 1/2 remainder earned income exclusion
192.50 couple's countable earned income
+*108.00* couple's countable unearned income
300.50 couple's total countable monthly income
x 6 months
1,803.00 countable monthly income
-1,700.00 income limit 2 in Group I
$ *103.00* *excess*

The couple's countable monthly income exceeds the medically needy income limit for a couple. Mr. Ingalls is placed on a spenddown of *$103* for the 6-month period *January 1* through *June 30.*

3. Both ABD Individual and NABD Spouse Have Income--Individual Is Eligible

EXAMPLE #9: ***(Using January 2000 figures)***
Harold Bergman, a disabled individual, applies for Medicaid. He lives in Group III with his NABD spouse, who earns $259 per month. They have no children. Mr. Bergman receives a pension (unearned income) of $165 a month and earns $100 gross per month. He does not have Medicare Part A. The couple's resources are within the Medicaid limit. Because Mrs. Bergman's income exceeds the deeming standard of *$257*, Mrs. Bergman's income is deemed to Mr. Bergman by combining Mrs. Bergman's income with Mr. Bergman's income to calculate his MN eligibility:

$165.00 Mr. Bergman's unearned income
+ 0 Mrs. Bergman's unearned income
$165.00 couple's unearned income
- 20.00 general income exclusion
$145.00 couple's countable unearned income

$259.00 Mrs. Bergman's earned income
+100.00 Mr. Bergman's earned income
359.00 couple's earned income
- 65.00 earned income exclusion
294.00
)÷ 2 ½ remainder earned income exclusion
147.00 couple's countable earned income
+145.00 couple's countable unearned income
$292.00 couple's total countable monthly income
x 6 months
$1752.00 countable income
- 2400.00 income limit for 2 in Group III
0 excess

The couple's countable income is within the MN income limit for 2 persons, so Mr. Bergman is eligible for Medicaid as medically needy beginning *January 1.*

M0530.204 CHANGES IN STATUS--MARRIED COUPLES

A. Introduction

There are several events which can change deeming status. All such changes affect deeming the month after the month in which the change

occurs, except as described below. This section contains the rules that apply when there is a change of status.

NOTE: These status changes are effective, for deeming purposes, the month after the month the change occurs. For example, if an NBD child moves out of the household in May, no allocation is given for that child beginning with June for purposes of determining eligibility.

B. NABD Spouse Becomes ABD

If an NABD spouse becomes an ABD spouse, the individual and spouse are treated as an ABD couple effective with the month the spouse becomes an ABD spouse. Eligibility is based on the couple's income for that month.

C. Individual Begins Living With an NABD Spouse

If an ABD individual begins living with an NABD spouse, deeming of the NABD spouse's income begins effective with the month after the month they begin living together.

D. NABD Spouse Dies

If an NABD spouse dies, deeming stops for purposes of determining eligibility effective with the month following the month of death.

E. Spouses Separate or Divorce--Not Due To Institutionalization

If an NABD spouse and ABD spouse separate, or their marriage ends in divorce, the NABD spouse's income is no longer deemed to determine eligibility effective with the month after the month of separation or divorce. In the month following the month in which separation occurred, the ABD individual is an assistance unit of one person with nothing deemed from the separated spouse.

NOTE: If an application is filed in the month of separation or divorce, deeming applies that month even if the application is filed on or after the date of separation or divorce.

1. Both Meet ABD Group and Both Apply

Financial eligibility is determined as an ABD couple assistance unit (two persons) through the month in which the couple separated. Each is a unit of one starting the month **after** the month in which they separated.

2. Only One Spouse Meets ABD Group or Applies

The ABD applicant spouse is an assistance unit of one person if the NABD spouse has no deemable income. Count the NABD spouse's resources and deem income to the ABD applicant only in the month in which the couple separated. Starting the month after the month of separation, do NOT count any resources or deem any income from the separated spouse.

F. One Spouse Becomes Institutionalized

If an ABD individual becomes institutionalized, either in a medical facility or in Medicaid CBC waiver services, deeming stops for purposes of determining eligibility for the institutionalized spouse effective with the first month in which the individual is institutionalized. Deeming stops for purposes of determining eligibility for the community spouse effective the month **following** the month of separation due to institutionalization.

1. Both Meet ABD Group and Apply

a. The Non Institutionalized Spouse

When determining the non institutionalized spouse's financial eligibility, the non institutionalized spouse is an assistance unit of one person beginning the first day of the month **following** the month in which the spouse was institutionalized. Do not deem the institutionalized spouse's resources or income to the non institutionalized spouse beginning the month following the month of separation.

b. The Institutionalized Spouse

For the institutionalized spouse who began institutionalization **before** September 30, 1989, the institutionalized spouse is an assistance unit of one person beginning the first day of the month in which the spouse was institutionalized.

For the institutionalized spouse who began institutionalization **on or after September 30, 1989**, *who has no community spouse*, see *subchapter M1460* to determine the institutionalized spouse's financial eligibility. *For the institutionalized spouse who began institutionalization **on or after September 30, 1989**, who has a community spouse, see subchapter M1480 to determine the institutionalized spouse's financial eligibility.*

2. Only One Spouse Meets Covered Group or Only One Applies

a. The Non Institutionalized Spouse

When determining the non institutionalized spouse's financial eligibility, the non institutionalized spouse is an ABD couple assistance unit of one person beginning the first day of the month **following** the month in which the spouse was institutionalized. Do not deem the institutionalized spouse's resources or income to the non institutionalized spouse begining the month following the month of separation.

b. The Institutionalized Spouse

For the institutionalized spouse who began institutionalization **before** September 30, 1989, the institutionalized spouse is an assistance unit of one person beginning the first day of the month in which the spouse was institutionalized.

For the institutionalized spouse who began institutionalization **on or after September 30, 1989**, *who has no community spouse*, see *subchapter M1460* to determine the institutionalized spouse's financial eligibility. *For the institutionalized spouse who began institutionalization **on or after September 30, 1989**, who has a community spouse, see subchapter M1480 to determine the institutionalized spouse's financial eligibility.*

G. Non Institutionalized Examples

1. NABD Spouse Becomes ABD

EXAMPLE #10: In November 1997, Mrs. Manners, a disabled individual, lives with her NABD spouse. Mrs. Manners has no income and Mr. Manners receives a monthly private company retirement benefit of

$310 (he is not disabled according to the Medicaid definition). Mrs. Manners is eligible for Medicaid in November; her eligibility is determined using deemed income from Mr. Manners. On December 1, 1997, Mr. Manners becomes age 65 and applies for Medicaid. Effective with December, the deeming rules no longer apply. The Mannerses are an ABD couple. Eligibility is determined using their combined income in December.

2. NABD Spouse and ABD Individual Separate

EXAMPLE #11: On September 15, 1997, Mrs. Ellen Bowers, a disabled individual, and her NABD spouse separate. They live in Group II. Mrs. Bowers' only income is a title II benefit of $150 per month. Mr. Bowers works and is paid a salary of $405 per month. To determine Mrs. Bowers' eligibility for September, the couple's unearned income is reduced by the general exclusion ($150 - $20 = $130). The couple's earned income is reduced by the earned income exclusion ($405 - $65 = $340)÷ 2 = $170). The couple's total countable income ($130 countable unearned + $170 countable earned = $300 monthly x 6 months = $1800) is compared to the income limit for an ABD couple ($1850 semi-annual). Mrs. Bowers is eligible in September. Effective with October, the deeming rules no longer apply when redetermining her eligibility. Her countable income is recalculated: $150 SSA - $20 general exclusion = $130 monthly countable x 6 months = $780. Because $780 is less than the income limit for 1 person in Group II, Mrs. Bowers remains eligible.

3. ABD Individual Begins Living With NABD Spouse

EXAMPLE #12: On August 2, 1997, Mrs. Barbara Rogers, an NABD spouse, returns to live with her ABD husband in Group III. She is working and earns $700 per month. In August, Mr. Rogers is eligible for Medicaid based on his own unearned income of $68. Effective September 1997, the deeming rules are applied to determine his eligibility. Mr. Rogers' $68 unearned income is reduced by the $20 general income exclusion, leaving $48. Mrs. Rogers' earned income is reduced by the earned income exclusion ($65 plus one-half the remainder), leaving $317.50. The total countable income ($365.50 x 6 = $2193) is within the income limit for a couple in Group III, so Mr. Rogers remains eligible.

4. NABD Spouse Dies

EXAMPLE #13: Mrs. Pauline Pinot is a disabled recipient who receives $150 a month in worker's compensation. She lived with her NABD husband until he died on August 15, 1997. He had been working part-time and received gross wages of $400 in July and $200 in August. Effective September 1997, Mrs. Pinot is eligible as an individual without a spouse and the income limit for an individual applies.

H. Institutionalized Examples

1. ABD Individual Becomes Institutional-ized

EXAMPLE #14: Mr. Malaga was admitted to a nursing facility on September 5, 1997. His NABD spouse is working and receives gross wages of $900 a month. Mr. Malaga is institutionalized beginning September 1997 and August is the last month in which income from his NABD spouse is deemed to him.

2. Individual Institutionalized Before 9-30-89

EXAMPLE #15: An institutionalized aged individual applies for Medicaid in August 1997. He has a 58-year-old spouse at home who is neither blind nor disabled. He was admitted to the institution from their home in February 1989. He is an assistance unit of one for both resource and income determinations because he is not living with his spouse and he was institutionalized before September 30, 1989. There may be an expected contribution from the spouse as a legally responsible relative.

3. ABD Couple--One Becomes Institutionalized

EXAMPLE #16: In October 1997, Mrs. B, a disabled individual, applies for Medicaid for herself and her husband. She lives in Group III. She separated from her ABD spouse, Mr. B, in October 1997 when he was admitted to a nursing facility. Mrs. B earns $459 per month. Mr. B receives a pension (unearned income) of $165 a month and earned $200 gross in October; he does not have Medicare Part A. Mr. B's financial eligibility is determined using the policy and procedures for married institutionalized individuals in *subchapter M1480*.

To determine Mrs. B's eligibility: the couple's combined resources are within the Medicaid limit in October 1997. Her income eligibility is calculated for October:

$165.00	Mr. B's unearned income
+ 0	Mrs. B's unearned income
$165.00	couple's unearned income
- 20.00	general income exclusion
$145.00	couple's countable unearned income in October

$459.00	Mrs. B's earned income
+200.00	Mr. B's earned income
659.00	couple's earned income
- 65.00	earned income exclusion
594.00	
)÷ 2	½ remainder earned income exclusion
297.00	couple's countable earned income
+145.00	couple's countable unearned income
$442.00	couple's total countable monthly income for October
400.00	income limit for 2 for 1 month Group III

November 1997 through March 1998:

$459.00	Mrs. B's earned income
- 20.00	general income exclusion
$439.00	
- 65.00	earned income exclusion
374.00	
) ÷ 2	½ remainder earned income exclusion
187.00	countable earned income
+ 0	countable unearned income
$187.00	total countable monthly income
x 5	months (November - March)

$ 935.00	countable income November - March
+442.00	countable income for October
1377.00	total countable income for 6 months
- 2025.00	income limit for October - March ($325 x 5=$1625 +$400 = $2025)
0	no excess for 6 months

Mrs. B's countable income for the 6-month period October 1997 through March 1998 is within the MN income limit for the period and she is eligible as a disabled medically needy individual beginning 10-1-97, eligibility Type 1.

M0530.300 BLIND/DISABLED CHILD UNDER AGE 21

A. Introduction

When determining the Medicaid eligibility of a blind/disabled (BD) child who is under age 19 years, first determine the child's MI eligibility because the MI covered group has no resource limit and a higher income limit. If the child's income exceeds the MI limit, then determine the child's MN eligibility using the resource and income deeming policy and procedures in this section.

B. Policy

An unmarried blind or disabled child is always an assistance unit of one person, even when he/she lives with siblings who are blind or disabled and also apply for Medicaid. The parent's(s') resources and income are deemed available to a blind or disabled child under age 21 years when the child lives with the parent(s) and when the parent(s) is not eligible for Medicaid. Do NOT deem a stepparent's resources or income to a BD child.

A married blind or disabled (BD) child under age 21 who does not live with his/her spouse is an assistance unit of one person. If the married BD child lives with his/her spouse, resources and income are deemed from the spouse according to section M0530.200 above. If the married BD child lives with his/her spouse **and** his/her parent(s), the parent(s) resources and income are deemed to the BD child **before** calculating the spouse's resources and income.

C. Child Under 21 Living Away From Home

A blind or disabled child under age 21 who is living away from home is considered living with his/her parent(s) for deeming purposes if:

- the child is not emancipated, and
- the absence is temporary and the child intends to return to the parent's home when the purpose of the absence (such as education, rehabilitation, medical care, vacation, visit) is completed.

Children living in foster homes or non medical (residential) institutions are NOT temporarily absent from home. They are indefinitely absent from home and are NOT living with their parents or siblings for Medicaid purposes.

Children in medical institutions (facilities) are temporarily absent from home if their stay in the medical facility is less than 30 consecutive days. If the stay has been, or is expected to be, 30 or more consecutive days, go to section M1410.010 to determine if the child is institutionalized in long-term care. A child who is institutionalized in a medical facility or Medicaid waiver services is NOT considered living with his or her parents for Medicaid eligibility purposes.

D. Deeming

A parent's income and resources are deemed to an BD child beginning:

- the month following the month the child comes home;
- the month following the month a child born in a hospital comes home from the hospital;
- the month of birth when a child is born in the parent's home;
- the month after the month of adoption; the month of adoption in Virginia is the month the interlocutory order or final adoption order, whichever comes first, is entered.

E. BD Child Assistance Unit Examples

EXAMPLE #17: A blind 16-year-old child lives with his 65-year-old father and 52-year-old mother. His mother is neither blind, disabled, nor pregnant. His father does not apply for Medicaid for himself. The child is an assistance unit of one for both resource and income determinations. A portion of his parents' resources and income is deemed available to him.

EXAMPLE #18: A 19-year-old disabled child lives with his mother and his two brothers who are under age 18. The children's father died. The mother applies for Medicaid for herself and all children. She is not eligible in the LIFC group and she meets no other covered group. When determining the disabled child's eligibility, the disabled child is not included in an assistance unit with his mother and brothers; the disabled child is an assistance unit of one, with deemed income and resources from the mother.

M0530.301 DEEMING RESOURCES FROM PARENTS

A. Policy

In determining eligibility of a BD child under 21 who lives with his parent(s), the resources of the child include the value of the countable resources of the parent(s), to the extent that the resources of the parent(s) exceed the resource limit of:

- an individual, if one parent lives in the household; or
- a couple, if two parents live in the household.

The value of parental resources is subject to deeming whether or not those resources are actually made available to the child.

B. More Than One BD Child In Household

If there is more than one blind or disabled BD child under age 21 in the household, equally divide the value of the deemed resources among those children.

If an BD child is later determined ineligible for Medicaid for any reason or is no longer subject to deeming (e.g., after attainment of age 21), divide the value of the deemed resources among the remaining BD children, effective with the first month the child is ineligible or no longer subject to deeming.

C. Excluded Resources

When determining the parent's resources, do not include the resources listed in section M0530.010 above.

D. Countable Resources

Total countable resources are the combination of the resources of the parents after all applicable resource exclusions are applied.

1. Subtract Resource Limit

From the parent's(s') total countable resources, subtract the resource limit of

- **$2,000** (one person) when one parent lives in the home, or
- **$3,000** (a couple) when both parents live in the home.

2. Deem Excess To BD Child

Deem the amount of the resources over the limit to the BD child. If more than one BD child lives in the household, divide the amount of resources over the limit equally among the number of BD children in the household.

E. Child's Total Countable Resources

A child's total countable resources are the combination of the value of the deemed resources from the parent(s) and the nonexcluded resources of the child.

F. Resource Limit

Compare the BD child's countable resources to the resource limit for one person. If the resources do not exceed the limit, the child meets the Medicaid resource eligibility requirement. If countable resources exceed the limit, the child is ineligible for Medicaid because of excess resources.

G. Example--BD Child Living With Parents- Child Meets Resource Requirement

EXAMPLE #19: Mr. and Mrs. Blake live together with their son, Thomas, who is age 16 and blind. Thomas has no resources of his own. Mr. and Mrs. Blake applied for Medicaid on behalf of Thomas on January 23, 1997.

The parents' resources are as follows:

$4,150 - savings belonging to both Mr. and Mrs. Blake

The resource calculation follows:

$4,150 parent's countable resources subject to deeming
- 3,000 couple resource limit
$1,150 deemed resources to Thomas
+ 0 child's resources
$1,150 child's countable resources

Since Thomas's countable resources do not exceed the resource limit for an individual, Thomas meets the resource eligibility requirement.

H. Example--Two BD Children Living With Parent and Stepparent - Children Meet Resource Requirements

EXAMPLE #20: John and Joan Goode, ages 15 and 16, are both disabled and live with their mother and stepfather. John's only resources are three U.S. savings bonds worth $25 each. Joan's resources are a $100 savings account and a stamp collection valued at $400. The parents own:

one automobile valued at $3,000
joint savings account with balance of $5,000
Mrs. Smith's cash on hand = $200

Mrs. Smith, John and Joan's mother, applies for Medicaid on their behalf on September 17, 1997. The parent's (mother's) resource calculation follows:

Parent's Excluded Resources: one automobile

Parent's Countable Resources:
$2,500 ½ savings account (mother's share of joint account)
+ 200 cash on hand
$2,700 parent's total countable resources
-2,000 individual resource limit
$ 700 value of deemed resources ($350 resources deemed to each

John's Resources (no excluded resources)
$ 75 savings bonds
+ 350 deemed from parent
$ 425 countable resources

Joan's Resources (stamp collection excluded)
$ 100 savings account
+ 350 resource value deemed
$ 450 countable resources

Since neither John's nor Joan's countable resources exceed the resource limit, they both meet the Medicaid resource eligibility requirement.

I. Example--Two Children Living with Parent and Stepparent - One Child Found NBD First and Other Child Becomes NBD as a Result

EXAMPLE #21: The same situation exists as described in Example #20 above except that Joan also owns four savings bonds worth $450 each, and John also owns a savings account worth $1,500.

Joan's resources (stamp collection excluded):

$ 100 savings account
1,800 savings bonds
+ 350 deemed from parent
$2,250 countable resources

John's resources:

$1,500 savings account
75 savings bonds
+ 350 deemed from parent
$1,925 countable resources

John initially meets the resource eligibility requirement because his countable resources do not exceed the resource limit. But Joan does not meet the resource eligibility requirement because her countable resources exceed the resource limit. Since Joan is ineligible, the parent's resources must all be deemed to John.

John's Resources (no excluded resources):

$ 75 savings bonds 1,500 savings account
+ 700 parent=s deemed resources
$ 2,275 countable resources

Because John's countable resources now exceed the limit for 1 person, he is not eligible for Medicaid because of excess resources. Both John and Joan are ineligible because of excess resources.

M0530.302 DEEMING INCOME FROM ONE PARENT

A. Policy

A BD child (blind or disabled child) under age 21 who resides in the same household with a parent is considered to share in the parent's income. A BD child living in the same household with a parent is subject to the deeming provisions as long as he/she is under age 21, if the individual meets the definition of a child in M0530.002 above. A child who is away at school may be considered to be temporarily absent from the parents' household and would also be subject to deeming.

The following subsections explain the rules to follow when deeming income from one parent when

- only one parent lives in the household, or
- the parent is married and living with his/her spouse who is not the BD child's parent (is the BD child's stepparent). Do NOT deem any of the stepparent's resources or income to the BD child(ren).

B. Excluded Income

When determining the parent's income, do not include the income listed in section M0530.020 above.

C. Deeming Rules

When a BD child lives in the same household with his/her parent, these deeming rules are applied in the following order:

1. Determine Parent=s Income

Determine the monthly amount of the Parent's earned and unearned income, applying the appropriate exclusions in M0530.020.

2. Determine NBD Child Allocation

a. Parent Is Not Living With Spouse

The allocation for each NBD child is the difference between the SSI payment limit for two persons and the SSI payment limit for one person.

The allocation amount automatically increases whenever the SSI limits increase. *See Appendix 1 to this subchapter for current amount.*

b. Parent Is Living With Spouse (BD Child's Stepparent)

1) Parent's own NBD child(ren): the allocation for each NBD child is the difference between the SSI payment limit for two persons and the SSI payment limit for one person. *See Appendix 1 to this subchapter for current amount.*

2) Parent's child(ren)-in-common with stepparent: calculate the stepparent's ability to meet the needs of the child(ren)-in-common. If the stepparent refuses to verify his/her income, **do not allocate any amount of the parent's income for the child(ren)-in-common**:

a) **Step 1:** Determine the stepparent's earned and unearned income, applying the appropriate exclusions in M0530.020.

b) **Step 2:** Deduct an allocation for each of the stepparent's own children living in the household who are **not** the children of the Parent. Reduce the allocation by the amount of the child's own countable income.

c) **Step 3:** Subtract the unearned and earned income exclusions from the stepparent's income remaining after deducting allocations.

d) **Step 4:** Deduct a **living allowance** for the stepparent. *See Appendix 1 to this subchapter for current amount.*

e) **Step 5:** Subtract the NBD child allocation from the remaining income after deducting the living allowance. (If only one

child-in-common lives in the household, the allocation is *the amount of the NBD child allocation.* If there *is* more than 1 child-in-common, multiply the allocation by the number of children-in-common). The result is the stepparent's contribution to the child(ren)-in-common.

(1) If the stepparent's contribution is **less than or equal to** the allocation amount, the stepparent is not able to fully meet the child(ren)-in-common's needs. **Use the allocation amount when calculating the parent's allocation for the child(ren)-in-common, and count the stepparent's contribution as income to the child(ren)-in-common**. If more than one child-in-common lives in the household, divide the stepparent's contribution by the number of children-in-common living in the household.

(2) If the remainder is **more than** the allocation amount, the stepparent is able to meet the child(ren)-in-common's needs. **DO NOT allocate any** of the parent's income for the child(ren)-in-common. .

3. Reduce NBD Child Allocation

Each NBD child's allocation is reduced by the amount of his or her own income. The items listed in section M0530.020 above are not included as income to the NBD child for purposes of reducing the allocation.

If any NBD children in the household have income, verify the NBD child's income. However, when the alleged income exceeds the amount of the NBD child allocation amount (i.e., no NBD child allocation will apply for that NBD child), document the allegation in the file but do not verify the income. Document an allegation in the file when any NBD child living in the household has no income. Do not redevelop the NBD child's income unless a change is alleged or there is a reason to believe a change has occurred.

4. Subtract NBD Child Allocation Amount

Subtract the allocations for NBD children first from the parent's **unearned** income. If the parent does not have enough unearned income to cover the allocations, the allocation balance is subtracted from the parent's **earned** income.

5. Subtract Unearned and Earned Income Exclusions

a. All Remaining Parental Income Is Earned

If all of the income of the parent that remains after applying the NBD child allocations is earned:

- Subtract $85 (the sum of the $20 general income exclusion and the $65 earned income exclusion);
- Subtract ½ of the remaining earned income.

b. All Remaining Parental Income is Unearned

If all of the income of the parent that remains after applying the NBD child allocations is unearned:

- subtract the $20 general income exclusion.

c. Parental Income is Both Earned and Unearned

If all of the income of the parent that remains after applying the NBD child allocations is both earned and unearned:

1) subtract $20 from the parent's unearned income. If the total unearned income is less than $20, subtract the balance of the $20 from the parent's earned income;

2) subtract $65 plus one-half the remainder from the earned income (after subtracting any of the remaining $20 exclusion).

6. Subtract Living Allowance for Parent

Subtract a living allowance for the parent from any remaining parental income, unless the parent receives a public assistance payment such as TANF. No living allowance is given to a parent who is receiving public assistance payments. The parental living allowance, even if the parent is married and living with his/her spouse who is not the BD child's parent, is the SSI monthly payment limit for an individual.

7. Result = Deemable Income

Any positive remainder, after subtracting the living allowance for the parent, is the parent's deemable income.

8. One BD Child in Household

If only one BD child lives in the household, the parent's deemable income is deemed to the child as unearned income.

Add the deemed income to the BD child's own unearned income. Subtract the appropriate unearned income exclusions, including the $20 general exclusion, to determine the child's countable unearned income in the month. Add the countable unearned income to any countable earned income the child has. Subtract the total countable income from the appropriate income limit for 1 person to determine whether or not the child is eligible for Medicaid, or to determine the amount of the child's medically needy spenddown.

9. Two or More BD Children in Household

If two or more BD children live in the household, divide the parent's deemable income equally among them.

To determine each BD child's income eligibility, add the deemed income to each BD child's own unearned income. Apply the appropriate unearned income exclusions, including the $20 general exclusion, to determine the child's countable unearned income in the month. Add the countable

unearned income to any countable earned income the child has. Subtract the total countable income from the appropriate income limit for 1 person to determine whether or not each child is eligible for Medicaid, or to determine the amount of the child's medically needy spenddown.

D. Examples

1. Two BD Children

EXAMPLE #22: ***(Using January 2000 figures)***
James and Janet Jackson are disabled children age 19 and 20 who live with their mother in a Group I locality. Their mother applied for Medicaid for them in *January*. The children have no income but their mother receives $640 in unemployment compensation each month. Since all of Mrs. Jackson's income is unearned and she has no NBD child allocation, her deemed income is calculated:

$640 parent's unearned income
- 20 general income exclusion
620 countable unearned
- *512* parent's living allowance
108 remainder deemed to BD children
)÷ 2 BD children
$54 deemed to each child

When the $20 general income exclusion is applied to each child's income, each child has *$34* monthly countable income.

$34 countable monthly income for each child
x 6 months
204 6 months' income
- 1300 income limit for 1 person Group I
0 excess

Because each child's countable income is within the income limit for 1 person, each child is eligible for Medicaid as an MN disabled individual.

2. Two BD Children; One Has Excess Income

EXAMPLE #23: ***(Using January 2000 figures)***
In *January*, Mrs. Jones applied for Medicaid for her 2 disabled children, John age 19 and James age 20. Also living in the household is her husband who is not the father of the BD children. They live in a Group III locality. Mrs. Jones receives $960 in unemployment compensation per month and James receives $200 from his grandparents each month. John has no income. Mrs. Jones has no resources to deem. Since all of Mrs. Jones's income is unearned and she has no NBD child allocation, her deemed income is calculated:

$960 parent's unearned income
- 20 general income exclusion
940 countable unearned
- *512* parent's living allowance
428 remainder deemed to BD children
)÷ 2 BD children
214 deemed to each child

James's income is calculated:

$200	unearned income from grandparents
+214	deemed from parent
414	James's total unearned income
- 20	general income exclusion
394	monthly countable income
x 6	months
2364	6 months' income
-1950	income limit for 1 Group III
$414	excess for James (spenddown)

James is ineligible for Medicaid because of excess income. He is placed on spenddown. John's income is calculated:

$214	deemed from parent
- 20	general income exclusion
194	monthly countable income
x 6	months
1164	6 months' income
- 1950	income limit for 1 Group III
0	excess for John

John is eligible for Medicaid as an MN disabled individual.

3. One BD Child; Stepparent In Home

EXAMPLE #24: ***(Using January 2000 figures)***
Jerry Smith is a 19 year-old disabled child who lives with his mother, stepfather, his 15 year-old sister, his 3 year-old half brother and his 2 step-siblings in a Group II locality. His mother, Mrs. Green, applied for Medicaid for him in *January*. Jerry has no income. His mother receives $540 in unemployment compensation each month. Mr. Green, his stepfather, earns $2,300 per month. Jerry's 15 year old sister and his 3 year old half brother have no income of their own. Jerry's step-siblings receive $50 a month each from their grandparents.

a. Mrs. Green's deemed income is calculated:

Stepparent's contribution to children-in-common:
Each step-sibling's allocation:

$257	allocation standard
- 50	each child's income
207	each child's allocation from stepparent=s income
x 2	children
414	total allocation for step-children

$2,300	Mr. Green's earnings
- 414	allocation for his 2 children
1,886	remainder
- 512	living allowance for Mr. Green
1,374	remainder

$1,374 remainder
- 257 allocation standard for 1 child-in-common
$1,117 stepparent's contribution to child-in-common

Because *$1,117* is greater than the allocation standard for 1 child-in-common, NONE of Mrs. Green's income is allocated for the 3-year old child-in-common.

NBD Child allocation calculation:

$ *257* allocation standard for 15 year old sister
- 0 income of child
257 allocation for NBD 15 year old child

$ 540 Mrs. Green's unearned income
- 257 allocation for her NBD child
283 remainder
- 20 general income exclusion
263 countable unearned
- 512 parent's living allowance
0 remainder to deem to BD child

Mrs. Green has no income deemed to Jerry. Because he has no income of his own, he is eligible for Medicaid as an MN disabled individual.

M0530.303 DEEMING INCOME FROM TWO PARENTS

A. Introduction

This section explains the rules to follow when deeming income from both of the BD child(ren)'s parents who live in the household with the BD child(ren).

B. Excluded Income

When determining the parents' income, exclude the income listed in section M0530.020 above.

C. Deeming Rules

These deeming rules are applied in the following order:

1. Determine Parent's Income

The monthly amount of the parents' earned and unearned income is determined, applying the appropriate exclusions in M0530.020.

2. NBD Child Allocation

a. NBD Child Allocation Amount

An allocation for each NBD child who lives in the household is deducted from the **NBD child's parent's** income. Exception: no allocation is given for any children who are receiving public assistance payments such as TANF payments.

The allocation for each NBD child is the difference between the SSI payment limit for two persons and the SSI payment limit for one person.

The allocation amount automatically increases whenever the SSI limits increase. *See Appendix 1 to this subchapter for current amount.*

b. Reduce NBD Child Allocation

Each NBD child's allocation is reduced by the amount of his or her own income. The items listed in section M0530.020 above are not included as income to the NBD child for purposes of reducing the allocation.

If any NBD children in the household have income, verify the NBD child's income. However, when the alleged income exceeds the amount of the NBD child allocation amount (i.e., no NBD child allocation will apply for that NBD child), document the allegation in the file but do not verify the income. Document an allegation in the file when any NBD child living in the household has no income. Do not redevelop the NBD child's income unless a change is alleged or there is a reason to believe a change has occurred.

c. Subtract NBD Child Allocation

1) **Step 1, Parent #1:** determine the NBD child allocation(s) for the NBD child(ren) of only one of the parents (Parent #1) when Parent #1 has an NBD child(ren) who is not the child(ren) of the other parent (Parent #2).

   a) Determine the NBD child's own income,

   b) Subtract the NBD child's income from the NBD child allocation amount,

   c) any positive remainder is the NBD child allocation for that child;

   d) repeat a), b) and c) for each of Parent #1's NBD children.

   e) total all of the Parent #1's NBD child(ren) allocations; the result is Parent #1's NBD child allocation for his/her own child(ren);

   f) subtract the Parent #1's NBD child(ren) allocation first from the Parent #1's **unearned** income. If Parent #1 does not have enough unearned income to cover the allocation, subtract the allocation balance from Parent #1's **earned** income.

2) **Step 2, Parent #2:** determine the NBD child allocation(s) for the NBD child(ren) of Parent #2 when Parent #2 has an NBD child(ren) who is not the child(ren) of the Parent #1.

   a) Determine the NBD child's own income,

b) Subtract the NBD child's income from the NBD child's allocation amount,

c) any positive remainder is the NBD child allocation for that child;

d) repeat a), b) and c) for each of Parent #2's NBD children.

e) total all of the Parent #2's NBD child(ren) allocations; the result is Parent #2's NBD child allocation for his/her own child(ren);

f) subtract the Parent #2's NBD child(ren) allocation first from the Parent #2's **unearned** income. If Parent #2 does not have enough unearned income to cover the allocation, subtract the allocation balance from Parent #2's **earned** income.

3) **Step 3, Parents' child(ren)-in-common:** when the parents have an NBD child(ren)-in-common (both parents are NBD child's parents):

a) Determine the NBD child-in-common's own income,

b) Subtract the NBD child's income from the NBD child-in-common's allocation amount,

c) any positive remainder is the NBD child allocation for the child-in-common;

d) repeat a), b) and c) for each of the parents' NBD children-in-common;

e) total all of the NBD child(ren)-in-common allocations; the result is the parents' NBD child-in-common allocation for their child(ren)-in-common;

f) combine the Parents' unearned income that remains after deducting each parent's NBD child allocations;

g) combine the parents' earned income that remains after deducting each parent's NBD child allocations;

h) subtract the Parents' NBD child(ren)-in-common allocation first from the Parents' **combined unearned** income.

If the Parents do not have enough unearned income left to cover the NBD child(ren)-in-common allocation, subtract the NBD child(ren) in-common allocation balance from the Parents' **combined earned** income.

3. Subtract Unearned and Earned Income Exclusions

a. All Remaining Parental Income Is Earned

If all of the income of the parents that remains after applying the NBD child-in-common allocation is earned:

- Subtract $85 (the sum of the $20 general income exclusion and the $65 earned income exclusion);
- Subtract ½ of the remaining earned income.

b. All Parental Income is Unearned

If all of the income of the parents that remains after applying the NBD child-in-common allocation is unearned:

- subtract the $20 general income exclusion.

c. Parental Income is Both Earned and Unearned

If all of the income of the parents that remains after applying the NBD child-in-common allocation is both earned and unearned:

1) subtract $20 from the parents' remaining unearned income. If the remaining unearned income is less than $20, the balance of the $20 is subtracted from the parents' remaining earned income;

2) subtract $65 plus one-half the remainder from the remaining earned income (after subtracting any of the remaining $20 exclusion).

4. Subtract Living Allowance for Parents

Deduct a living allowance for the parents from any remaining parental income, unless the parents receive a public assistance payment such as TANF. No living allowance is given to parents who receive public assistance payments. The parental living allowance is the SSI monthly payment limit for a couple (2 persons).

5. Result = Deemable Income

Any positive remainder, after subtracting the living allowance for the parents, is the parents' deemable income.

6. One BD Child in Household

If only one BD child lives in the household, the parents' deemable income is deemed to the child as unearned income.

Add the deemed income to the BD child's own unearned income. Subtract the appropriate unearned income exclusions, including the $20 general exclusion, to determine the child's countable unearned income in the month. Add the countable unearned income to any countable earned income the child has. Subtract the total countable income from the

appropriate income limit for 1 person to determine whether or not the child is eligible for Medicaid, or to determine the amount of the child's medically needy spenddown.

7. Two or More BD Children in Household

If two or more BD children live in the household, **divide** the parents' deemable income equally among the BD children.

To determine the income eligibility of the BD child(ren) who apply for Medicaid, add the deemed income to the BD child's own unearned income. Subtract the appropriate unearned income exclusions, including the $20 general exclusion, to determine the child's countable unearned income in the month. Add the countable unearned income to any countable earned income the child has. Subtract the total countable income from the appropriate income limit for 1 person to determine whether or not the child is eligible for Medicaid, or to determine the amount of the child's medically needy spenddown.

D. Examples

1. One NBD Child in Common; Parents Have Both Earned and Unearned Income

EXAMPLE #25: ***(Using January 2000 figures)***
Bobby Miller, a disabled child age 19, lives with his mother and father and a 10-year-old NBD brother in a Group II locality. On *January 3,* his mother applies for Medicaid for him. She receives an annuity payment of $285 and his father earns $1,025. Bobby receives $250 per month from a trust fund set up for him by his deceased grandmother. His brother has no income.

Parents' deeming calculation:

$285	mother's unearned income
-257	NBD child allocation
28	unearned income to deem from mother
- 20	general income exclusion
8	parents' countable unearned income
$1025	father's earned income
- 65	earned income exclusion
960	
)÷ 2	½ remainder earned income exclusion
480	countable earned income
+ *8*	countable unearned income
488	
-769	living allowance for the parents
0	excess to deem

None of his parents' income is deemed to Bobby. Bobby's MN income eligibility is calculated:

$250	monthly unearned income
- 20	general exclusion
230	countable income
x 6	months
$1380	countable 6 months' income

1380 countable 6 months= income
-1500 income limit for 1 Group II
0 excess

Bobby is eligible for Medicaid as an MN disabled individual.

2. One NBD Child in Common; Parents Have NBD Children Of Their Own

EXAMPLE #26: ***(Using January 2000 figures)***
Billie Barty, a disabled child age 19, lives with her mother, father, her twin brother age 19, her mother's 20-year-old NBD son and her father's 20 year-old daughter in a Group III locality. On *January 4*, her mother applies for Medicaid for Billie. Her mother receives an annuity payment of $585 per month and her father earns $3,000 per month. Billie receives $150 per month from a trust fund set up for her by her deceased grandmother. Her half-siblings have no income.

a. Parent #1's (mother's) deeming calculation:

$585 mother's unearned income
-257 NBD child allocation (20 year old)
328 remainder unearned income

b. Parent #2's (father's) deeming calculation:

$3000 father's earned income
- 257 NBD child allocation (20 year old)
2743 remainder earned income

c. Parents= child-in-common allocation and deeming calculations:

$ *328* mother's remainder unearned income
+ 0 father's remainder unearned income
328 parents' total remainder unearned income
- 257 NBD child-in-common allocation
71 parents' countable unearned income
- 20 general income exclusion
51 parents' countable unearned income

$2,743 father's remainder earned income
- 65 earned income exclusion
2,678
)÷ 2 ½ remainder earned income exclusion
1,339 countable earned income
+ *51* countable unearned income
1,390 total countable income
- *769* living allowance for parents
621 deemed to Billie

d. Billie's income calculation:

$150 monthly unearned income
+ *621* deemed from parents
771 total unearned income

771	total unearned income
- 20	general exclusion
751	countable income
x 6	months
$ *4,506*	countable 6 months' income
- 1,950	income limit for 1 Group III
2,556	excess (spenddown)

Billie is not eligible for Medicaid because of excess income and is placed on spenddown.

M0530.304 CHANGES IN STATUSC PARENTS OF CHILDREN

A. Introduction

Deeming of a parent's income to an BD child can begin or end when there has been a change in the family's situation. Except where noted below, all changes in status are effective with the month following the month the change occurs. The rules that apply when such a change of status occurs are listed below.

NOTE: There are other status changes in addition to the ones described in B. These other changes are effective, for deeming purposes, the month after the month the change occurs. For example, if an NBD child moves out of the household in May, no allocation is given for that child beginning with June (for purposes of determining eligibility of a blind or disabled child).

B. Policy

1. Parent Dies

If a parent dies, deeming stops from that parent beginning with the month following the month of death. If the child lives with two parents and one dies, deeming continues from the surviving parent to determine eligibility. Only the surviving parent's income is used, and one parental living allowance is subtracted.

2. Parent and BD Child No Longer Lives in Same Household

If a parent and BD child no longer live in the same household, deeming of that parent's income stops effective the month after the month the parent (or child) leaves the household for purposes of determining eligibility.

NOTE: If a parent (or child) was temporarily absent from the household, this rule applies effective with the month after the month the parent's (or child's) absence is no longer considered temporary.

3. Parent and BD Child Begin Living in Same Household

If an BD child begins living with a parent in the same household (e.g., a newborn child comes home from a hospital), the parent's income is deemed to the child for purposes of determining eligibility beginning the month after the month they begin living together.

NOTE: An BD child born at home is subject to deeming effective with the month of birth.

4. BD Child Becomes Institution-alized

If an BD child becomes institutionalized, either in a medical facility or under a Medicaid CBC waiver, deeming stops for purposes of determining eligibility effective the month in which institutionalization began.

5. Child Attains Age 21

Deeming stops effective the month following the month in which a child attains age 21. An individual attains age 21 on the day preceding the anniversary of his/her birth. Eligibility is determined using only the individual's own income. The individual's income for the current month and subsequent months must include any income in the form of cash provided by the parents.

C. Examples

1. Parent Dies

EXAMPLE #27: ***(Using January 2000 figures)***
Henry Walden is a disabled child who lives with his parents in Group III. On *January 4,* Mrs. Walden died. She had been working and received gross wages of $981 in January. Mr. Walden's only income is a pension check of $450. Henry has no income. There are no NBD children living in the household. In *January*, Henry's eligibility is determined by calculating deemed income from both his parents. His father's unearned income of $450 is reduced by $20, leaving $430. His mother's earned income of $981 is reduced by the earned income exclusion ($65 plus one-half the remainder) leaving $458. The total income remaining ($888) is then reduced by the parents' living allowance ($*769*), which leaves deemed income of *$119*. The $20 general income exclusion is subtracted from Henry's income, which leaves him with *$99* countable income. Beginning with *February*, Henry's eligibility is determined using only his father's income, since Henry has no income of his own and his mother died in *January*.

2. BD Child Begins Living With Parent

EXAMPLE #28: Gene Prescott, a disabled child age 19, is a Medicaid recipient who lives in a private residential facility. In October, he is discharged from the facility and goes home to live with his mother and his NBD sister. Beginning with November, his mother's resources and income are deemed to Gene to determine his eligibility.

M0530.400 MULTIPLE DEEMING

A. Introduction

When more than one ABD individual lives in the same household and there is a parent-child relationship, a multiple deeming situation may exist. The following sections provide the rules to follow in parent-child multiple deeming situations. When this type of deeming is involved, it may or may not be necessary to recalculate eligibility, depending on the situation.

M0530.401 DEEMING INCOME FROM AN NABD SPOUSE TO AN ABD INDIVIDUAL AND A BD CHILD

A. Policy

If a BD child (or children) under age 21 lives in the same household with his/her parents who are an ABD individual (spouse) and an NABD spouse, income is always deemed first to the ABD individual (i.e., the parent who is aged, blind or disabled). Then, any remaining income is deemed to the BD child(ren).

B. Determining the Spouse's and Child's Eligibility

The steps below are followed to determine eligibility for Medicaid when both an ABD individual (spouse) and a BD child under age 21 live in the same household with an NABD spouse/parent.

1. Determine the amount of the NABD spouse's earned and unearned income using the appropriate exclusions in M0530.020.

2. Deduct an allocation for each NBD child in the household from the NABD spouse's income as described in M0530.203.

3. Follow the rules in M0530.203 to determine if any of the NABD spouse's income is deemed to the individual, and if so, to determine countable income for a couple. Follow the rules in M0530.301 and 302 to determine the BD child's eligibility.

   NOTE: Excess income, if any, is determined from the "couple" calculation.

4. If the ABD spouse/parent **is eligible** for Medicaid after the NABD spouse's income has been deemed, **no** income is deemed to the BD child from his/her parents. To determine the child's eligibility, compare the child's own countable income (without income deemed from his/her parents) to the income limit for 1 person.

5. If the ABD individual (parent) is **not** eligible for Medicaid after the NABD spouse's income has been deemed, deem any excess monthly income to the BD child.

   When the couple's countable income exceeds the income limit, the ABD spouse/parent is **not** eligible for Medicaid and is placed on a spenddown. The spenddown amount is based on the amount of the monthly excess income which was deemed to the BD child. Deeming income does not reduce the ABD spouse/parent's countable income.

C. Examples

1. Parents' Income Less Than Couple Limit

EXAMPLE #29: Mrs. Crowley, a blind individual, lives with her husband and their disabled child, John in Group III. Mrs. Crowley has been receiving Medicaid for 4 months. She and John have no income. Mr. Crowley is employed and earns $825 in August 1997. First

determine Mrs. Crowley's eligibility. Since Mr. Crowley's income exceeds the deeming standard, the $825 is treated as the earned income available to Mr. and Mrs. Crowley as a couple. Because they have no unearned income, reduce the $825 by the $20 general income exclusion, and then by the earned income exclusion ($65 plus one-half the remainder). This leaves $370 in countable income, which is less than the $400 income limit in Group III for a couple, so Mrs. Crowley is eligible for Medicaid. Therefore, no income is deemed to John. Since John's total countable income (zero) is less than the income limit for an individual, John is also eligible for Medicaid.

2. Parents' Income Exceeds the Couple Limit

EXAMPLE #30: Mr. Potter, a disabled individual, resides with his NABD spouse and their disabled son, Dwayne who is age 19, in Group II. Mr. Potter and Dwayne have no income. Mrs. Potter works and earned $1,195 in September 1997. Since Mrs. Potter's income is more than the deeming standard, the $1,195 earned income is treated as income available to Mr. and Mrs. Potter as a couple. Next, the income is reduced by the $20 general income exclusion and then by the $65 plus one-half the remainder (earned income exclusion), leaving $555 in countable income. This exceeds the monthly income limit in Group II by $246.67. Mr. Potter is ineligible because the couple's $555 countable income exceeds the Group II income limit for a couple. His spenddown amount is $1480 ($555 x 6 = 3330 - 1850 = 1480).

Since Mr. Potter is ineligible, $246.67 is deemed to Dwayne. Treat the $246.67 deemed to Dwayne as unearned income, and apply the $20 general income exclusion, reducing Dwayne's countable income to $226.67. Multiply his monthly countable income by 6 months. Compare Dwayne's 6 months' countable income to the semi-annual income limit for 1 person in Group II. Because his countable income does not exceed the income limit. Dwayne is eligible for Medicaid as an MN disabled individual.

Deeming Allocations

The deeming policy determines how much of a legally responsible relative's income is deemed to the applicant/recipient. The allocation amount increases automatically whenever the SSI payment limit increases.

NBD (Non-blind/disabled) Child Allocation

The NBD child allocation is equal to the difference between the SSI payment for two persons and the SSI payment for one person.

SSI payment for couple - SSI payment for one person = NBD child allocation

2009, 2010 *and 2011*: $1,011 - $674 = $337

Parental Living Allowance

The living allowance for one parent living with the child is the SSI payment for one person.

SSI payment for one person = $674 for 2009, 2010 *and 2011*

The living allowance for both parents living with the child is the SSI payment for a couple.

SSI payment for both parents = $1,011 for 2009, 2010 *and 2011*

Deeming Standard

The NABD (non-age/blind/disabled) spouse deeming standard is the difference between the SSI payment for two persons and the SSI payment for one person.

SSI payment for couple - SSI payment for one person = deeming standard

2009 , 2010 *and 2011*: $1,011 - $674 = $337

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CHAPTER M06
FAMILIES AND CHILDREN RESOURCES

SUBCHAPTER 10

GENERAL RULES FOR FAMILIES AND CHILDREN RESOURCES

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M06 FAMILIES AND CHILDREN RESOURCES

M0610.000 GENERAL RULES FOR FAMILIES AND CHILDREN RESOURCES

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M0610.000 GENERAL RULES FOR FAMILIES AND CHILDREN RESOURCES

M0610.001 OVERVIEW

A. Introduction

Medicaid is a needs based program. Two financial criteria, income and resources, are used to determine if a person is in need and is financially eligible for Medicaid. *Most F&C categorically needy covered groups (see subchapter M0320) do not have resource requirements. Resource policy does not apply to the following categorically needy covered groups:*

- *MI Pregnant Women & Newborn Children;*
- *Family Planning Services;*
- *MI Child Under Age 19 (FAMIS Plus);*
- *IV-E Foster Care or IV-E Adoption Assistance Recipients;*
- *Low Income Families With Children (LIFC);*
- *Individuals Under Age 21;*
- *Special Medical Needs Adoption Assistance; and*
- *BCCPTA.*

This section addresses how to determine resource eligibility for the following:

- *F&C in Medical Institution, Income ≤ 300% SSI;*
- *F&C Receiving Waiver(CBC) Services;*
- *F&C Hospice; and*
- *all F&C medically needy covered groups.*

All real and personal property legally owned by each member of the family unit/budget unit (FU/BU) is evaluated and the countable value is considered in determining Medicaid eligibility for the FU/BU.

Resources of each member of a FU/BU are evaluated using the rules in this chapter. Resource eligibility is determined by comparing the countable resources to the appropriate limit based on the composition of FU/BU. The policy governing the formation of the FU/BU is contained in M05.

B. Policy Principles

1. Monthly Determinations

Eligibility with respect to resources is a determination made for each calendar month, beginning with the third month prior to the month in which the application is received.

2. Countable Resources

Any assets that are resources but are not specifically excluded by policy are countable resources. Only countable resources are used to determine resource eligibility. See:

- M0610.002 for the resource limits;
- M0610.100 for the distinction between assets and resources;
- M0630.100 for a listing of exclusions.

3. Whose Resources Must Count

Medicaid law requires that resources are only considered available between spouses and from parents to their children under age 21 who live at home.

4. Whose Resources Must Count

Medicaid law does not allow certain resources to be considered in determining eligibility. Do not count resources:

- from a step-parent to a step-child;
- from siblings to siblings;
- from child to parent;
- from spouse or parent, living apart unless it is a voluntary financial contribution (Exception for long-term care, *see M1480);*
- from an alien sponsor.

5. Total Countable Resources

The total value of the countable resources owned or deemed available to all FU members are counted in determining the resource eligibility of each FU member.

The total value of the countable resources owned or deemed available to all BU members are counted in determining the resource eligibility of each BU member.

6. Resource Eligibility

If the total countable value of the FU/BU's countable resources are at or below the resource limit at any point during the application month, retroactive month, or a month in which the case is pending, resource eligibility exists for that month.

7. Excess Resources

After determining countable resources in accordance with B.2. through 5. above, if the family unit has resources other than the excluded items listed in M0630 totaling more than the allowable resource limit, determine if budget units can be formed. See Budget Unit rules in M0520. If BUs cannot be formed, or the BU's countable resources exceed the resource limit, resource eligibility does not exist.

If the FU/BU has a real property resource, see M0630.105 and M0630.110 for reasonable effort to sell real property.

8. Income Not Resources

When determining the value of resources available to the family/budget unit, do not consider any income as a resource in the month in which it is received.

M0610.002 RESOURCE LIMITS

A. Introduction

A separate resource limit is set for each Medicaid classification. A resource limit is the maximum dollar amount of countable resources a FU or BU may own and the individuals within that unit be eligible for Medicaid.

B. Policy Principles

1. Resource Eligibility

A FU or BU with countable resources equal to or less than the resource limit applicable to the individual's covered group classification is resource eligible. A FU or BU with countable resources in excess of the limit applicable to the individual's covered group classification is not eligible for Medicaid.

2. Resource Limits

F&C Classification	Limit
Categorically Needy	$1000 for the FU or BU
Medically Needy	$2000 for one person $3000 for two persons and $100 for each additional person in the FU or BU

M0610.100 DISTINCTION BETWEEN ASSETS AND RESOURCES

A. Introduction

Everything an individual owns is an asset. A resource is an asset the individual owns, has the right, authority, or power to convert to cash, and is not legally restricted from using for his/her support and maintenance. Changes in situations may result in an asset becoming a resource or a resource becoming an asset. The distinction is important as resources may affect Medicaid eligibility and assets that are not income or resources do not affect eligibility.

B. Definitions

1. Assets

Assets are all monies received and everything owned. An asset that is not income or a resource does not impact Medicaid eligibility.

EXAMPLE: An individual has an ownership interest in property but is not legally able to transfer that interest to anyone else. This ownership interest in the property is the individual's asset but because he is legally restricted from selling it (converting it to cash), it is not a resource and it does not meet the definition of income. It remains an asset, but it is not counted in determining his financial eligibility.

2. Resources

Resources are cash and any other real and personal property that a member of the family or budget unit:

- owns;
- has the right, authority, or power to convert to cash (if not already cash); and
- is not legally restricted from using for his/her support and
- maintenance.

NOTE: A trust may be a countable resource even though the individual does not have the authority to convert it to cash or is legally restricted from using it. See subchapters M1120.200-202 and M1140.400-404 for policy and procedures specific to determine if a trust (other than one established by a will) is a resource.

3. **Countable Resources** — Resources that are not specifically excluded by policy are countable resources.

4. **Real Property** — Real property is land, including buildings or immovable objects attached permanently to the land. (See M620.150 for a mobile home that is taxed as real property.)

5. **Personal Property** — Personal property is any property that is not real property. The term encompasses such things as cash, tools, farm and business equipment, life insurance policies, automobiles, and mobile homes taxed as personal property.

6. **Ownership** — Ownership of property by an individual means that the individual has a clear legal entitlement to the property, real or personal, or a specific portion thereof.

C. Policy

1. **Sale or Trade of an Asset** — Proceeds from the sale or trade of an asset must be evaluated as income in the month of receipt.

2. **Sale or Trade of a Resource** — Proceeds from the sale or trade of a resource are also resources. The sale or trade of a resource is converting a resource from one form to another.

3. **Increased Value** — Increases in the assessed or market value of a resource are not income.

4. **Resources with Zero Value** — Property does not cease to be a resource simply because it has no current market value. Even though there is no value to count, the property remains a resource for so long as it meets the definition of a resource in B.2. above. If the property develops a market value at a later time, this is an increase in the value of a resource, not a receipt of income.

M0610.200 UNKNOWN ASSETS

A. Policy — Real or personal property the family or budget unit is unaware of and had no reason to be aware of is not considered an available resource for the period of time the unit can demonstrate it did not know or had no reason to know about the property. Once the unit becomes aware or has reason to become aware of the existence of the resource, it is considered available to the unit.

B. Development and Documentation

The family/budget unit has the burden of proving that the members of the unit were unaware of and had no reason to be aware of the resource.

- Obtain a signed statement from the applicant/recipient or authorized representative.
- Obtain supporting documentation including (but not limited to) signed statements from other individuals who are familiar with the individual's situation.

M0610.400 WHAT VALUES TO APPLY TO RESOURCES

A. Introduction

The countable value of a resource is the owner's pro rata share of the equity value. The equity value is the fair market value minus encumbrances (legal debts) against the property. This section contains the procedures for determining the fair market values, equity values, and the countable values of resources.

B. Policy

The value of an asset as a resource to the individual or family is the client's equity in the real or personal property.

C. Establishing Fair Market Value

The fair market value of a resource is determined as follows:

1. Real Property

For real property other than the home, apply the local assessment rate to the tax assessed value

2. Personal Property

For personal property (other than motor vehicles) if it is taxed, use the tax assessed value. If not taxed, obtain one statement from a knowledgeable source such as a supplier or distributor.

3. Motor Vehicles

For countable motor vehicles:

a. the average trade-in value in the National Automobile Dealers Association (NADA) Official Used Car Guide, or

b. for an older car which does not appear in the current NADA guide, the average trade-in value found in the NADA Official Older Used Car Guide, or

c. if the vehicle is not listed in the NADA books, the value which is assessed for tax purposes, or

d. if the methods listed above are not available:

- one statement from a licensed dealer, or
- the statement of the applicant/recipient.

D. Equity Value

Equity value (EV) is the fair market value minus encumbrances (legal debts) against the property.

E. Disputed Fair Market Value

If the applicant/recipient disagrees with the fair market value as established above, the value may be changed using the following procedures:

1. Vehicles

Advise the applicant/recipient that the fair market value can be changed if the individual provides:

- one statement from a licensed dealer, or
  if the statement is not obtainable, the statement of the applicant/recipient

2. Real or Personal Property

Advise the individual in writing that the fair market value can be changed if the individual provides:

- two written estimates from appropriate qualified parties of the resource's current fair market value, or
- the reassessed tax value of real or personal property.

3. Qualified Parties

Appropriate qualified parties for this purpose are:

- personal property - Persons deemed qualified by the agency to value the property in question.
- real property - Lending institutions, appraisers, or licensed real estate firms.

4. Revised Fair Market Value of Real or Personal Property

The revised fair market value of real or personal property is the lesser of the following:

- the average of the two estimates;
- the current agency established value; or
- the reassessed value of real or personal property.

5. Redetermination

If found eligible based on the revised fair market value, the recipient is not required to reestablish the fair market value at each redetermination.

The revised fair market value will serve as the fair market value until:

- the worker has reason to believe the fair market value has increased, or
- the value of other resources available to the recipient increases; or

- the recipient acquires additional resources which, when combined with the established fair market value of the disputed resource, cause the total value of the FU/BU's resources to exceed the applicable resource limit.

The recipient must reestablish the fair market value of the disputed resource according to item E. 1.- 4. above.

M0610.500 OWNERSHIP

A. Introduction

The case record must contain verified information regarding ownership of property and its value, where applicable.

B. Definition

Ownership of property by an individual means the individual has a clear legal entitlement to the property, real or personal, or a specific portion thereof.

C. Shared Ownership

Assume, absent evidence to the contrary, that each owner of shared property owns only his or her fractional interest in the property. Divide the total value of the property among all of the owners in direct proportion to the ownership share held by each.

D. Property Owned by SSI Recipient

The value of any property owned by an SSI recipient living in the home is not a countable resource to individuals who meet a F&C covered group even though the SSI recipient is a child or is the parent of the child(ren) who meets a F&C covered group.

When property is owned jointly by an SSI recipient and a Medicaid applicant/recipient in the Families and Children categories, refer to:

- M0640.100 for policy on jointly owned real property,
- M0640.210 for policy on joint bank accounts, and
- M0640.300 for policy on jointly owned vehicles.

M0610.600 DETERMINING ELIGIBILITY BASED ON RESOURCES

A. Policy

The value of any asset that meets the definition of a resource counts against the applicable resource limit to the extent that the instructions in M0630 do not provide for its exclusion.

The total of the countable equity value of each countable resource belonging to or deemed to a member of the family/budget unit is compared to the resource limit. The resource limit is based on the number of individuals in the FU/BU and the classification of the individuals. If the total of countable resources is less than or equal to the resource limit, the individual is eligible for Medicaid. If the total of countable resources exceeds the resource limit, the individual is not eligible for Medicaid.

CHAPTER M06
FAMILIES AND CHILDREN RESOURCES

SUBCHAPTER 20

IDENTIFYING RESOURCES

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M0620 IDENTIFYING RESOURCES

M0620.140 TRUSTS

A. Trusts Established By a Will

For all classifications, any trust established by a will must be evaluated by the Assistant Attorney General (AAG) to determine if it is a countable resource.

B. Operating Procedure for Trusts Established by a Will

1. The applicant/recipient or authorized representative must submit the trust documents to the agency.
2. The agency must obtain such documents within the time standards established for determining initial/continuing eligibility and forward the documents to the Medicaid Regional Specialist who will consult with the Assistant Attorney General.
3. If the AAG advises that it is available without further court action, the amount of the trust must be counted as an available resource and compared to the appropriate resource limit.
4. If the AAG determines that the trust is not available, it is not a countable resource.
5. If the AAG cannot determine the availability of the trust or determines that court action is necessary to make the trust funds available, the applicant/recipient must initiate action, within 30 days of notification by the agency, to have the court release the trust funds.

Pending a determination by the court, the trust is not considered available provided the applicant/recipient demonstrates continued efforts to have the trust released.

C. All Other Trusts

For all classifications, follow policy in M1120.201.

M0620.150 MOBILE HOMES

A. Policy

A mobile home in which the applicant/recipient lives and its contents are excluded resources.

If a mobile home is not used as the applicant/recipient's home, it is a countable resource.

B. Procedure

1. Determine if Real or Personal Property

If a mobile home is not used as the applicant/recipient's home, determine if the property is taxed as real property or taxed as personal property.

2. Establish Fair Market Value

Use policy in M0610.400 to establish the fair market value of the mobile home as real or personal property.

3. Rental Income

If the mobile home is not used as the applicant/recipient's home, but is rented, it is a countable resource and the rental income is countable.

C. References

- Income From Self-Employment, M0720.200.
- Rental Income, M0730.505.
- Reasonable Effort to Sell Real Property, M0630.105 and M0630.110.

CHAPTER M06
FAMILIES AND CHILDREN RESOURCES

SUBCHAPTER 30

F&C EXCLUDED RESOURCES

M0630 Changes

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M0630.000 F&C EXCLUDED RESOURCES

M0630.001 OVERVIEW

A. Introduction

After determining that an asset meets the definition of a resource, determine that resource's effect on eligibility. Certain resources do not count against the resource limit; i.e., they are excluded.

B. Procedure

Section M0630.100 below contains the policy and procedures for determining if an individual's resource is excluded from determining eligibility for Medicaid in and Families and Children (F&C) covered group.

M0630.100 EXCLUDED RESOURCES

A. Identifying Excluded Resources

As long as they are identifiable, exclude the resources described in the sections below.

If any funds derived from an excluded resource are combined with other resources, the individual must provide documentation to verify the excluded amount. Otherwise, the funds must be counted in determining eligibility.

B. Types of Excluded Resources

1. Resources Owned By SSI Recipient

Resources (real and personal property) owned solely by any individual in the household who is receiving SSI are excluded from the F&C individual's eligibility determination.

When property is owned jointly by an SSI recipient and a Families & Children applicant/recipient, only the share of the property owned by the F&C individual is considered available.

2. Trusts

See M0620.140 to determine if a trust is excluded.

3. Sold or Transferred

When any of the excluded resources are sold or transferred into cash or other liquidable assets, these items are countable resources and will be considered in relation to the applicable resource limit.

EXAMPLE #1: Ms. C sells her excluded vehicle and receives $500 from the sale. This sum of money is a countable resource.

EXAMPLE #2: Ms. H. sells her excluded home. She receives net proceeds of $20,000. This money is a countable resource and will be considered in relation to the applicable resource limit.

4. Life Estates

A life estate gives an individual certain property rights for the duration of his or her life, or someone else's life. A life estate in real property is not a countable resource.

C. Procedure

Sections M0630.110 through M0630.160 below contain the policy and procedures for determining whether a resource is partially or totally excluded in the resource eligibility determination.

- M0630.115 Home Property
- M0630.120 Personal Property
- M0630.125 Savings *or Other Investment* Account for *Purpose of Self-Sufficiency*
- M0630.130 Casualty Property Loss
- M0630.140 Government Program Benefits & Payments
- M0630.150 Education Assistance
- M0630.160 Indian Tribe Funds and Land.

M0630.105 REASONABLE EFFORT TO SELL FOR THE CATEGORICALLY NEEDY COVERED GROUPS

A. Policy

When ownership of real property alone, or in combination with other countable assets, causes the family/budget unit's resources to exceed the $1000 resource limit, the applicant/recipient must be given the opportunity to receive Medicaid for the otherwise eligible family/budget unit for a maximum period of nine consecutive months while efforts are being made to dispose of the real property.

B. Determining Nine Month Period

The nine-month period runs for nine consecutive months regardless of whether Medicaid is received during all of that period. For an applicant, the period begins with the first month of entitlement. For a recipient, the nine-month period begins the month in which the recipient receives the property. When it is learned that the recipient owns property which has not been reported, the nine-month period begins in the month the unit became aware or had reason to become aware of the existence of the resource.

C. Procedures

1. Written Notice

Advise the applicant/recipient, in writing:

- of the amount by which the real property exceeds the resource limit;
- that if he/she is willing to make reasonable effort to sell the property he/she is eligible for Medicaid during the nine-month period, if otherwise eligible.

- that the disposition of the property will be evaluated as an asset transfer.

2. Good Faith Effort

The eligibility worker must:

- Explain to the applicant/recipient that agreeing to sell the property includes making good faith efforts to sell the property within a range of 10% of fair market value.
- Explore with the applicant/recipient ways to satisfy a good faith effort, which includes but is not limited to, listing the property with a real estate company, advertising in various ways, etc. Document discussion.
- Advise that failure to make good faith efforts to sell will result in ineligibility.
- Verify the good faith efforts to dispose of the property during the third and sixth months of the disposal period. Document the case record.

3. Notification of Contract

Advise the applicant/recipient to report to the agency no later than the next working day after a contract to sell the property is made.

4. Failure to Sell

If the property has not been sold in the nine-month period, the individual and family is no longer eligible in an F&C CN covered group. The family remains ineligible until the property has been disposed of or until such time as the property does not preclude eligibility.

D. One-Time Exclusion

This exclusion of property is a one-time per resource, limited exclusion. If the individual reapplies in an F&C or CN covered group and still owns the property, the property cannot be excluded under the reasonable effort to sell provision.

M0630.110 REASONABLE EFFORT TO SELL FOR THE MEDICALLY NEEDY

See policy and procedures in M1130.140

M0630.115 HOME PROPERTY

A. Policy

For all F&C classifications, the home in which the applicant/recipient lives and its contents are excluded.

If income is received from the use of the property or buildings on it, evaluate the income as earned or unearned income according to M07.

B. Definitions

1. Home

The home means the house, lot, and all contiguous property. It also means any buildings, in addition to the house, which are situated on the property.

2. Contiguous Property

Contiguous property means the land, and improvements which are not separated from the house lot by land owned by others. Streams and public rights of way which run through the property and separate it from the home will not affect the property's contiguity.

3. Other Shelter as Home Property

If the family/budget unit is using a vehicle, a boat, a camper, or another type of shelter as a home, this shelter is an excluded resource. Ownership of this resource does not affect eligibility for the period of time the family/budget unit lives in it. The month the family/budget unit moves to a house or apartment, the vehicle, boat, camper, or other shelter that the family/budget unit owns becomes an available resource and must be evaluated per M0640.

M0630.120 PERSONAL PROPERTY

A. Motor Vehicle

1. *All Groups Other Than Medically Needy (MN)*

For F&C covered groups other than MN, one motor vehicle with an equity value of $1,500 or less is excluded.

2. MN

For the MN covered groups, one vehicle of any value is excluded.

B. Income-producing Farm or Business Equipment

For all classifications, income producing farming and business equipment is excluded. If farm or business equipment is not producing income, it is countable personal property.

C. Tools and Equipment

For all classifications, the following are excluded:

- tools and equipment belonging to a temporarily disabled member of the family/budget unit during the period of disability;
- tools and equipment belonging to an unemployed parent when such tools and equipment have been and will continue to be used for employment.

D. Life Insurance

1. *All Groups Other Than MN*

For F&C covered groups other than MN, the cash value of any life insurance policy owned by the individual or his/her spouse is counted.

2. MN

For MN covered groups, all life insurance policies on a person under age 21 years are excluded.

Any life, retirement, or other related types of insurance policies with face values totaling $1500 or less on any one person 21 years old and over are excluded. When the face values of such policies of any one person exceed $1500, the cash surrender value of the policies is counted as a resource.

E. Burial Plots

1. *All Groups Other Than MN*

For F&C covered groups other than MN, one burial plot per member of the family/budget unit is excluded.

2. MN

All burial plots are excluded for MN.

F. EITC Refunds or Advance Payments

For all classifications, Earned Income Tax Credit refunds and advance payments are excluded as resources in the month following the month of receipt. Any portion of the refund or advance payment retained after the month following the month of receipt is a countable resource.

G. Bona Fide Loans

For all classifications, all bona fide loans are excluded, regardless of the intended use. See M0640.800.

M0630.121 BURIAL ARRANGEMENTS

A. *All Groups Other Than MN*

1. Bona Fide Funeral Agreement

A bona fide funeral agreement covering a family/budget unit member with a maximum equity value of $1500 per individual is excluded. A bona fide funeral agreement is a formal agreement for funeral and burial expenses, such as a revocable burial contract, burial trust, or another funeral arrangement (generally with a licensed funeral director). Passbook bank accounts, or simple "set asides" of savings for funeral expenses, and cash surrender values of life insurance policies are not bona fide funeral agreements and **are not** excluded resources.

NOTE: Funds in excess of the $1500 burial limit per individual are counted against the resource limit. See section M0640.500.

2. Irrevocable Burial Contracts

Irrevocable burial contracts, regardless of value, are not counted as resources since they cannot be converted to cash by the individual.

B. MN

Burial funds are excluded from resources up to a maximum of $3,500 per individual. From August 1, 1994 on, in order for resources to be disregarded under the burial funds exclusion, they must be in the following forms:

- irrevocable burial trusts established on or after August 11, 1993;
- revocable burial trusts;
- revocable burial contracts;

- other revocable burial arrangements (including the value of certain installment sales contracts for burial spaces);
- cash;
- financial accounts (e.g., savings or checking accounts);
- other financial instruments with a definite cash value (e.g., stocks, bonds, certificate of deposit, life insurance policies, etc.).

Use the ABD policy and procedures in M1130.410 and M1130.420 for MN F&C groups.

M0630.125 SAVINGS OR OTHER INVESTMENT ACCOUNT FOR THE PURPOSE OF SELF-SUFFICIENCY

A. Policy

For all covered groups *that have resource requirements*, up to $5,000 of principal and interest in one savings or other investment account for the purpose of self-sufficiency, is excluded. Investment accounts may include but are not limited to, mutual funds, money market accounts and stock ownership.

Any excess principal and/or interest over the $5,000 limit is a countable resource.

B. Requirements

1. Must Be Kept Separate

The funds on deposit in such an account cannot be commingled with funds intended for another use.

2. More Than One Account

If the family unit has more than one savings account established for self-sufficiency, the family unit must specify which account is the excluded resource.

3. Withdrawals

Self-sufficiency expenditures may include expenses related to securing and maintaining employment, education, home purchase, vehicle purchase, starting a business or other purposes reasonably determined to promote self-sufficiency. If any amount is withdrawn from the account for any purpose other than self-sufficiency, any portion of the amount determined to be misused will be treated as a countable resource in the month following the month withdrawn, if it is retained.

C. Notification

The eligibility worker must explain the policy in this section to the applicant/recipient who has one of these accounts.

D. Documentation

When a savings or investment account established for the purpose of self-sufficiency is first reported or discovered, the agency must verify the amount in the account and obtain a written statement from the applicant/recipient which includes the purpose of the account. The balance must be verified at application and redetermination.

M0630.126 WALKER V. BAYER SETTLEMENT PAYMENTS

A. Policy

Section 4735 of the Balanced Budget Act of 1997 (P.L. 105-33) states that payments described in this subsection from the settlement of the Susan Walker v. Bayer Corp., et.al., class action lawsuit are NOT counted as resources in determining eligibility for Medicaid. Payments described in this subsection are:

1. payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corp., et.al., 96-C-5024 (N.D.III.); and

2. payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement of Walker v. Bayer Corp., et.al., and that is signed by all affected parties on or before the later of

    - December 31, 1997, or
    - the date that is 270 days after the date on which such release is first sent to the persons to whom the payment is to be made.

To be excluded as a resource, the Walker v. Bayer funds cannot be commingled with other funds.

The interest earned on these funds is NOT excluded.

B. Development & Documentation

Information received by claimants in this lawsuit shows that claimants can choose to receive the payment in one of three ways - in a lump sum, a structured settlement, or a special needs trust. Regardless of which form the individual chooses, the payment(s) are excluded if the requirements in subsection A above are met AND the payments are held in a separate account or financial instrument. To be excluded as a resource, the Walker v. Bayer funds cannot be commingled with other funds.

1. Verification

Verify the source of the funds from a letter from the individual's attorney or a copy of the check which identifies the payor as a Walker v. Bayer settlement account. Verify by deposit records that all the funds deposited in the account or financial instrument were from the Walker v. Bayer settlement.

2. Count the Interest Earned

Exclude only the Walker v. Bayer payment amounts that were deposited. Any interest earned on these funds must be evaluated as unearned income in the month of receipt and as a resource thereafter.

M0630.130 CASUALTY PROPERTY LOSS PAYMENTS

A. Policy

For all classifications, cash and in-kind items received for the repair or replacement of lost, damaged, or stolen resources may be excluded for up to 12 months.

In situations involving casualty property loss payments for the repair or replacement of damaged/lost resources, such payments will not be considered resources if the recipient:

- initiates action to repair or replace the resource prior to or within 30 calendar days after the receipt of the payment; AND
- expends the payment for such repair or replacement within 12 months after receipt; AND
- keeps the payment separate from other resources.

NOTE: If the payment is not kept separately from other resources, the lump sum policy in M0730.800 applies.

B. Development and Documentation

Verification of initiation of action to repair or replace the resource, expending the payment within 12 months, and the use of the payment must be documented in the record.

M0630.140 GOVERNMENT PROGRAM BENEFITS & PAYMENTS

A. Policy

For all classifications, certain government benefits and payments are excluded resources.

B. Excluded Benefits and Payments

1. *SNAP*

The value of the food coupons under the *Supplemental Nutrition Assistance Program (SNAP) (formerly* Food Stamps) is excluded.

2. USDA Commodities

The value of foods donated under the U.S.D.A. Commodity Distribution Program is excluded.

3. Child Nutrition Act

The value of supplemental food assistance received under the Child Nutrition Act of 1966 is excluded. This includes all school meal programs, the Women, Infants and Children (WIC) Program and the Child Care Food Program.

4. Relocation Assistance

Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 is excluded.

5. Older Americans Act

Any benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended, is excluded.

6. Domestic Volunteer Service Act	Payments to VISTA volunteers under Title I, when the monetary value of such payments is less than minimum wage as determined by the director of the Action Office, and payments for services or reimbursement for out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and other programs pursuant to Titles II and III, of Public Law 93-113, the Domestic Volunteer Service Act of 1973 are excluded. The worker must contact the Action Office at the following address or telephone number when VISTA payments are reported: Action Office, 400 N. 8th Street, Richmond, Virginia 23219, (804) 771-2197.
7. Support Disregards	Disregarded support payments, if retained following the month of receipt, are excluded resources. See M0730.
8. Disaster Relief	Federal major disaster and emergency assistance provided under the Disaster Relief and Emergency Assistance Amendments of 1988 and disaster assistance provided by state and local governments, and disaster assistance organizations (Public Law 100-707) are excluded.
9. Payments to Japanese Ancestry & Aleuts	Payments received by individuals of Japanese ancestry under the Civil Liberties Act of 1988, and by Aleuts under the Aleutian and Pribilof Islands Restitution Act (Public Law 100-383) are excluded.
10. Agent Orange	Any payment received from the Agent Orange Settlement Fund or any other fund established in response to the Agent Orange product liability litigation is excluded. To verify whether a payment is an Agent Orange payment, use documents in the individual's possession. If the individual cannot provide verification or the situation is unclear, write to the Agent Orange Veteran Payment Program, P. O. Box 110, Hartford, CT 06304, Attention: Agent Orange Verification. Include in the request the veteran's name and social security number. If a survivor of the qualifying veteran was paid, also provide the survivor's name and social security number.
11. Radiation Exposure Compensation	Payments received by individuals under the Radiation Exposure Compensation Act (Public Law 101-426) are excluded.
12. Certain HUD Funds	Funds in an escrow account established under the Family Self-Sufficiency Program of the Department of Housing and Urban Development are excluded.
13. Victims of Nazi Persecution	Payments received by victims of Nazi persecution under Public Law 103-286 are excluded.

M0630.150 EDUCATION ASSISTANCE

A. Policy

For all classifications, certain types of education assistance payments are excluded resources.

B. Excluded Education Assistance

1. Programs Administered By U.S. Secretary of Education

Any grant or loan to any undergraduate student for educational purposes made or insured under any program administered by the U.S. Secretary of Education is excluded. Programs that are administered by the U.S. Secretary of Education are:

- Pell Grants,
- Supplemental Educational Opportunity Grant,
- Perkins Loan,
- Guaranteed Student Loans (including the Virginia Education Loans),
- PLUS Loans,
- Congressional Teachers Scholarship Program,
- College Scholarship Assistance Program,
- Virginia Transfer Grant Program.

2. Programs Under Title IV of Higher Education Act

Student financial assistance received under Title IV of the Higher Education Act is excluded. Assistance excluded under this provision, whether awarded to an undergraduate or graduate student, includes but is not limited to:

- Pell Grants,
- Supplemental Educational Opportunity Grants,
- State Student Incentive Grants,
- Federal College Work-Study Programs,
- Perkins Loans (formerly National Direct Student Loans), and
- Guaranteed Student Loans (including PLUS loans and Supplemental Loans for Students).

3. Student Assistance Under Public Law 101-392

Student financial assistance received under the Carl D. Perkins Vocational and Applied Technology Education Act made available for attendance costs (Public Law 101-392) is excluded. Attendance costs are defined below:

a. tuition and fees normally assessed a student carrying the same academic workload as determined by the institution, including costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study; and

b. an allowance for books, supplies, transportation, dependent care, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution.

4. BIA Student Assistance

Student financial assistance received under Bureau of Indian Affairs (BIA) Student Programs is excluded.

C. Documentation

Obtain verification of the source of the education assistance through the school.

M0630.160 INDIAN TRIBE FUNDS & LAND

A. Policy

For all classifications, certain types of Indian funds and land are excluded resources.

B. Excluded Funds and Land

1. Funds and Distributions

Any funds distributed to, or held in trust for, members of any Indian tribe under the following Public Laws are excluded:

- Public Law 92-254,
- Public Law 93-134,
- Public Law 94-540,
- Public Law 98-64,
- Public Law 98-123,
- Public Law 98-124,
- Public Law 97-458.

Additionally, interest and investment income accrued on such funds while held in trust, and purchases made with such interest and investment income, are excluded.

2. Native Corporations Under P.L. 100-241

The following types of distributions received from a Native Corporation under the Alaska Native Claims Settlement Act (Public Law 100-241) are excluded:

a. Cash (including cash dividends on stock received from a Native Corporation) to the extent that the total received does not exceed $2,000 per individual per calendar year;

b. Stock (including stock issued or distributed by a Native Corporation as a dividend or distribution on stock);

c. A partnership interest;

d. Land or an interest in land (including land or an interest in land received from a Native Corporation as a dividend or distribution on stock); and

e. An interest in a settlement trust.

3. Maine Indians & Micmacs Settlement Acts

Funds received pursuant to the

- Maine Indians Claims Settlement Act of 1980 (Public Law 96-420), and
- Aroostook Band of Micmacs Settlement Act (Public Law 102-171)

are excluded.

4. Income From Submarginal Land

Income derived from certain submarginal land of the United States which is held in trust for certain Indian tribes (Public Law 94-114) is excluded.

C. Documentation

Obtain verification of the type of Indian funds or land through the tribal council.

CHAPTER M06
FAMILIES AND CHILDREN RESOURCES
SUBCHAPTER 40

TYPES OF COUNTABLE RESOURCES

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M0640.000 TYPES OF COUNTABLE RESOURCES

M0640.001 OVERVIEW

A. Introduction

This subchapter contains instructions for the development of resources whose value ordinarily will count toward the resource limit. Use these instructions only after you have made certain that the asset:

- is a resource, based on instructions in the M0610 subchapter; and
- is not an excluded resource, based on instructions in the M0630 subchapter.

NOTE: A trust may or may not be a countable resource. See M0620.140 to determine if a trust established by a will is a countable resource. For all other trusts, see M1120.201.

NOTE: If the individual is a married institutionalized individual, go to *subchapter M1480.*

REAL PROPERTY

M0640.100 NON-HOME REAL PROPERTY

A. Definition

Non-home real property consists of land and buildings or immovable objects that are attached permanently to the land and that do not meet the definition of a home (house, lot and all contiguous property).

B. Development and Documentation of Fair Market Value

Ascertain fair market value from the Commissioner of Revenue or Assessor's Office.

C. Ownership/Value

1. Sole Owner

If the applicant/recipient is the sole owner, the property is a resource.

If the applicant/recipient is the sole owner with a living spouse, the property is a resource to the applicant/recipient regardless of the spouse's willingness to join in a deed to sell the property.

2. Tenants by Entirety

If the property is held by the applicant/recipient and spouse as tenants by the entirety with survivorship at common law:

a. When the applicant/recipient and spouse are living together, the property is a resource regardless of the spouse's consent to sell.

When the spouses live apart, if the separated spouse gives consent to dispose of property, one-half of the total value of the property is

considered a resource to the applicant/recipient. If the separated spouse does NOT give consent to dispose of property, **none** of the property is counted as a resource to the applicant/recipient.

b. If a decree of divorce has been entered, one-half of the total value of the property is considered a resource.

c. If the spouse is deceased, *the* total value of the property is a resource.

d. If the non-applicant spouse cannot be located by the agency or if that spouse refuses to cooperate with the agency, he/she is considered unwilling to give his/her consent to sell the property or to join in a deed and the property is not a resource. Document the case record regarding the separated spouse's refusal to cooperate or the agency's inability to locate the applicant's spouse.

3. Tenants in Common

If the applicant/recipient jointly owns property with other than a spouse as tenants in common or joint tenants, the applicant/recipient's prorata share is considered a resource. If the joint owner refuses to join in a deed to sell the property, the estimated cost of a partition suit is deducted to determine the value of the applicant/recipient's share of the property.

a. If documentation does not clearly establish the applicant/recipient's interest in jointly owned property, the eligibility worker must contact the Medicaid Regional Specialist to obtain an interpretation from the Assistant Attorney General.

b. Deduct the estimated cost of partitioning and attorney fees in establishing equity value when the joint owner refuses to join in a deed to sell:

- Estimated costs associated with a partition suit must be based on prevailing community charges as determined by a local person having knowledge of the cost of such an action.

- Shared partition costs (commissioner's fees, survey costs, etc.) are deducted from the whole property's value.

- The individual's attorney's fees is deducted from the individual's prorata share of the property value that remains after deducting shared partition costs (and liens, if any).

- After calculation, add the remainder to other countable resources and compare the total to the resource limit for the FU/BU classification.

M0640.110 OTHER PROPERTY RIGHTS

A. Life Estates

A life estate gives an individual certain property rights for the duration of his or her life, or someone else's life. A life estate in real property is not a countable resource.

B. Remainder Interest

When property is owned by one party and a second party has a life estate or "life rights" to the property, then the first party has a remainder interest in the property. A remainder interest is a countable resource.

To determine the fair market value of a remainder interest in property, multiply the tax assessed value of the property by the fraction corresponding to the age of the individual who has life rights. M0640, Appendix 1 contains the table used to perform this calculation.

M0640.200 CASH AND LIQUID ASSETS

A. Policy

Cash held by the individual is a resource. Money in a financial institution is a liquid asset and is a resource. Absent evidence to the contrary, assume that the person designated as the owner on the account owns all the funds in the account and has the right to withdraw funds from the account.

Interest received is treated as income in the month received and as a resource thereafter.

B. Development and Documentation

1. Document, in addition to the balances themselves:

   - the name and address of the financial institution;
   - the account number(s); and
   - the exact account designation.

2. Cash and liquid assets can be verified by documentation in the individual's possession such as: savings account book, bank statement, trust agreements, or affidavits.

3. Other acceptable verification includes bank clearances, credit union records, savings and loan records, and joint bank account statements.

4. When it is necessary to request account information from a financial institution, have the individual sign an authorization for the release of the information.

M0640.210 JOINT BANK ACCOUNTS

A. Policy

If it is established that an applicant/recipient, owns a joint bank account with another party and that all funds in the joint account belong to the other party, and the account was established for the convenience of the other party, it is not considered a resource to the applicant/recipient.

If it cannot be established that all the funds in the account belong to the other party, the applicant/recipient's pro rata share will be considered the

resource.

B. Development and Documentation

Verify ownership of the account by a statement from both parties. If a statement of ownership cannot be obtained from both parties, assume the applicant/recipient owns a pro rata share of the account. For example, if the account is owned by the applicant/recipient and one other individual, the applicant/recipient's pro rata share is one-half.

M0640.300 MOTOR VEHICLES

A. Policy

1. *All Groups Other Than MN*

One motor vehicle owned by the FU/BU with an equity value up to $1500 is excluded. Any equity value above $1500, is a countable resource.

2. MN

One vehicle of any value is an excluded resource.

3. Used as a Home

For all classifications, if the FU/BU is using a vehicle, a boat, or a camper as a home, the vehicle is excluded for the period of time the FU/BU lives in it. The month that the FU/BU moves to a house or an apartment the vehicle, boat, camper, or other shelter that the FU/BU owns becomes an available resource and must be evaluated.

B. Value of Vehicle

1. Listed in NADA

The average trade-in value listed in the current NADA Official Used Car Guide or the average trade-in value listed in the NADA Official Older Used Car Guide is considered the fair market value from which encumbrances must be deducted in order to establish equity value. Do not adjust the average trade-in value amount specified in the NADA guides for optional features, special equipment for the handicapped, mileage, condition, operability, etc.

2. Not Listed in NADA

If a motor vehicle is not listed in the current NADA Guide, or the Older Used Car Guide, the applicant/recipient may provide a statement of assessment for tax purposes which contains the value of the vehicle in order to establish the equity value.

3. Licensed Dealer's Statement

If a tax assessment statement is not available, the applicant/recipient can provide a licensed dealer's statement in order to establish the value. It is the responsibility of the applicant/recipient to obtain this licensed dealer's statement, but if assistance is requested, the EW must contact a licensed dealer to ascertain the fair market value.

4. Re-verification of Equity Value

Re-verify the motor vehicle's equity value only at redetermination unless the recipient reports a change in equity value before redetermination.

5. ***Disputed Value*** — *If the applicant/recipient disagrees with the fair market value established by the agency, the individual must be given an opportunity to dispute the finding and provide the agency with a written statement of the value from a disinterested knowledgeable source, such as a used car dealer.*

If eligibility is established using the revised vehicle value, the value of the vehicle is not re-verified at subsequent redeterminations.

C. Ownership of Two or More Vehicles

1. ***All Groups Other Than MN*** — If two or more motor vehicles are owned by the family/budget unit, the motor vehicle with the highest equity value will be excluded up to $1,500.
The equity value in all other vehicles plus the equity *value* above $1500 in the excluded vehicle is combined and is counted as a resource.

2. **MN** — *If more than one vehicle is owned, the individual's vehicle with the highest equity value is excluded. The equity value in all other vehicles must be counted*. The value used for countable vehicles is the average trade-in value listed in NADA Guide. In the event the vehicle is not listed, the value assessed by the locality for tax purposes may be used.

D. Motor Vehicles Jointly Owned — If a motor vehicle is owned jointly by a member of the family/budget unit with any individual not in the family/budget unit, the agency must establish whether or not the non-member is willing to sell the vehicle(s). If the non-member is willing to sell, the family/budget unit member's prorata share of the equity is considered an available resource.

If it is established that the non-member is not willing to sell, then the vehicle(s) is not counted as a resource. The non-member's refusal to cooperate with the agency or the agency's inability to locate the non-member is considered his/her unwillingness to sell the property.

M0640.400 LIFE INSURANCE

A. Policy

1. ***All Groups Other Than MN*** — A life insurance policy is a resource if it generates a cash surrender value (CSV). Its value as a resource is the amount of the CSV.

All life insurance policies on a person under age 21 years are excluded.

2. **MN** — Any life, retirement, or other related types of insurance policies with face values totaling $1,500 or less on any one person 21 years old and over are excluded. When the face values of such policies of any one person exceed $1,500, the cash surrender value of the policies is counted as a resource.

B. Development and Documentation

Verify the availability and the cash value of the policy by contacting the insurance companies or examining the policies of all family/budget unit members.

M0640.500 BURIAL ARRANGEMENTS FOR COVERED GROUPS *OTHER THAN MN*

A. Policy

A bona fide funeral agreement covering a family/budget unit member, with a maximum equity value of $1,500 per individual is excluded. A bona fide funeral arrangement is a formal agreement for funeral and burial expenses, such as a revocable burial contract, burial trust, or another funeral arrangement (generally with a licensed funeral director). Passbook bank accounts, or simple "set asides" of savings for funeral expenses, and cash surrender values of life insurance policies are not bona fide funeral agreements and **are not** excluded resources. See M0630.121.

B. Excess Funds

Funds in excess of the $1,500 per individual limit are counted against the resource limit.

C. Irrevocable Contracts

Irrevocable burial contracts, regardless of value, are not counted as resources since they cannot be converted to cash by the individual.

M0640.510 BURIAL ARRANGEMENTS FOR THE MEDICALLY NEEDY

A. Policy

Burial funds are excluded from resources up to a maximum of $3,500 per individual. From August 1, 1994 on, in order for resources to be disregarded under the burial funds exclusion, they must be in the following forms:

- irrevocable burial trusts established on or after August 11, 1993;
- revocable burial trusts;
- revocable burial contracts;
- other revocable burial arrangements (including the value of certain installment sales contracts for burial spaces);
- cash;
- financial accounts (e.g., savings or checking accounts);
- other financial instruments with a definite cash value (e.g., stocks, bonds, certificate of deposit, life insurance policies, etc.).

B. Reduction of Burial Exclusion

The maximum exclusion amount is reduced by:

1. the face value of life insurance on the life of an individual owned by the individual or his spouse if the cash surrender value of such policies has been excluded from countable resources; and

2. the amount of any other revocable or irrevocable trust, contract, or other arrangement specifically designated for the purpose of meeting

the individual's or his spouse's burial expenses when that trust, contract, or other arrangement is not a countable resource.

C. Development and Documentation

Use the ABD policy and procedures in M1130.410 and M1130.420 for medically needy F&C groups.

M0640.800 LOANS

A. Policy

All bona fide loans are excluded, regardless of intended use. Loans may be from a private individual as well as from a commercial institution.

If the applicant/recipient indicates that money received was a loan, but does not provide required verification, the money is unearned income in the month received and a resource thereafter.

B. Bona Fide

A simple statement signed by both parties indicating that the payment is a loan and must be repaid is sufficient to verify that a loan is bona fide.

C. Used to Purchase Resource

Any resource purchased with the proceeds of a loan must be evaluated to determine if the resource is totally or partially excluded according to resource policy in M06.

D. Encumbrance Against Property

When a bona fide loan is used to purchase real or personal property, the amount owed on the loan is considered an encumbrance against the property if the loan is a recorded deed of trust or lien against the property.

E. Interest on Proceeds of a Loan

Interest earned on the proceeds of a loan while held in a savings account, checking account, or other financial instrument are counted as unearned income in the month received and a resource thereafter.

M0640.900 CHILD SUPPORT REFUNDS

A. Policy

Refunds of child support from the Division of Child Support Enforcement (DCSE) identified as closed case refunds are countable resources.

B. Reference

M0730.400

FAMILIES AND CHILDREN REMAINDER INTEREST TABLE

AGE	REMAINDER	AGE	REMAINDER	AGE	REMAINDER
0	.02812	40	.08429	80	.56341
1	.01012	41	.08970	81	.58033
2	.00983	42	.09543	82	.59705
3	.00992	43	.10145	83	.61358
4	.01019	44	.10779	84	.63002
5	.01062	45	.11442	85	.64641
6	.01116	46	.12137	86	.66236
7	.01178	47	.12863	87	.67738
8	.01252	48	.13626	88	.69141
9	.01337	49	.14422	89	.70474
10	.01435	50	.15257	90	.71779
11	.01547	51	.16126	91	.73045
12	.01671	52	.17031	92	.74229
13	.01802	53	.17972	93	.75308
14	.01934	54	.18946	94	.76272
15	.02063	55	.19954	95	.77113
16	.02185	56	.20994	96	.77819
17	.02300	57	.22069	97	.78450
18	.02410	58	.23178	98	.79000
19	.02520	59	.24325	99	.79514
20	.02635	60	.25509	100	.80025
21	.02755	61	.26733	101	.80468
22	.02880	62	.27998	102	.80946
23	.03014	63	.29304	103	.81563
24	.03159	64	.30648	104	.82144
25	.03322	65	.32030	105	.83038
26	.03505	66	.33449	106	.84512
27	.03710	67	.34902	107	.86591
28	.03938	68	.36390	108	.89932
29	.04187	69	.37914	109	.95455
30	.04457	70	.39478		
31	.04746	71	.41086		
32	.05058	72	.42739		
33	.05392	73	.44429		
34	.05750	74	.46138		
35	.06132	75	.47851		
36	.06540	76	.49559		
37	.06974	77	.51258		
38	.07433	78	.52951		
39	.07917	79	.54643		

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CHAPTER M07
FAMILIES AND CHILDREN INCOME
SUBCHAPTER 10

GENERAL---F & C INCOME RULES

M0710 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/01/11	Appendix 6, page 1
UP #5	7/1/11	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1
TN #95	3/1/11	Appendix 6, pages 1, 2 Appendix 7
Update (UP) #1	7/1/09	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1

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M0710.000 GENERAL-- F&C INCOME RULES

M0710.001 OVERVIEW

A. Introduction

Medicaid is a needs based program. Two financial criteria, income and resources, are used to determine if a person is in need and is financially eligible for Medicaid. This section addresses how to determine an individual's income eligibility.

B. Use of Family Units/Budget Units

Family Units (FUs) are formed to establish whose income and resources are counted in determining financial eligibility. If financial eligibility does not exist at the family unit level for one or more persons for whom Medicaid was requested and if budget unit (BU*)* rules permit, form BUs.

Financial eligibility is determined at the BU level for each person for whom Medicaid was requested and who was financially ineligible in the FU determination. Eligibility is not determined for an individual who was found eligible in the FU determination.

See M0520 for F&C Family Unit/Budget Unit (FU/BU) policy and procedures.

C. Individual Income Eligibility

An individual's income eligibility is based on the total countable income available to his/her FU/BU.

Each source of income received by a member of the FU/BU is evaluated and the countable amount determined based on the policy in this chapter. The countable amount of each FU/BU member's income is added to the countable amount of the income of all other FU/BU members. That total is used to determine the income eligibility of each individual within that FU/BU. The FU/BU's total countable income is compared to the income limit that is applicable to the individual's classification and to the number of members in the FU/BU.

D. Policy Principles

1. Income

Everything an individual owns and all monies received are assets. Monies received are income in the month received when the monies are cash or its equivalent.

Income may be either earned or unearned. See M0720 for earned income and M0730 for unearned income.

2. Verification

All income other than Workforce Investment Act and the earned income of a student under age 19 must be verified. When attempts to verify income are unsuccessful because the person or organization who is to provide the information cannot be located or refuses to provide the information to both the applicant/recipient and the eligibility worker, a third party statement, a collateral contact, or as a last resort, the applicant's/recipient's written statement can be used as verification and to determine the amount of *income to be counted*.

Failure of the applicant/enrollee to verify his income results in the agency's inability to determine Medicaid eligibility and the applicant/enrollee's Medicaid coverage must be denied or canceled.

3. **Converted Income**

For the ongoing evaluation period, all income received more frequently than monthly must be converted to a monthly amount.

- Weekly income is multiplied by 4.3
- Bi-weekly income is multiplied by 2.15
- Semi-monthly income is multiplied by 2.

4. **Available Income**

Retroactive period –available income is the gross income actually received in each month in the retroactive period.

Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months. The applicant's actual gross income received in the application month may be used *to determine eligibility for that month* if the application is processed after the month has passed and the person is eligible only when using the actual gross income for the month.

5. **MI, CN, CNNMP Monthly Income Determination Period**

An income eligibility determination is made for each calendar month for which eligibility is being evaluated in the Medically Indigent (MI), Categorically Needy (CN), and Categorically Needy Non-Money Payment (CNNMP) classifications.

6. **MN - Ongoing 6 Month Income Determination Period**

Medically Needy (MN) income eligibility for the ongoing period is based on income that is anticipated to be received within the six month period beginning with the month of application.

7. **MN - Retro 3 Month Income Determination Period**

MN income eligibility for the retroactive period is based on income that was actually received in the three-month period immediately prior to the month of application.

8. **Countable Income**

Assets that meet the definition of income minus the exclusions allowed by policy are countable income. Only countable income is used to determine income eligibility. See M0720 Earned Income, M0730 Unearned Income.

9. **Whose Income is Counted**

The total countable income of all FU members is used in determining the income eligibility of each FU member. The total countable income of all BU members is used in determining the income eligibility of each BU member.

10. **Income Eligibility**

If the total amount of the FU/BU's countable income is equal to or less than the income limit for the evaluation period, income eligibility exists.

11. **Excess Income**

When an FU has countable income totaling more than the allowable CN, CNNMP, or MI income limit for the evaluation period, eligibility at the FU level does not exist. If ineligible at the FU level and policy permits breaking the FU into BUs, a BU evaluation must be completed.

When a BU has countable income totaling more than the allowable CN, CNNMP, or MI income limit for the evaluation period, eligibility as CN, CNNMP, or MI does not exist. Evaluate the BU's as Medically Needy eligibility if one or more of the BU members meets a MN covered group. If no members of the BU meet a MN covered group, the BU is not eligible for Medicaid because of excess income.

12. Excluded Income

State and federal policy require that certain types of income or portions of income be excluded (not counted) when determining income eligibility. See:

- Earned Income Exclusions, M0720.500
- Unearned Exclusions, M0730.099

M0710.002 INCOME LIMITS

A. Introduction

The individual's Medicaid classification determines which income limit to use to determine eligibility.

B. Income Limits

1. CN and CNNMP

Refer to M0710, Appendix 1 for the LIFC 185% of the Standard of Need Chart, M0710, Appendix 2 for the grouping of localities, and M0710, Appendix 3 for the F&C 90% and 100% Income Limit Charts.

2. MN

Refer to M0710, Appendix 2 for the grouping of localities and M0710, Appendix 5 for the MN income limits.

3. MI

Refer to M0710, Appendix 6 for the MI income limits.

M0710.003 NET COUNTABLE INCOME

A. Policy Principle

Income is

- cash, or
- its equivalent unless specifically listed in M0715 as not being income.

B. Available Income

Retroactive period –available income is the gross income actually received in each month in the retroactive period.

Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months. The applicant's actual gross income received in the application month may be used *to determine eligibility for that month* if the application is processed after the month has passed and the person is eligible only when using the actual gross income for the month.

C. Net Countable Income

Net countable income is all money, both earned and unearned, which is available to the members of the FU/BU, after portions specifically excluded and all amounts that are not income are subtracted.

Sometimes, countable income includes more or less money than is actually received. For example, gross earnings before deductions are counted when determining eligibility for FAMIS; no deductions or exclusions are subtracted from the gross earnings.

M0710.004 INCOME EXCLUSIONS

A. Introduction

Medicaid eligibility is based on countable income. See M0710.003 for the definition of countable income. In determining countable income, apply any income exclusions. Some exclusions totally negate the amount of income received. Other exclusions reduce the amount counted.

B. Definition

Excluded income is an amount which is income but does not count in determining eligibility.

C. Policy Principles

Some Federal laws other than the Social Security Act prohibit counting some income for Medicaid purposes. Section 402(a) of the Social Security Act provides for several income exclusions in determining countable income for Medicaid purposes.

D. References

- Earned income exclusions, M0720.500
- Unearned income exclusions, M0730.099

M0710.010 RELATIONSHIP OF INCOME TO RESOURCES

A. Policy

In general, anything received in a month from any source is income to an individual, subject to the definition of income in M0710.003.

Anything the individual owns in the month under consideration is subject to the resource counting rules.

An item received in the current month is income for the current month only. If held by the individual until the following month, that item is subject to resource counting rules.

B. References

- Definition of Resources, M0610.100
- Conversion or sale of a resource, M0715.200
- Casualty property loss payments, M0630.650
- Lump sums, M0730.800

M0710.015 TYPES OF INCOME

A. Policy Principle

Income is either earned or unearned, and different rules apply to each.

B. Types of Income

1. Earned Income

Earned income consists of the following types of payments:

- wages;
- salaries, and/or commissions;
- profits from self employment; or
- severance pay.

2. Unearned Income

Unearned income is all income that is not earned income. Some types of unearned income are:

- annuities, pensions, and other periodic payments;
- alimony and support payments;
- dividends, interest, and royalties; or
- rent*al income*.

C. References

- Definition of net countable income, M0710.003
- Earned income, M0720
- Unearned income, M0730

M0710.030 WHEN INCOME IS COUNTED

A. Policy Principles

For applications and reapplications, the income generally to be counted is the income verified for the calendar month prior to the month of application or the most current equivalent (last 4 weekly pays, last 2 bi-weekly pays, or last 2 semi-monthly pays). When evaluating eligibility for a retroactive period, income eligibility is based on income actually received each month in the retroactive period.

For redeterminations, the income generally to be counted is the income verified for the month prior to the month of review or the most current equivalent.

B. Exceptions to Policy Principles

1. Payment Not Received In Normal Month of Receipt

FU/BUs receiving monthly or semi-monthly income, such as state or federal payments or semi-monthly pay checks, must have the income assigned to the normal month of receipt even if mailing cycles, weekends or holidays cause the income to be received in a different month.

EXAMPLE #1: The applicant/*enrollee* is employed and is paid semi-monthly on the first and sixteenth. Because June 1 falls on a Saturday, the client receives her June 1 paycheck on May 31. The Eligibility Worker will count the paycheck received May 31 as income for June.

2. Self-Employment or Sale of Livestock or Cash Crops

Profit from the sale of livestock or cash crops, such as tobacco or peanuts, or from small businesses, such as but not limited to, vending stands, home beauty shops, or small grocery stores, is prorated on an annual basis or over the number of months in which the income is earned, whichever is appropriate. Federal farm subsidies are prorated over a 12-month period.

3. Contract Income

Guaranteed salaries paid under contract are prorated over the period of the contract even though the employee elects to receive such payments in

fewer months than are covered by the contract. When the contract earnings will be received monthly over a period longer than that of the contract, the earnings must be prorated over the number of months the income is anticipated to be received.

C. References

Contract Income, M0720.400
Income From Self-Employment, M0720.200

M0710.610 HOW TO ESTIMATE INCOME

A. Monthly Estimates

Generally, estimate future income on a monthly basis.

1. Anticipated Income

Anticipated income means any income the applicant/*enrollee* and local agency are reasonably certain will be received during the month. If the amount of income or when it will be received is uncertain, that portion of the FU/BU's income that is uncertain is not counted by the local agency. Reasonably certain means that the following information is known:

- who the income will come from,
- in what month it will be received, and
- how much it will be (i.e., rate, frequency and payment cycle).

2. Fluctuating Income

When income fluctuates, use the previous months' actual receipts that will provide an accurate indication of the individual's future income situation. *Average the income received in no more than 3 previous months.*

See section M0720.155 C. for detailed information about how to estimate fluctuating income.

3. Income Expected Less Than Once a Month

Determine the specific month(s) of receipt and use the amount(s) estimated for the appropriate month(s).

4. Converting to Monthly Totals

To estimate income for an income evaluation, convert to a monthly amount:

- multiply average weekly amounts by 4.3
- multiply average bi-weekly amounts by 2.15
- multiply semi-monthly amounts by 2

5. Partial Month Income

If the FU/BU will receive less than a full month's pay, use the exact monthly figure or an average per pay period times the actual number of pays. If actual income is used in any given calculation, adjust the figure for subsequent months if the actual income varies.

6. Examples

a. Example #2

The client's weekly pay for the prior month was:

$220.40
$175.80
$210.00
$195.70

To obtain a monthly amount, multiply the weekly average by 4.3.

$801.90 (total of the pay stubs) divided by 4 (number of paystubs) equals $200.48 (average weekly amount).

$200.48 x 4.3 = $862.06 monthly income.

b. Example #3

The client's bi-weekly pay for the prior month was:

$185.40
$209.50
$394.90

To obtain a monthly amount, multiply the bi-weekly average by 2.15. $394.90 (total of the pay stubs) divided by 2 (number of pay stubs) equals $197.45 (average bi-weekly amount).

$197.45 x 2.15 = $424.52 monthly income.

c. Example #4

The client's salary is $100 weekly. The pay does not vary. The client is paid every Friday.

The client reports she quit her job and will receive a final weekly paycheck on September 3. Since the client was paid for a partial month, the exact amount of $100 will be used.

d. Example #5

The client reports she quit her job on June 21. She will receive a final bi-weekly paycheck on July 5.

For the month of May, she received $190 and $220 for a total of $410. This amount is divided by two (the number of pays) to determine the average bi-weekly pay of $205. $205 is used to calculate her July Medicaid eligibility.

B. Procedure

1. When a Change Occurs

An anticipated change in income occurs when you expect an individual's income to start, to stop, or to come in at a different rate in the future.

2. How to Develop a Change

When you anticipate an increase in income, use only that income which the individual is reasonably certain he will receive.

3. Handling Changes in Income

When a change in income occurs, redetermine Medicaid eligibility.

C. Documentation

1. What the File Must Contain

Verify and document the case record regarding the rate and frequency of payment (i.e., weekly, biweekly, semi-monthly, monthly, etc.) and the payment cycle (i.e., on what day the client is paid).

The case record must be documented to reflect the method used to arrive at the anticipated income.

2. Who May Provide an Estimate

Estimates of income may come from the applicant/recipient, employer, or representative.

M0710.700 DETERMINING ELIGIBILITY BASED ON INCOME

M0710.710 CATEGORICALLY NEEDY (CN)

A IV-E Foster Care/Adoption Assistance recipient's money payment meets the income eligibility criteria in the F&C CN classification. No separate income eligibility determination is completed for Medicaid.

M0710.720 MEDICALLY INDIGENT (MI)

The following procedures apply to the Medically Indigent classification:

A. Income Charts

The countable income of all FU/BU members allowing income exclusions when appropriate, is compared to the m*edically indigent* income limits. Refer to subchapter M0710, Appendix 6 for the MI Income Limits.

B. Gross Income

Total gross income includes all gross earned income, *other than Workforce Investment Act income and income of a child under age 19 who is a student. It also includes* unearned income of all FU/BU members and any income deemed available to the family/budget unit.

C. Excluded Income

The following income is excluded when income is compared to MI limits:

1. ***Unearned Income*** All unearned income specifically excluded per M0730.099;

2. ***Earned Income*** Earned income is excluded in the following order:

- standard work exclusion of the first $90 of gross earned income for each employed member of the assistance unit whose income is not otherwise exempt per M0720.520;
- child care/incapacitated adult care exclusion per M0720.540

D. Income Eligibility If the countable income (gross income minus above exclusions) is equal to or less than the MI income limit for that covered group, the members of the FU/BU meeting that classification are income eligible. If the countable income exceeds the income limit, the FU/BU is not eligible as MI.

Determine if any members of the FU/BU would be eligible as CNNMP or MN.

M0710.730 CATEGORICALLY NEEDY NON-MONEY PAYMENT (CNNMP)

The following procedures apply to the Categorically Needy Non-Money Payment (CNNMP) classification:

A. Individuals under 21 in Nursing Facilities or ICF/MR Individuals under 21 in nursing facilities or ICF/MR are evaluated as individuals in medical facilities and their income is screened at 300% of SSI (see M0810.002 A. 3.).

B. Individuals under 21 in Foster Care/Adoption Assistance Individuals under 21 in foster care or receiving adoption assistance are evaluated as Medically Indigent if they are under age 19 or pregnant. If they are not eligible as MI, evaluate their eligibility as CNNMP using the following procedures:

1. Step 1- 185% Screen The child's countable income is the total gross earned income, other than Workforce Investment Act income and*/or other earned* income of a child under age 19 who is a student. It also includes unearned income, other than the unearned income listed in M0730.099.

Screen income at LIFC 185% of the standard of need. Refer to M0710, Appendix 1 for the LIFC 185% of Standard of Need Chart.

If the countable income exceeds the LIFC 185% standard of need, the child is not eligible as an Individual Under 21 in FC/Adoption Assistance. If the income is equal to or less than LIFC 185% standard of need, proceed to Step 2.

2. Step 2 - 100 % Screen

Once the total countable income of the child is determined to be less than or equal to LIFC 185% standard of need, the child's income must be screened at F&C 100% income limit in the locality where the child resides outside an institution. Refer to M0710, Appendix 2 for the grouping of localities and M0710, Appendix 3 for F&C 100% Income Limit for one person.

Total gross income is all earned income, other than Workforce Investment Act income and/*or other earned* income of a child under age 19 who is a student. It also includes unearned income of the child, including contributions. The following income is excluded when income is screened at 100%:

a. All unearned income specifically excluded in M0730.099;

b. Earned income is excluded in the following order:

- standard work exclusion of the first $90 of gross earned income for each employed member of the family/budget unit whose income is not otherwise exempt per M0720.520;
- child care/incapacitated adult care exclusion per M0720.540.

If the countable income (gross income minus above exclusions) is equal to or less than the F&C 100% income limit, the child is eligible as an Individual Under 21 in FC/Adoption Assistance.

If the countable income exceeds F&C income limit, evaluate eligibility as MN.

C. LIFC (Non-View)

1. Step 1 – 185% Screen

In order to meet the income requirements for Medicaid in the Low Income Families with Children (LIFC) covered group, the family/budget unit's countable income must be screened at LIFC 185% standard of need and the F&C 90% income limit (prospective determination) to determine the family/budget unit's eligibility. If the income of the assistance unit is equal to or less than LIFC 185% of the standard of need, income is then screened at the F&C 90% income limit, allowing income exclusions, when appropriate. Refer to M0710, Appendix 1 for LIFC 185% Standard of Need Chart.

Total gross income for this purpose includes all gross earned income, other than Workforce Investment Act income and/*or other earned* income of a child under age 19 who is a student. It also includes unearned income, such as net countable support, benefits, etc., and any income deemed available to the family/budget unit.

The following income is excluded when income is screened at 185%:

a. All unearned income specifically excluded per M0730.099;

b. Unemployment compensation benefits received by either parent.

If the countable income (gross income minus above exclusions) is equal to or less than LIFC 185% of the standard of need proceed to Step 2.

If the countable income is in excess of LIFC 185% standard of need, the FU/BU is not eligible as CNNMP. Determine if any members of the FU/BU would be eligible as MN.

2. Step 2 - 90% Screen

Once the total gross countable income of the family/budget unit is determined to be less than or equal to LIFC 185% standard of need, income must then be screened at the F&C 90% income limit. Refer to M0710, Appendix 2 for the grouping of localities and M0710, Appendix 3 for the F&C 90% income limits.

Total gross income includes all gross earned income, other than Workforce Investment Act income and*/or other earned* income of a child under age 19 who is a student. It also includes unearned income of all FU/BU members and any income deemed available to the family/budget unit. The following income is excluded when income is screened at 90%:

a. All unearned income specifically excluded per M0730.099;

b. Earned income is excluded in the following order:

- standard work exclusion of the first $90 of gross earned income for each employed member of the family/budget unit whose income is not otherwise exempt per M0720.520;
- $30 plus 1/3 exclusion and the $30 monthly earned income exclusion if an FU/BU member received LIFC Medicaid in any one of the preceding four months per M0720.525 and M0720.526; and
- child care/incapacitated adult care exclusion per M0720.540.

If the countable income (gross income minus above exclusions) is equal to or less than F&C 90% income limit, the individuals in the FU/BU that meet a CNNMP covered group are income eligible.

If the countable income is in excess of the F&C 90% income limit, the FU/BU is not eligible as CNNMP. Determine if any members of the FU/BU would be eligible as MN.

D. VIEW Participants

VIEW participants' income eligibility in the LIFC covered group is determined by comparing all of the FU's gross earned income, other than Workforce Investment Act and*/or other earned* income of a child under age 19 who is a student, to the 100% Federal Poverty Limit (FPL) and unearned income to the F&C 90% income limit. If the earned income of the FU is equal to or less than 100% of the FPL, then the unearned income is screened as the F&C 90% income limit for the locality. If the FU's unearned countable income is equal to or less than the F&C 90% income limit, income eligibility for VIEW participants in the LIFC covered group is established.

If the FU's earned or unearned income exceeds the limits, the FU is not eligible as VIEW participants in the LIFC covered group. BU policy does not apply to the VIEW participant income eligibility determination. Determine if any family members are eligible as LIFC (non-VIEW) or in any other covered group.

1. Step 1 - Earned Income

Determine the total gross earned income, other than Workforce Investment Act income and*/or other earned* income of a child under age 19 who is a student, of all required FU members. Compare the total gross earned income to the 100% FPL Chart (see subchapter M0710, Appendix 6) for the income limit for the appropriate FU size.

Total gross income for this purpose includes all gross earned income of both adults and children in the FU.

If the gross countable earned income is equal to or less than 100% FPL for the FU, proceed to Step 2.

If the gross earned income is greater than 100% FPL for the FU, the FU is not eligible in the LIFC covered group. Determine if any family members are eligible in any other covered group.

2. Step 2 - Unearned Income

Once the earned income is determined to be equal to or less than 100% FPL, unearned income must be screened at the F&C 90% income limit. Refer to M0710, Appendix 2 for the grouping of localities and M0710, Appendix 3 for the F&C 90% income limit.

Total unearned countable income includes all unearned income of all family unit members and any unearned income deemed available to the FU. Exclude all unearned income in listed in M0730.099.

If the countable unearned income is equal to or less than the F&C 90% income limit, the individuals in the FU meet the income requirements for the LIFC covered group and are eligible.

If the countable unearned income is greater than the F&C 90% income limit, the individuals in the FU do not meet the income requirements for the LIFC covered group. Determine if any member of the FU is eligible in any other covered group.

M0710.740 MEDICALLY NEEDY (MN)

The following procedures apply to the Medically Needy (MN) classification:

A. Locality Grouping and Income Limits

The countable income, allowing income exclusions when appropriate, is compared to the Medically Needy (MN) income limits for the locality and the number of members in the FU/BU.

Refer to M0710, Appendix 2 for the grouping of localities and M0710, Appendix 5 for the Medically Needy income limits.

B. Gross Income

Total gross income includes all gross earned income, other than Workforce Investment Act income and*/or other earned* income of a child under age 19 who is a student. It also includes the unearned income of all FU/BU members and any income deemed available to the family/budget unit.

C. Excluded Income

The following income is excluded when income is compared to MN limits:

1. *Unearned Income*

All unearned income specifically excluded per M0730.099;

2. *Earned Income*

Earned income is excluded in the following order:

- standard work exclusion of the first $90 of gross earned income for each employed member of the assistance unit whose income;
- is not otherwise exempt per M0720.520;
- child care/incapacitated adult care exclusion per M0720.540.

D. Income Eligibility

If the countable income (gross income minus above exclusions) is equal to or less than the appropriate MN limit for the locality and the number of members in the FU/BU, the FU/BU is income eligible as MN. If the countable income is in excess of the MN limit, the FU/BU must be placed on an MN spenddown following policy in chapter M13.

LIFC 185% OF STANDARDS OF NEED (MAXIMUM MONTHLY INCOME)
EFFECTIVE 7/01/*11*

Family/Budget Unit Size	GROUP I	GROUP II	GROUP III
1	*$355.57*	*$423.79*	*$591.83*
2	*557.71*	*625.94*	*796.42*
3	*718.48*	*784.15*	*957.22*
4	*871.97*	*940.17*	*1113.12*
5	*1027.91*	*1113.12*	*1320.17*
6	*1152.08*	*1239.75*	*1444.40*
7	*1303.14*	*1388.38*	*1595.44*
8	*1466.32*	*1549.15*	*1753.83*
Each additional person add	*148.51*	*148.51*	*148.51*

GROUPING OF LOCALITIES *EFFECTIVE 7/01/01*

GROUP I		GROUP II	GROUP III
Counties	Madison	Counties	Counties
	Mathews		
Accomack	Mecklenburg	Albemarle	Arlington
Alleghany	Middlesex	Augusta	Fairfax
Amelia	Nelson	Chesterfield	Montgomery
Amherst	New Kent	Henrico	Prince William
Appomattox	Northampton	Loudoun	
Bath	Northumberland	Roanoke	
Bedford	Nottoway	Rockingham	Cities
Bland	Orange	Warren	
Botetourt	Page		Alexandria
Brunswick	Patrick		Charlottesville
Buchanan	Pittsylvania	Cities	Colonial Heights
Buckingham	Powhatan		Falls Church
Campbell	Prince Edward	Chesapeake	Fredericksburg
Caroline	Prince George	Covington	Hampton
Carroll	Pulaski	Harrisonburg	Manassas
Charles City	Rappahannock	Hopewell	Manassas Park
Charlotte	Richmond County	Lexington	Waynesboro
Clarke	Rockbridge	Lynchburg	
Craig	Russell	Martinsville	
Culpeper	Scott	Newport News	
Cumberland	Shenandoah	Norfolk	
Dickenson	Smyth	Petersburg	
Dinwiddie	Southampton	Portsmouth	
Essex	Spotsylvania	Radford	
Fauquier	Stafford	Richmond	
Floyd	Surry	Roanoke	
Fluvanna	Sussex	Staunton	
Franklin	Tazewell	Virginia Beach	
Frederick	Washington	Williamsburg	
Giles	Westmoreland	Winchester	
Gloucester	Wise		
Goochland	Wythe		
Grayson	York		
Greene			
Greensville			
Halifax	Cities		
Hanover			
Henry	Bristol		
Highland	Buena Vista		
Isle of Wight	Danville		
James City	Emporia		
King George	Franklin		
King & Queen	Galax		
King William	Norton		
Lancaster	Suffolk		
Lee			
Louisa			
Lunenburg			

F&C Monthly Income Limits Effective 7/01/*11*

Group I

Family/Budget Unit Size	100%	90%
1	*$192.20*	*$172.44*
2	*301.47*	*272.50*
3	*388.37*	*348.87*
4	*471.34*	*423.93*
5	*555.63*	*500.30*
6	*622.75*	*562.19*
7	*704.40*	*634.61*
8	*792.61*	*712.28*
Each additional person add	*80.28*	*73.69*

Group II

Family/Budget Unit Size	100%	90%
1	*$229.08*	*$206.68*
2	*338.35*	*304.11*
3	*423.87*	*383.12*
4	*508.20*	*456.85*
5	*601.69*	*538.54*
6	*670.14*	*603.00*
7	*750.48*	*674.10*
8	*837.38*	*753.12*
Each additional person add	*80.28*	*73.69*

Group III

Family/Budget Unit Size	100%	90%
1	*$319.91*	*$289.64*
2	*430.50*	*387.07*
3	*517.42*	*466.07*
4	*601.69*	*539.82*
5	*713.61*	*642.50*
6	*780.76*	*703.07*
7	*862.40*	*776.81*
8	*948.02*	*855.82*
Each additional person add	*80.28*	*73.69*

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MEDICALLY NEEDY INCOME LIMITS EFFECTIVE 7/01/*11*

	GROUP I		GROUP II		GROUP III	
# of Persons in Family/Budget Unit	Semi-Annual	Monthly	Semi-Annual	Monthly	Semi-Annual	Monthly
1	*$1711.70*	*$285.28*	*$1975.04*	*$329.17*	*$2567.56*	*$427.92*
2	*2179.46*	*363.24*	*2432.27*	*405.37*	*3095.78*	*515.96*
3	*2567.56*	*427.92*	*2830.91*	*471.81*	*3489.26*	*581.54*
4	*2896.74*	*482.79*	*3160.08*	*526.68*	*3818.43*	*636.40*
5	*3225.92*	*537.65*	*3489.26*	*581.54*	*4147.62*	*691.27*
6	*3555.09*	*592.51*	*3818.43*	*636.40*	*4476.79*	*746.13*
7	*3884.27*	*647.37*	*4147.62*	*691.27*	*4805.97*	*800.99*
8	*4279.28*	*713.21*	*4542.62*	*757.10*	*5135.15*	*855.85*
Each addt'l person add	*442.39*	*73.73*	*442.39*	*73.73*	*442.39*	*73.73*

MEDICALLY INDIGENT CHILD UNDER AGE 19 (FAMIS PLUS) *AND PLAN FIRST* INCOME LIMITS FEDERAL POVERTY LEVEL (FPL) EFFECTIVE 1-20-11* ALL LOCALITIES			
# of persons in Family/Budget Unit	**100% FPL Monthly Limit**	**133% FPL Monthly Limit**	***200% FPL Monthly Limit****
1	$908	$1,207	*$1,815*
2	1,226	1,631	*2,452*
3	1,545	2,054	*3,089*
4	1,863	2,478	*3,725*
5	2,181	2,901	*4,362*
6	2,500	3,324	*4,999*
7	2,818	3,748	*5,635*
8	3,136	4,171	*6,272*
Each additional person add	319	424	*637*

AC 091 - MI Child under age 6 with income less than or equal to 100% FPL

AC 092 - MI Child age 6 to 19 with income less than or equal to 100% FPL

AC 090 - MI Child under age 6 with income greater than 100% FPL and less than or equal to 133% FPL

AC 092 - **Insured** MI Child age 6 to 19 with income greater than 100% FPL and less than or equal to 133% FPL

AC 094 - **Uninsured** MI Child age 6 to19 with income greater than 100% FPL and less than or equal to 133% FPL

*AC 080 – Plan First for men and women with income less than or equal to *200%* FPL ***(effective 10-01-2011)****.*

MEDICALLY INDIGENT PREGNANT WOMAN
INCOME LIMITS
133% FPL
EFFECTIVE *1-20-11*
ALL LOCALITIES

# of persons in Family/Budget Unit	133% FPL Monthly Limit
2	*1,631*
3	*2,054*
4	*2,478*
5	*2,901*
6	*3,324*
7	*3,748*
8	*4,171*
Each additional person add	*424*

AC 091 - Pregnant Woman with income less than or equal to 133% FPL

TWELVE MONTH EXTENDED MEDICAID INCOME LIMITS 185% of FEDERAL POVERTY LIMITS EFFECTIVE *1-20-11* ALL LOCALITIES	
# of Persons in Family Unit/Budget Unit	**185% FPL Monthly Limit**
1	*$1,679*
2	*2,268*
3	*2,857*
4	*3,446*
5	*4,035*
6	*4,624*
7	*5,213*
8	*5,802*
Each additional person add	*589*

AC 081 – LIFC one parent or caretaker in home

AC 083 – LIFC both parents in home

CHAPTER M07
FAMILIES AND CHILDREN INCOME
SUBCHAPTER 15

WHAT IS NOT INCOME

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M0715.000 *F&C* WHAT IS NOT INCOME

M0715.001 WHAT IS NOT INCOME – GENERAL

A. Introduction

Some items that an individual receives are not income because they do not meet the definition of income and others are income but are excluded by federal statutes. In making income determinations, the eligibility worker must distinguish between an asset that is income and an asset which is not income by definition. This subchapter addresses assets that are not income based on federal regulation. Only those items specifically listed in the law and regulations can be excluded from income.

B. Policy

An asset received is not income if it is not cash or its equivalent (check, money order, etc.), or if it is listed in this subchapter.

C. Documentation

Document the receipt of the assets described in this subchapter and the determination that they are not income.

Verification is limited to establishing that the monies received is of a type listed in this chapter. Verify that the money received is one of the types listed in this subchapter.

M0715.050 REIMBURSEMENTS

A. Policy

Reimbursements for out-of-pocket expenses are not countable income.

B. Types of Reimbursements

Reimbursements may include, but are not limited to, reimbursement for travel expenses such as mileage, reimbursement to the caretaker of a child for child care expenses, reimbursement for expenses incurred as a volunteer, etc.

Payments from the Department of Medical Assistance Services to Medicaid registered drivers or Health Insurance Premium Payment (HIPP) participants are reimbursements and are not income.

M0715.100 MEDICAID RECIPIENT IS AN AGENT

A. Policy

Money which belongs to another person that is handled by an individual to pay expenses for that other person is not income to the individual. The individual is acting as an agent for the other person.

B. Examples

Example 1:

Mrs. C. has a son in the Army who is currently in Germany. He sends her $250 a month to pay his car payment of $250 a month. None of this money is considered as income to Mrs. C.

Example 2:

Mrs. X and Mrs. Y live in the same house which is rented in Mrs. X's name. Mrs. Y gives Mrs. X an established portion of the rent each month. Mrs. X adds her portion to Mrs. Y's and pays the rent. Since this is a shared shelter arrangement, Mrs. Y's portion of the rent is not considered income to Mrs. X.

M0715.200 CONVERSION OR SALE OF A RESOURCE

A. Policy

Receipts from the sale, exchange, or replacement of a resource are not income, but are resources that have changed their form.-

This includes cash or in-kind items that are provided to replace or repair a resource that has been lost, damaged, or stolen.

B. Reference

Casualty Property Loss Payments, M0630.130

M0715.270 INCOME TAX REFUNDS

A. Policy

Income tax refunds (including Earned Income Tax Credit payments and refunds) are not income.

B. Tax Withheld Prior to Application Date

Income tax refunds are not income even if the income from which the tax was withheld or paid was received in a period prior to application for Medicaid.

M0715.350 PROCEEDS OF A LOAN

A. Introduction

Proceeds of a loan are not income to the borrower because of the borrower's obligation to repay the loan.

B. Policy

1. Loan Not Income

All bona fide loans, regardless of the intended use, are not income. This includes loans obtained for any purpose and may be from a private individual as well as from a commercial institution.

2. Documentation of Bona Fide

A simple statement signed by both parties indicating that the payment is a loan and must be repaid is sufficient to verify that a loan is bona fide.

3. Loan Not Bona Fide

If an individual indicates that money received was a loan but does not provide required verification, the money is to be treated as unearned income in the month received and a resource thereafter.

4. Interest on a Loan

Interest earned on the proceeds of a loan while held in a savings account, checking account, or other financial instrument will be counted as unearned income in the month received and as a resource thereafter.

M0715.370 SHELTER CONTRIBUTED

A. Policy

Shelter that is contributed is not income.

This includes payments for shelter made to a third party (such as a rental agency) in lieu of or in addition to child support, whether *the payments made in lieu of support are* based on a court order, *establishment or pending establishment of a child support order, or* a mutual voluntary agreement between the Medicaid applicant/enrollee. *The payments made to a third party are* ***not*** *counted as income.*

B. Reference

Child/Spousal Support, M0730.400

M0715.400 BILLS PAID BY A THIRD PARTY

A. Policy

Bills paid by a third party directly to a supplier are not income.

EXAMPLE: A church pays the electric company for Mrs. Brown's electric bill. This is a bill paid by a third party and is not income to Mrs. Brown.

B. Exceptions

Pending establishment of a child support obligation by the District Child Support Enforcement Office, payments made to a third party such as a day care provider or telephone company in lieu of or in addition to child support, whether based on a court order or a mutual voluntary agreement between the Medicaid applicant/recipient and the responsible person, are NOT counted as unearned income to the family/budget unit.

Third party payments made by an absent spouse in lieu of spousal support are treated as contributions in kind and are not counted as income.

C. Reference

Child/Spousal Support, M0730.400

CHAPTER M07
FAMILIES AND CHILDREN INCOME
SUBCHAPTER 20

F & C EARNED INCOME

M0720 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	pages 5, 6
TN #91	05/15/2009	page 11

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M0720.000 F & C EARNED INCOME

M0720.001 OVERVIEW

A. Introduction

This subchapter provides policy and procedures for identifying and counting earned income.

B. Policy

1. What Constitutes Earned Income

Earned income may be received in cash and consists of:

- wages
- profit from self-employment

The source and amount of all earned income other than Workforce Investment Act and student income must be verified.

2. Earned Income Exclusions

Earned income exclusions are subtracted from the gross monthly income in determining eligibility.

C. References

- Income From Self-Employment, M0720.200
- Income From Real Property, M0720.250
- Income From Room and Board, M0720.260
- Income From Day Care, M0720.270
- Income From Small Businesses/Cash Crops, M0720.280
- *Income From Uniformed (Military) Services, M0720.290*
- Contract Income, M0720.400
- Earned Income Exclusions, M0720.500

M0720.100 WAGES -- GENERAL

A. Definition

Wages are what an individual receives (before deductions; not "take home" pay) for working as someone else's employee.

NOTE: Under certain circumstances, services performed as an employee are deemed to be self-employment rather than wages.

B. Policy

1. Kinds of Wages

Wages may take the form of:

- contract earnings
- commissions

- pay for jury duty
- severance pay
- tips
- vacation pay
- sick pay from employer or employer-obtained insurance

2. When to Count Wages are calculated on a monthly basis and counted at the earliest of the following points:

- when they are received, or
- when they are credited to the individual's account, or
- when they are set aside for the individual's use.

Absent evidence to the contrary, if FICA *(Federal Insurance Contributions Act)* taxes have been deducted from an item, assume it meets the definition of wages. Failure to deduct FICA taxes does not mean the income is not wages.

EXAMPLE #1:
Mrs. Green is employed by Mr. Brown who owns a small business. Mr. Brown does not deduct FICA taxes from Mrs. Green's income. Mrs. Green's income from Mr. Brown is wages.

C. Verification Verify wages, salaries, and commissions by pay stubs, pay envelopes, a written statement from the employer, or by the eligibility worker's verbal contact with the employer.

When attempts to verify income are unsuccessful because the person or organization who is to provide the information cannot be located or refuses to provide the information to both the applicant/*enrollee* and the eligibility worker, a third party statement, a collateral contact, or as a last resort, the applicant's/*enrollee*'s written statement can be used as verification and to determine the amount of income to be counted.

Verify tips by a weekly record of the tips prepared by the employed individual.

M0720.105 INCOME FROM A CORPORATION

If a person has incorporated a self-employment enterprise either alone or with other persons and draws a salary from the business, the wages drawn are regular earned income, not self-employment income.

M0720.110 HOW TO COUNT INCOME IN THE RETROACTIVE PERIOD

When evaluating eligibility for a retroactive period, income eligibility is based on income actually received each month in the retroactive period.

M0720.155 HOW TO ESTIMATE EARNED INCOME

A. General Ongoing income eligibility is determined based on the income that is anticipated (expected) to be received within the ongoing evaluation

period. Income received in prior periods is normally used to determine the amount of income to be received in future periods. Income from the prior period is averaged and converted to a monthly amount. That monthly amount is the amount anticipated to be received in each of the future months. New sources of income may be anticipated based on statements from the provider of the income.

B. Definitions

1. Anticipated Income

Income the individual and local agency are reasonably certain will be received during the ongoing evaluation period.

To be reasonably certain that income will be received determine:

- from whom the income will come (the provider);
- in what month and on what dates it will be received (frequency and payment cycle); and
- how much will be received (rate).

2. Fluctuating Income

Fluctuating income is earned income where neither the pay rate nor hours per pay period can reasonably be predicted.

3. Income Base Period

A period of time immediately prior to the month of application/ redetermination that includes one or more pay periods, or the most current equivalent {last four (4) weekly pays, last two (2) bi-weekly pays, or last two (2) semi-monthly pays} that is used to provide an accurate reflection of the individual's future income.

4. Monthly Income

Monthly income is the income received in an average month. An average month contains 4.3 weeks. Income received more frequently than monthly is converted to a monthly figure.

5. Pay Period

The time period covered by each pay check. A pay period may be weekly, bi-weekly, semi-monthly, monthly or longer periods of time.

C. Income Base Period Used

Use the income received in the month prior to the month of application/redetermination unless the prior month's income cannot by itself provide an accurate indication of anticipated income.

When the prior month's income cannot by itself provide an accurate indication of anticipated income, the applicant/recipient must be given the opportunity to provide the additional information necessary to accurately project monthly income.

***1.* Seasonal Income**

When the individual's income fluctuates seasonally, use the most recent season, past seasons, or the current calendar month prior to the month of application/redetermination, as an indicator of future income.

Use the information obtained from the income provider and worker judgment to determine the anticipated income. Document the file to support how the income was anticipated.

2. **Migrant Or Seasonal Farm Worker**

For migrant and seasonal farm workers, the income that is reasonably certain to be received is based on formal or informal commitments for work for an individual, rather than on the general availability of work in an area.

Base income on the information obtained from the income provider and worker judgment to determine the anticipated income. Document the file to support how the income was anticipated.

Do not base income on an assumption of optimum weather or field conditions.

3. **New or Increased Income**

Use the income provider's statement of the beginning date, the amount of income to be received, the frequency of receipt, and the day/dates of receipt to establish the amount to be received per pay period.

4. **Terminated Income**

Income from a terminated source must only be verified when it was received in a month in which eligibility is being determined.

5. **Decreased Income**

Use the income provider's statement of the beginning date of the decrease, the new amount of income to be received, the frequency of receipt, and the day/date of receipt to establish the amount to be received per income period. Document the file to support how the income was anticipated.

If an employed person anticipates a decrease in wages that is not supported by evidence in the file, the individual must be advised to report the decrease as soon as it can be verified. Adjustments are made when the decrease is verified.

D. Calculating Estimated Monthly Income

1. ***Average Income***

When the income amounts received in each pay period are different, calculate the average amount of income received per pay period. Average the income received in no more than 3 previous months. Use the income received in previous months that provide an accurate indication of the individual's future income situation.

2. **Full Month's Income**

Total the income received in the Income Base Period. Divide that total by the number of pay periods in the Income Base Period. The result is the average amount to be received per pay period. If the income is received more frequently than monthly, convert the income to a monthly amount.

To convert to monthly income:

- Multiply weekly wage by 4.3; or
- multiply biweekly wage by 2.15; or
- multiply semi-monthly wage by 2.

3. Partial Month's Income — If less than a full month's income is received or expected to be received, do not convert to a monthly amount. Use the actual amount received or expected to be received.

C. References — How to Estimate Income, M0710.610.

M0720.200 INCOME FROM SELF-EMPLOYMENT

A. Policy — Self-employment is defined as a business, farming or commercial enterprise in which the individual receives income earned by his own efforts, including his active engagement in management of property. Self-employment situations include, but are not limited to, domestic workers, day care providers including babysitters, and chore and companion service providers.

1. Salary from Corporation Owned by Individual — *If an individual has incorporated a self-employment enterprise either alone or with other persons (such as an "S-corporation"), and he draws a salary from the corporation, the wages drawn are regular earned income; they are NOT self-employment income. In such a situation, the person's share of the net worth of the corporation is a resource.*

2. Profit is Earned Income — The profit from self-employment is earned income. Profit from self-employment means the total income received, less the allowable business expenses directly related to producing the goods or services and without which the goods or services could not be produced.

B. Business Expenses

1. Definition — Business expenses are expenses directly related to producing goods or services and without which the goods or services could not be produced. *Allowable business expenses* include, but *are* not limited to, the following:

2. Expenses Included

- payments on the interest of the purchase price of, and loans for, capital assets such as real property, equipment, machinery and other goods of a durable nature;
- insurance premiums;
- legal fees;
- expenses for routine maintenance and repairs;
- advertising costs;
- bookkeeping costs.

3. Expenses NOT Included — Business expenses **do not** include:

- payments on the principal of the purchase price of, and loans for, capital asset, such as real property, equipment, machinery and other goods of a durable nature;

- the principal and interest on loans for capital improvements of real property;
- net losses from previous periods;
- federal, state, and local taxes;
- personal expenses, entertainment expenses, and personal transportation;
- money set aside for retirement purposes;
- depreciation of equipment, machinery, or other capital investments necessary to the self-employment enterprise.

C. Verification Verification is proof of the gross amount of income received and proof of the business related expenses. Verify gross income received and business related expenses by self-employment bookkeeping or tax records.

M0720.250 INCOME FROM REAL PROPERTY

A. Policy Income from real property is self-employment income when the individual is actively engaged in the managerial responsibilities of the income producing property. Income from real property is determined on a monthly basis except farm subsidies which are prorated over a twelve month period.

If the individual is not actively involved in the management responsibilities, income received from the property is unearned income. See M0730.505.

When income from real property is received, the case record must clearly indicate the basis for determining whether or not the individual produces it by his own efforts or whether or not he is actively engaged in management.

B. Profit Deduct the amount of the allowable business expenses from the gross income to determine profit from real property.

M0720.260 INCOME FROM ROOM AND BOARD

A. Policy Income from room and board is earned income from self-employment if the applicant/recipient produces the income from his own efforts or carries managerial responsibilities. Income from room and board is determined on a monthly basis.

B. Procedure

1. Verify Gross Income Verify gross income received by self-employment bookkeeping records.

2. Determine Profit

Deduct the amount of allowable business expense from the gross income to determine profit from self-employment.

a. Board

The profit from board is the monthly gross income from boarders less the food allowance for one person living in a group (at 100%) per boarder. See Table I, M0710, Appendix 4.

b. Room Rent

The profit from room rent is 65% of the monthly gross income received if heat is furnished, 75% of gross income if heat is not furnished.

c. Room and Board

The profit from room and board is determined by

- subtracting from the monthly gross income the food allowance for one person living in a group (at 100%) per boarder as in a. above, and
- multiplying the balance by 65% if heat is furnished, 75% if heat is not furnished.

M0720.270 INCOME FROM DAY CARE

A. Policy

Income from day care is earned income from self-employment. Income from day care is determined on a monthly basis.

B. Procedure

1. Day Care Provided in Applicant/Recipient's Home

a. Day Care for Children Living in the Home

Verify gross monthly income by self-employment bookkeeping or tax records or a written statement from the person who pays the day care costs.

Do not deduct the cost of meals and snacks. Profit is sixty-five percent of the gross income from day care.

b. Day Care for Children Not Living in the Home

Verify gross monthly income by self-employment bookkeeping or tax records or a written statement from the person who pays the day care costs.

From the average monthly gross income received, deduct the cost of meals and snacks that are provided for the children. Sixty-five percent of the balance is profit from day care.

The cost of meals is determined using the following method:

- Determine the number of days in the month in which meals were provided for each child and the number of meals provided to each child per day;

- Add to obtain the total number of meals provided for all children during the period;

- Multiply the total meals provided by 40 cents per meal to obtain monthly cost of meals provided for all children.

The cost of snacks is determined using the following method:

- Determine the number of days in the month in which snacks were provided for each child and the number of snacks provided to each child per day;

- Add to obtain the total number of snacks provided for all children during the period;

Multiply the total snacks provided by 20 cents per snack to obtain monthly cost of snacks provided for all children.

2. Day Care Provided Outside Applicant/Recipient's Home

Verify gross monthly income by self-employment bookkeeping or tax records or a written statement from the person who pays the day care costs.

Do not deduct the cost of meals and snacks. Profit is sixty-five percent of the gross income from day care.

M0720.280 INCOME FROM SMALL BUSINESSES/CASH CROPS

A. Policy

Income from the sale of live stock or cash crops, such as tobacco or peanuts, or from federal farm subsidies, or from small businesses, such as but not limited to, vending stands, home beauty shops, or small grocery stores, is earned income from self-employment.

B. Profit

To determine the profit from small businesses and cash crops, deduct the applicable business expenses directly related to producing the goods or services and without which the goods or services could not be produced.

1. Sale of Livestock or Cash Crops

The profit is prorated on an annual basis or over the number of months in which it was earned.

2. Small Businesses

The profit is prorated on an annual basis or over the number of months in which it was earned.

3. Federal Farm Subsidies

The profit is prorated on an annual basis.

C. Verification

Verify gross monthly income by self-employment bookkeeping or tax records.

M0720.290 INCOME FROM UNIFORMED SERVICES (MILITARY)

A. Introduction

Compensation to most members of the Uniformed Services takes the form of earned income and other payments.

If the military employee receives a payment that is not listed below, contact a Medical Assistance Program Consultant for guidance.

B. Earned Income

The following forms of compensation are countable earned income:

- *basic pay,*
- *subsistence allowance (food)*
- *housing allowance (when not also listed as a deduction on the pay stub),*
- *special and incentive pay, such as bonuses, flight pay, overseas pay.*

C. Payments That Are Not Income

The following payments are not countable income for Medicaid eligibility:

- *clothing*
- *hostile fire pay (combat pay).*

Any amount of income received by or made available to household members for deployment or service in a combat zone will not count as income for Medicaid purposes ***unless the payment was received before the deployment****. This exclusion includes items such as, but not limited to, incentive pay for hazardous duty, special pay for imminent duty or hostile fire duty.*

D. Verification

The Leave and Earnings statement (LES) is the pay slip issued to military service members. The LES shows all types of compensation and deductions.

M0720.400 CONTRACT INCOME

A. Introduction

Contract income and guaranteed wages are based on a contract between the employer and the employee. The contract specifies the period it covers and the rate and frequency of the pay the employee will receive.

B. Definitions

1. Contract Earnings

Contract earnings are wages guaranteed by a contract. This does not include work on an hourly or piecework basis or self-employment.

2. Guaranteed Wage

A guaranteed wage is one which is received by an individual employed on a contractual basis and paid over a period of time.

C. Policy

Wages received by an individual employed on a contractual basis are prorated over the period of time the contract covers even though the employee elects to receive such payments in **fewer** months than are covered by the contract.

If the income is received in **more** months than is covered by the contract, the income is prorated over the period the income is anticipated to be received.

EXAMPLES:

1. Months Wages Received = Months In Contract

A contract period is November 1997 - June 1998 (8 months). The individual chooses to receive the contract income over the eight-month period. The contract amount is divided by eight months to arrive at the monthly gross income.

2. Months Wages Received = Fewer Months Than In Contract

A contract period is September 1997 - August 1998 (12 months). The individual chooses to receive the contract income over a 10-month period. The contract amount is divided by the contract period of 12 months to arrive at the monthly gross income.

3. Months Wages Received = More Months Than Covered By Contract

A contract period is September 1997 - January 1998 (5 months). The individual receives the contract income monthly over a 12-month period. The contract amount is divided by the number of months in which the income is received (12).

D. Verification

Verify the terms of the contract by obtaining a copy of the contract.

E. Procedures

1. Additional Earnings

When a contract specifies a set amount to be paid over the contract period, plus additional monies of an uncertain amount if additional work is available and done, only the base contract is prorated. Additional monies earned over and above the base contract are counted as income when they can be anticipated.

2. Decrease in Income

When a contract calls for no pay for those days not worked, the salary for those days should not be counted if it can be anticipated at the time that the prospective determination is made that certain days will be missed. Otherwise, the income calculation is to be based on the maximum salary. If the individual informs the local agency that days are missed, recalculate the countable monthly amount for the entire contract period.

3. Changes in Contract

If the contract amount changes during the contract period, recalculate the amount of income to be received in the contract period. To determine the new monthly income amount, divide the contract amount by the number of months in the original contract period.

EXAMPLES:

a. Decrease In Pay

A school bus driver's 12 month contract states that she will receive $1,250 for the year, but that she will not be paid for days the school is closed or for days she is sick. When she applies on February 10, she has already missed three days for snow in the contract year and she was sick for two days. The contract reads that $10 will be deducted for each day not worked. The case is approved with income of $100 per month.
($1,250 - 50 = $1,200 $1,200 / 12 = $100)

b. Increase In Pay

On December 11, the school bus driver reports that her 12 month contract which began September 1 will be increased by 10% effective January 1. The income that is anticipated to be received is recalculated for the months in the original contract period using the increased figure of $110 ($1,200 X 10% = $120; $1,200 + 120 = $1,320; $1,320 / 12 = $110
$110 will be the contract income for January - August.

EARNED INCOME EXCLUSIONS

M0720.500 GENERAL

A. Policy

The source and amount of all earned income other than *Workforce Investment Act and student income* must be *verified; however*, not all earned income counts when determining Medicaid eligibility. Federal and state laws and regulations require that certain types of earned income be totally or partially excluded when determining Medicaid eligibility.

B. Earned Income Exclusions

Income exclusions are applied, in the following order, to earned income for family unit/budget unit (FU/BU) members as appropriate to the covered group.

See Families and Children (F&C) Earned Income Exclusions chart in Appendix 1 to this subchapter.

1. Workforce Investment Act Income

Earned income of an eligible child (less than 18, or 18 and expected to graduate prior to 19) derived from employment in a program under the Workforce Investment Act is excluded. Do not request verification of income from employment under the Workforce Investment Act.

2. Student Income

Earned income of an individual under age 19 who is a student is excluded. Do not request verification of student income.

For this exclusion, a student is any individual under age 19 who is attending any type or level of school, part-time or full-time. Do not verify school attendance; declaration of school attendance is sufficient.

3. *2010 Census Income*

Income paid by the U.S. Census Bureau to temporary employees specifically hired for the 2010 census is NOT counted when determining eligibility for medical assistance.

4. Standard Work Exclusion

A standard work exclusion of the first $90 of gross monthly earned income is excluded for each employed member of the FU/BU whose income is not otherwise exempt. For LIFC, the standard work exclusion is not allowed in the 185% screening. See M0720.520.

5. $30 Plus 1/3 Earned Income Exclusion

For the LIFC covered group only, $30 plus 1/3 of the remaining monthly earned income is excluded for 4 consecutive months from the total earnings (other than those specified above) and from self-employment of each employed member of the FU/BU. The $30 plus 1/3 earned income exclusion is not allowed in the 185% screening. See M0720.525.

6. $30 Earned Income Exclusion

For the LIFC covered group only, $30 per month earned income is excluded for 8 consecutive months following the receipt of 4 months of the $30 plus 1/3 earned income exclusion from total earnings (other than those specified above) and from self-employment of each employed member of the FU/BU. The $30 earned income exclusion is not allowed in the 185% screening. See M0720.526.

7. Child Care/ Incapacitated Adult Care Exclusion

Monthly anticipated child care expenses or incapacitated adult care expenses, up to the appropriate maximums, which are paid for by the caretaker-relative must be excluded. For LIFC, the child care/incapacitated adult care exclusion is not allowed in the 185% screening. See M0720.540.

M0720.505 WORKFORCE INVESTMENT ACT INCOME EXCLUSION

A. Policy

Earned income of any eligible child derived from employment under the Workforce Investment Act is excluded. Do not request verification of earnings under the Workforce Investment Act.

M0720.510 STUDENT EARNED INCOME EXCLUSION

A. Policy

Earned income of a*n individual* under age 19 who is a student is excluded. Do not verify school enrollment or request verification of student earned income.

For this exclusion, a student is any individual under age 19 who is attending any type or level of school, part-time or full-time. Declaration of school attendance is sufficient for the student earned income exclusion.

M0720.520 STANDARD WORK EXCLUSION

A. Policy The first $90 of gross earned income is excluded for each employed individual in the FU/BU whose income is not otherwise exempt regardless of when it is reported. For LIFC, the standard work exclusion is not allowed in the 185% screening.

B. Procedure Apply this exclusion to the amount of earned income

M0720.525 $30 PLUS 1/3 EARNED INCOME EXCLUSION

A. Policy The $30 plus 1/3 earned income exclusion policy applies only to individuals in the LIFC covered group. $30 monthly, plus 1/3 of the remainder of earned income of each employed member of the FU/BU must be excluded for 4 consecutive months IF the employed member was enrolled in Medicaid in the LIFC covered group during any one of the preceding 4 months.

The $30 plus 1/3 earned income exclusion is not given if the individual has already received the exclusion for 4 consecutive months as a LIFC recipient UNLESS there has been an interim period of 12 consecutive months in which he has not been enrolled in Medicaid in the LIFC covered group.

This exclusion does NOT apply when determining an individual's eligibility in any other Medicaid covered group.

B. Procedures

Apply the $30 plus 1/3 earned income exclusion for the 4 consecutive months:

- to the amount of earned income remaining after the standard work exclusion.
- to each period of employment until the exclusion has been allowed for 4 consecutive months.

EXAMPLE #1: Ms. Doe was an employed Medicaid recipient who lost her job in March. $30 plus 1/3 of the remainder of earned income was excluded in February and March. She had no earnings in April. She went back to work in May. Her entitlement to $30 plus 1/3 earned income starts over because $30 plus 1/3 earned income was previously excluded for just 2 consecutive months. She will be entitled to the $30 plus 1/3 earned income exclusion for May, June, July and August.

1. $30 Plus 1/3 Earned Income Exclusion for Applicants

For Medicaid applicants in a LIFC covered group only (including the LIFC individual being added to an existing family/budget unit), $30 monthly plus 1/3 the remainder, of earned income of each employed member of the FU/BU must be excluded for 4 consecutive months only if:

- the employed individual received (was enrolled in*)* Medicaid in the LIFC covered group during any one of the preceding four months; and
- the individual's FU/BU passes the 185% income screen without applying the $30 plus 1/3 earned income exclusion.

a. Determining the Preceding 4 Months

When determining the preceding four months for applicants, begin with the earliest month of the retroactive period if the applicant received a Medicaid covered medical service in the retroactive period. If the applicant did not receive a Medicaid covered medical service in the retroactive period, begin with the month of application.

When determining the preceding four months for persons being added to the FU/BU, begin with the month assistance was requested for that individual.

b. When the Exclusion Begins

The 4 months of the $30 plus 1/3 earned income exclusion begins with:

- the first month in the retroactive period in which the individual has earned income, or
- the month of application if no Medicaid covered medical service was received in the retroactive period

2. $30 Plus 1/3 Earned Income Exclusion for Recipients

For Medicaid recipients in the LIFC covered group only, $30 plus 1/3 of the remainder, of earned income of each employed member of the FU/BU must be excluded for the 4 consecutive months.

a. Determining the Preceding 4 Months

When determining the preceding 4 months, begin with the month in which the recipient's eligibility is being determined. If the employed member was enrolled in Medicaid in the LIFC covered group during any one of the preceding four months, $30 plus 1/3 of the remainder of earned income must be excluded for 4 consecutive months.

b. When the Exclusion Begins

Entitlement to the 4 months of the $30 plus 1/3 earned income exclusion begins with the month in which the recipient's eligibility is being determined or reviewed if the recipient has been employed but the agency worker is applying the $30 plus 1/3 earned income exclusion for the first time.

EXAMPLE #2: Ms. Green has been a Medicaid recipient in the LIFC covered group since May 1998. She has been employed since January 1996. The worker is reviewing her eligibility in March 2000 because she reported a change in her earnings for March. The $30 plus 1/3 earned income exclusion has never been used in calculating Ms. Green's countable income. The worker applies the $30 plus 1/3 earned income exclusion beginning March 1, 2000, and ending June 30, 2000.

3. Re-entitlement to the $30 Plus 1/3 Earned Income Exclusion

If an individual has received the $30 plus 1/3 earned income exclusion for 4 consecutive months and has not been enrolled in Medicaid in the LIFC covered group in any of the 12 consecutive months following the last month in which the exclusion was given, the individual can again be eligible for the $30 plus 1/3 earned income exclusion.

EXAMPLE #3: Ms. Grey, a Medicaid recipient, had $30 plus 1/3 of her earned income excluded for the months of August, September, October, and November 1998 (4 consecutive months). She requested that her case be closed effective December 1, 1998. She reapplied for Medicaid in December 1999. She had no earned income. She became employed in January 2000. She is eligible for the $30 plus 1/3 earned income

exclusion because she was not a member of a LIFC FU/BU for 12 consecutive months (December 1998 through November 1999) following the last month in which she received the $30 plus 1/3 earned income exclusion (November 1998).

M0720.526 $30 EARNED INCOME EXCLUSION

A. Policy

The $30 earned income exclusion applies only to individuals in the LIFC covered group. A $30 earned income exclusion is available for an additional 8 months immediately following receipt of 4 months of the $30 plus 1/3 earned income exclusion by any employed member of the FU/BU. This 8-month period is fixed and begins the month following the 4th consecutive month of the $30 plus 1/3 earned income exclusion.

B. Procedures

Apply the $30 earned income exclusion:

- to the amount of earned income after the standard work exclusion.
- for a fixed 8-month period of time that begins the month following the 4th consecutive month of the $30 plus 1/3 exclusion.

If an individual has received the $30 plus 1/3 earned income exclusion for 4 consecutive months and received the $30 earned income exclusion for 8 additional months, the individual is not eligible for the $30 plus 1/3 earned income exclusion and the $30 earned income exclusion again until the individual has not been enrolled in Medicaid in the LIFC covered group for 12 consecutive months.

a. Unbroken Coverage As LIFC

The $30 earned income exclusion is applied beginning the month immediately following the 4 consecutive months of the $30 plus 1/3 earned income exclusion.

EXAMPLE #4: Ms. White, a Medicaid recipient in the LIFC covered group since January 1998, became employed June 1, 1999. In determining continued eligibility for Medicaid, $30 plus 1/3 of her earned income is excluded from countable income in June, July, August, and September (4 consecutive months) because Ms. White had been enrolled in Medicaid in the LIFC covered group during all four of the four months preceding June 1999. In October 1999 through May 2000, (8 consecutive months), $30 of her earned income is excluded. In June 2000 the exclusion was no longer allowed because she had received the full extent of the exclusion as of May 31, 2000.

b. Received Assistance Only Four Months

If an individual has received the $30 plus 1/3 earned income exclusion for 4 consecutive months, the fixed period of time that the exclusion is

available continues until the 8 consecutive months has ended. If the individual is not enrolled in Medicaid in the LIFC covered group in any of the following 8 consecutive months, the individual will not receive the $30 earned income exclusion.

EXAMPLE #5: A LIFC recipient becomes employed in January and receives the $30 plus 1/3 earned income exclusion for February, March, April and May. She is entitled to a $30 earned income exclusion for the 8-month period of June through January. She requests her case be closed in June. The 8-month time period for the $30 earned income exclusion continues to run. In February she reapplies and is employed. She is not eligible to receive the $30 earned income exclusion.

c. Reapplies in 8-Month Period

If an individual becomes ineligible for Medicaid for any reason and reapplies during the 8-month $30 earned income exclusion period, the individual will be eligible for the exclusion for the remaining months of the 8-month period.

EXAMPLE #6: A LIFC recipient becomes employed in January and receives the $30 plus 1/3 exclusion on earned income received in February, March, April and May. She is entitled to a $30 earned income exclusion on income received in June through January. The recipient requests her case be closed in July. The 8-month period continues to run. She reapplies in September and is found eligible. The $30 earned income exclusion applies to her earnings in the months of September through January.

d. Received $30 Earned Income Exclusion For Less than Eight Months Due to Loss of Earnings

If an individual receives the $30 earned income exclusion for less than 8 months because of a loss of earnings, the individual will again be eligible for the remaining months of the 8-month period if the individual receives earned income.

EXAMPLE #7: Mrs. Tan, a Medicaid recipient, received the $30 plus 1/3 earned income exclusion in January, February, March , and April (first 4 consecutive months). She received the $30 earned income exclusion in May and June. She loses her job in June. In August, she becomes employed. She is eligible for the $30 earned income exclusion for the months of September through December.

M0720.540 CHILD CARE/INCAPACITATED ADULT CARE EXCLUSION

A. Policy

Anticipated child or incapacitated adult care expenses paid or anticipated to be paid by the family/budget unit for children or incapacitated adults in the family unit, up to the appropriate maximums, must be excluded from earned income in determining Medicaid eligibility when the expenses are necessary because of employment or seeking employment.

a. Both parents are in the home

When both parents are in the household, both parents must be employed or seeking employment to *receive* the child care/incapacitated adult care exclusion. The child care/incapacitated adult care exclusion is based on a *parent's* employment status.

When only one parent is employed and the other parent is not employed or seeking employment and is not able to care for the child(ren) or incapacitated adult, the dependent/incapacitated adult care expense exclusion may be granted when:

*1) the paid child or incapacitated adult care is necessary, **and***

2) a physician provides a statement that the parent is disabled and unable to care for the child(ren) or incapacitated adult in question. The doctor's statement must also indicate the anticipated length of time that the parent will be unable to care for the child(ren) or incapacitated adult.

b. LIFC 185% screening

For LIFC, the child or incapacitated adult care exclusion is not allowed in the 185% screening.

B. Definitions

1. Full-time Employment

Full-time employment means employed to work 30 hours or more per week on an on-going basis; or working, or expected to work 120 hours or more per month (for an individual working on a fluctuating basis).

2. Part-time Employment

Part-time employment means employed to work less than 30 hours per week on an on-going basis; or working or expected to work less than 120 hours per month (for an individual working on a fluctuating basis).

3. Not Employed Throughout a Month

Not employed throughout a month means an individual began or terminated employment within the month.

C. Operating Principle

1. Verification

a. Incapacity

Incapacity of the adult who requires care must be supported by a professional determination. The medical examination for Medicaid and GR is used for this purpose, unless incapacity is established by receipt of Social Security Disability benefits.

b. Employment Status

An individual's employment status is verified by either an employer's statement of the number of hours employed to work, or actually worked

or by pay stubs. For self-employed individuals, the agency is required to accept the client's statement concerning the number of hours worked, unless the agency has reason to question the validity of the statement.

c. Expenses

Verification of child/incapacitated adult care expenses is not required. Accept the parent/caretaker's declaration of the amount of the child/incapacitated adult care expense.

2. Amount of Exclusion

a. Full-time Employment

For full-time employment, deduct an amount equal to the anticipated cost, not to exceed $175 per month, for care of each child, age 2 and older and/or incapacitated adult in the family unit. In the case of child care for a child under 2 years old, deduct the anticipated cost not to exceed $200 per month.

b. Part-time Employment

For part-time employment, deduct an amount equal to the anticipated cost, not to exceed $120 per month, for care of each child and/or incapacitated adult in the family unit.

c. Not Employed Throughout a Month

1) If an individual has worked, or is expected to work, 120 hours or more in that month, deduct an amount not to exceed the full-time exclusion.

2) If an individual has worked, or is expected to work, less than 120 hours in that month, deduct an amount not to exceed the part-time exclusion.

3. Conversion to Monthly Amount

If child care/incapacitated adult care is payable on a weekly or bi-weekly basis, the amount of the monthly expense may be calculated using the 4.3 (weekly), or 2.15 (bi-weekly), or 2 (semi-monthly) conversion factors.

FAMILIES & CHILDREN EARNED INCOME EXCLUSIONS

EXCLUSION	CRITERIA	LIMITATIONS
Workforce Investment Act M720.505	child < age 19	none
Student Earnings M720.510	child < age 19 in school	none
$90 Standard Work M720.520	available for EACH person in the FU/BU whose earnings are being counted	not allowed in 185% screening for LIFC
$30 plus 1/3 (LIFC only) M720.525	applicants must have received LIFC Medicaid in at least one of the preceding 4 months can be allowed until exclusion has been received for 4 consecutive months once received for 4 consecutive months cannot allow again until person has not been enrolled in Medicaid in a LIFC covered group for 12 consecutive months	not allowed in 185% screening for LIFC 4 consecutive months
$30 (LIFC only) M720.526	allowed immediately following the $30 plus 1/3 exclusion	not allowed in 185% screening for LIFC fixed 8-month period
Child Care/ Incapacitated Adult Care M720.540	allowed for child or adult in FU/BU amount based on employment status of applicant/recipient and age of child or adult = or >30 hours/week or 120 hours/month <2 years= $200 maximum per child >2 years= $175 maximum per child or adult < 30 hours/week or 120 hours/month $120 per child or adult	not allowed in 185% screening for LIFC allowed as long as child or adult is in FU/BU *for child care, if both parents are in home, both must be employed*

CHAPTER M07
FAMILIES AND CHILDREN INCOME
SUBCHAPTER 30

F & C UNEARNED INCOME

M0730 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	pages 7, 8
TN #93	01/01/2010	page 2
TN #91	05/15/2009	Table of Contents pages 7-8a

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GENERAL

M0730.001 INTRODUCTION TO UNEARNED INCOME

A. Policy - General

Unearned income is all income received by members of the family/budget unit that is not earned income. Unearned income consists of:

- benefits, including public assistance benefits received from another state
- royalties
- child/spousal support
- dividends and interest
- some rental income
- gifts
- some home energy assistance
- contributions
- lump sums

B. Policy - When to Count Unearned Income

Unearned income is counted as income in the earliest month it is:

- received by the individual;
- credited to the individual's account; or
- set aside for the individual's use.

C. *Available Income*

Retroactive period –available income is the gross income actually received in each month in the retroactive period.

Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months. The applicant's actual gross income received in the application month may be used if the application is processed after the month has passed and the person is eligible only when using the actual gross income for the month.

D. Policy - What Amount of Unearned Income is Counted

The amount of unearned income received is counted as income.

EXCEPTION: When the Medicare Part B premium is deducted from the Social Security or Railroad Retirement benefits, that amount must be added to the actual benefit being received.

E. Verifications

Verify the amount of the unearned income by an award letter or notice, a benefit payment check, or through contact with the source of the unearned income, unless the source of the unearned income is listed in M0730.099 B. Verification of unearned income that is totally excluded is not required.

F. References

What is income, M0710.003
What is not income, M0715.050
When income is counted, M0710.030
How to estimate income, M0710.610

UNEARNED INCOME EXCLUSIONS - GENERAL

M0730.050 OVERVIEW OF EXCLUSIONS

A. Definitions

An exclusion is an amount of income that does not count in determining eligibility.

B. Policy Exclusions never reduce unearned income below zero. No unused unearned income exclusion may be applied to earned income.

C. Procedure First determine whether what is received is income. Next apply any appropriate exclusions of unearned income listed in this subchapter.

D. Reference What is not income, M0715.050

M0730.099 GUIDE TO EXCLUSIONS

A. Introduction The following provides a list of exclusions of unearned income:

B. List of unearned income exclusions

1. Home Produce Home produce of the individual utilized for his/her family's own consumption is excluded.

2. *SNAP* *Supplemental Nutrition Assistance Program (SNAP)* (formerly *Food Stamps)* benefits are excluded.

3. Commodities The value of foods donated under the U.S.D.A. Commodity Distribution Program, including those furnished through school meal programs, is excluded.

4. Federal Relocation Assistance Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 is excluded.

5. Nutrition Program for the Elderly Any benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended, are excluded.

6. Grant or Loan Administered by U.S. Secretary of Education Any grant or loan to any undergraduate student for educational purposes made or insured under any program administered by the U.S. Secretary of Education is excluded. Programs that are administered by the U.S. Secretary of Education include: Pell Grant, Supplemental Educational Opportunity Grant, Perkins Loan, Guaranteed Student Loan, including the Virginia Educational Loan, PLUS Loan, Congressional Teacher Scholarship Program, College Scholarship Assistance Program, and the Virginia Transfer Grant Program.

7. College Work Study Programs Any funds derived from the federal College Work Study Program or any other college work study programs are excluded.

8. Educational Scholarships and Grants All educational scholarships and grants are excluded.

9. Vocational Rehabilitation Training Allowances

Training allowances (transportation, books, required training expenses and motivational allowances) provided by Vocational Rehabilitation for persons participating in Vocational Rehabilitation Programs are excluded.

The exclusion is not applicable to the allowances provided by VR to the family of the participating individual.

10. SSI, TANF or Auxiliary Grant

Any portion of an SSI, TANF and/or Auxiliary Grant payment is excluded. *NOTE: A VIEW Transitional Payment (VTP) is NOT TANF and is counted as unearned income.*

11. VISTA Payments

Payments to VISTA Volunteers under Title I, when the monetary value of such payments is less than minimum wage as determined by the Director of the action office, and payments for services of reimbursement for out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides, or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and other programs pursuant to Titles II and III, of Public Law 93-113, the Domestic Volunteer Service Act of 1973 are excluded. The worker must contact the Action Office at the following address or telephone number when VISTA payments are reported; Action Office, 400 N. 8th Street, Richmond, Virginia 23219, (804) 771-2197.

12. VA Educational Allowances

The Veterans Administration educational amount for the caretaker 18 or older is excluded when it is used specifically for educational purposes. Any additional money included in the benefit amount for dependents is counted as income to the individual for whom intended.

13. Foster Care/ Adoption Assistance Payments

Foster care or adoption assistance payments received by anyone in the assistance unit are excluded.

14. Job Corps Payments to Eligible Children

Any unearned income received from Title IV, Part B (Job Corps) of the Job Training Partnership Act (JTPA) by an eligible child (less than 18 or 18 and expected to graduate by the end of the month in which he turns 19) is excluded as an incentive payment. However, any payment received by any other Job Corps participant or any payment made on behalf of the participant's eligible child(ren) is counted as income to the individual.

15. Fuel Assistance Program

Any payment made under the Fuel Assistance Program is excluded.

16. Child Nutrition Act

The value of supplemental food assistance received under the Child Nutrition Act of 1966 is excluded. This includes all school meal programs, the Women, Infants and Children (WIC) Program, the child care food program, and U.S.D.A. reimbursement payments to day care providers which are authorized by the National School Lunch Act.

17. HUD Payments

HUD Section 8 and Section 23 payments are excluded.

18. JTPA Income to Eligible Children

Any unearned income received by an eligible child (less than 18 or 18 and expected to graduate by the end of the month in which he turns 19) under Title II, Parts A and B, and Title IV, Part A of the Job Training Partnership Act (JTPA) is excluded.

19. Certain Funds for Indian Tribes

Any funds distributed to, or held in trust for, members of any Indian tribe under Public Law 92-254, 93-134, 94-540, 98-64, 98-123, 98-124 or 97-458 are excluded. Additionally, interest and investment income accrued on such funds while held in trust, and purchases made with such interest and investment income are excluded.

20. Alaska Native Claims Settlement Act

The following of distributions received from a Native Corporation under the Alaska Native Claims Settlement Act (Public Law 100-241) are excluded:

a. Cash (including cash dividends on stock received from a Native Corporation) to the extent that the total received does not exceed $2,000 per individual per calendar year;

b. Stock (including stock issued or distributed by a Native Corporation as a dividend or distribution on stock);

c. A partnership interest;

d. Land or an interest in land (including land or an interest in land received from a Native Corporation as a dividend or distribution on stock); and

e. An interest in a settlement trust.

21. Income from Submarginal Land

Income derived from certain submarginal land of the United States which is held in trust for certain Indian tribes (Public Law 94-114) is excluded.

22. Child/Spousal Support Payments

The first $50 of total child or child and spousal support payments received by the family/budget unit is excluded. The $50 exclusion is only applicable to current child/spousal support payments received each month. (See M0730.400)

23. DCSE Payments of Excluded Support

Payments sent to the recipient by the State which are identified as excluded support are excluded. See M0730.400.

24. Disaster Relief

Federal major disaster and emergency assistance provided under the Disaster Relief and Emergency Assistance Amendments of 1988 and disaster assistance provided by state and local governments and disaster assistance organizations (Public Law 100-707) is excluded.

25. Certain Payments to Japanese and Aleut

Payments received by individuals of Japanese ancestry under the Civil Liberties Act of 1988, and by Aleut under the Aleutian and Pribilof Islands Restitution Act (Public Law 100-383) are excluded.

26. ESP or VIEW Support Payments

Payments by Employment Services Program or VIEW for support services such as transportation, uniforms, child care, etc. are excluded. *VIEW Transitional Payments (VTP) are NOT excluded; VTP must be counted as unearned income.*

27. Agent Orange Payments

Any payment received from the Agent Orange Settlement Fund or any other fund established in response to the Agent Orange product liability litigation is excluded. To verify whether a payment is an Agent Orange payment, use documents in the individual's possession. If the individual cannot provide verification or the situation is unclear, write to the Agent Orange Veteran Payment Program, P.O. Box 110, Hartford, CT 06104, Attention: Agent Orange Verification. Include in the request the veteran's name and social security number. If a survivor of a qualifying veteran was paid, also provide the survivor's name and social security number.

28. Radiation Exposure Compensation Act Payments

Payment received by individuals under the Radiation Exposure Compensation Act (Public Law 101-426) is excluded.

29. Maine Indians Claims Settlement Act

Funds received pursuant to the Maine Indians Claims Settlement Act of 1980 (Public Law 96-420); and the Aroostook Band of Micmacs Settlement Act (Public Law 102-171) are excluded.

30. Higher Education Act Student Financial Assistance

Student financial assistance received under Title IV of the Higher Education Act. Assistance to be excluded under this provision, whether awarded to an undergraduate or graduate student, includes but is not limited to:

- Pell Grants,
- Supplemental Educational Opportunity Grants,
- State Student Incentive Grants,
- Federal College Work-Study Programs,
- Perkins Loans (formerly National Direct Student Loans), and
- Guaranteed Student Loans (including PLUS loans and Supplemental Loans for Students).

31. Carl D. Perkins Student Financial Assistance

Student financial assistance received under the Carl D. Perkins Vocational and Applied Technology Education Act made available for attendance costs (Public Law 101-392) is excluded. Attendance costs are defined below:

- tuition and fees normally assessed a student carrying the same academic workload as determined by the institution, and including

costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study; and

- an allowance for books, supplies, transportation, dependent care, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution.

32. HUD Self-Sufficiency Program

Funds paid to an escrow account established under the Family Self-Sufficiency Program of the Department of Housing and Urban Development are excluded.

33. BIA Student Assistance

Student financial assistance received under Bureau of Indian Affairs (BIA) student assistance programs is excluded.

34. Interest on Certain Savings Accounts

Interest earned on a savings account for the purpose of paying for tuition, books, and incidental expenses at any elementary, secondary, or vocational school or any college or university for a family member, for making a down payment on a primary residence, or establishing a business is excluded.

35. Up To $2000/yr. Received by Individual Indians

Up to $2,000 per year of income received by individual Indians, which is derived from leases or other uses of individually-owned trust or restricted lands is excluded.

36. Nazi Persecution Payments

Payments received by victims of Nazi persecution under Public Law 103-286 are excluded.

37. First $30 for Special Occasions

The first $30 received by each individual in the family/budget unit per calendar quarter for special occasions, such as birthdays, Christmas, etc. is excluded. See M0730.520.

38. Lump Sum

A lump sum plus all other earned and unearned income that is less than 100% of need in the locality for the number of members in the FU/BU is excluded from countable unearned income when evaluating lump sum income. See M0730.800.

39. Walker v. Bayer Settlement Payments

Section 4735 of the Balanced Budget Act of 1997 (P.L. 105-33) states that payments described in this subsection from the settlement of the Susan Walker v. Bayer Corp., et.al., class action lawsuit are NOT counted as income in determining eligibility for Medicaid. Payments described in this subsection are:

a. payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corp., et.al., 96-C-5024 (N.D.III.); and

b. payments made pursuant to a release of all claims in a case that entered into in lieu of the class settlement of Walker v. Bayer Corp., et.al., and that is signed by all affected parties on or before the later of

- December 31, 1997, or
- the date that is 270 days after the date on which such release is first sent to the persons to whom the payment is to be made.

Information received by claimants in this lawsuit shows that claimants can choose to receive the payment in one of three ways – in a lump sum, a structured settlement, or a special needs trust. Regardless of which form the individual chooses, the payment(s) are excluded if the above requirements are met.

Verify the source of the funds from a letter from the individual's attorney or a copy of the check which identifies the payor as a Walker v. Bayer settlement account.

Any interest earned on these funds is NOT excluded. Any interest earned on these funds must be evaluated as unearned income in the month of receipt and as a resource thereafter.

40. Combat Zone Income

Any amount received by or made available to household members for deployment or service in a combat zone will not count as income for Medicaid purposes unless the payment was received before the deployment. This exclusion includes items such as, but not limited to, incentive pay for hazardous duty, special pay for imminent duty or hostile fire duty or certain re-enlistment bonuses, or special pay for certain occupational or educational skills.

M0730.100 MAJOR BENEFIT PROGRAMS

A. Policy

Annuities, pensions, retirement benefits, and disability benefits are unearned income. The amount of unearned income actually being received, not the entitlement amount, is counted as income.

EXCEPTION: When the Medicare Part B premium is deducted from the Social Security or Railroad Retirement benefits, that amount must be added to the actual benefit being received.

B. Definitions

1. Annuity An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer.

2. Pensions and Retirement Benefits Pensions and retirement benefits are payments to a worker following his retirement from employment. These payments may be paid directly by a former employer, by a trust fund, an insurance company, or other entity.

3. Disability Benefits Disability benefits are payments made because of injury or other disability.

C. List of Benefits The following are examples of benefits:

Social Security Benefits
VA Payments
Worker's Compensation
Railroad Retirement
Black Lung Benefits
Civil Service Payments
Military Pensions
VIEW Transitional Payments

D. Procedure Verify entitlement amount and amount being received by documents in the applicant/enrollee's possession, such as an award letter or benefit payment check, or by contact with the entitlement source.

M0730.200 UNEMPLOYMENT COMPENSATION

A. Policy Unemployment Compensation received by an individual is counted as unearned income. The amount counted is the gross benefit before any taxes or deductions.

B. Procedures

1. General Procedures Count Unemployment Compensation as unearned income for all covered groups, but do not count it in the 185% income screening for LIFC.

Exclude Unemployment Compensation in the 185% income screening for LIFC. Count Unemployment Compensation in the 90% income screening.

2. Special $25 Weekly Exclusion The American Recovery and Reinvestment Act of 2009 (P.L. 111-5) authorized *increased* payments, *called Federal Additional Compensation (FAC)*, of $25.00 per week to certain individuals receiving Unemployment Compensation payments. *FAC* increased payments *are* authorized for Unemployment Compensation payments made through *December 4*, 2010, *provided that the initial claim for compensation was filed on or before May 23, 2010. Claims filed after May 23, 2010 are not subject to the increased payments.*

The individual's entitlement to Unemployment Compensation is not affected—the individual will only receive the number of payments to which the individual would normally be entitled.

FAC increased payments are excluded from countable income. If the individual's Unemployment Compensation claim was filed on or before May 23, 2010, exclude the first $25.00 of Unemployment Compensation for payments made through December 4, 2010.

If the claim was filed after May 23, 2010, the individual does not receive the additional weekly $25.00. DO NOT exclude the FAC payments from countable income.

M0730.210 TRADE ADJUSTMENT ASSISTANCE ACT INCOME

A. Policy

The Trade Adjustment Assistance Act is administered by the Virginia Employment Commission. The Act allows qualified unemployed individuals to receive additional weeks of Unemployment Compensation (UC). UC benefits are counted as unearned income. The amount counted is the gross benefit before any taxes or deductions.

B. Procedure

See M0730.200, above, for procedures to use in counting UC benefits.

M0730.400 CHILD/SPOUSAL SUPPORT

A. Policy

Support received by an individual, whether it comes directly from the provider or is redirected to the individual by DCSE, is unearned income. The support received by the individual is subject to the $50 Support Exclusion.

B. TANF Recipients

1. Distribution of Support

As a condition of eligibility for Temporary Assistance to Needy Families (TANF), an individual is required to assign to the State any rights to support from an absent parent of a child receiving TANF.

The State, through the Division of Child Support Enforcement (DCSE), sends the first $100 of support collected in a month on behalf of the TANF assistance unit to that unit. (If the total support collected is less than $100, the entire amount is sent to the unit.) Any remaining amount of support is kept by the State as reimbursement of TANF payments made to the family. If DCSE collects more support than the State is entitled to

keep as reimbursement for TANF paid, it will forward the excess amount to the TANF assistance unit. That excess amount is counted as unearned income.

2. $100 Pass Through

Child support collected by DCSE and paid to a TANF assistance unit as a $100 (or less) pass-through of child support, is income to the Medicaid family/budget unit when the pass-through check exceeds $50.00 per month. The amount of the monthly pass-through check that exceeds $50.00 is counted for Medicaid eligibility.

3. Amount in Excess of the Pass-Through

Child support collected by DCSE and forwarded to a TANF family because the support exceeds the amount which the State is entitled to keep as reimbursement for TANF is a payment of child support and is counted as unearned income.

4. Retained by State

Child support collected by a State and retained as reimbursement for TANF payments is not income to a Medicaid applicant/enrollee.

5. After TANF Stops

If the Medicaid enrollee has been removed from the TANF unit and is no longer included in the money payment, the assignment of rights to support for that individual is no longer valid (except with respect to any unpaid support obligation that has accrued under the assignment). From that point forward, the Medicaid enrollee is entitled to receive from the State his or her share of any support collected on his behalf. Any support received is unearned income in the month received.

C. Individual Not Receiving TANF

1. Direct Child/Spousal Support

Support collected by DCSE and paid to the Medicaid family/budget unit is unearned income in the form of child support to the family/budget unit. Support paid directly to the Medicaid family/budget unit by an absent parent or spouse is unearned income in the form of child/spousal support to the family/budget unit.

2. Support Exclusion

The first $50 of total child or child and spousal support paid to the family/budget unit is excluded. The $50 exclusion is only applicable current child/spousal support payments received each month. The $50 exclusion does not apply to alimony that is not commingled with child support.

D. Payments Made to Third Party (Other Than DCSE)

Pending establishment of a child support obligation by the District Child Support Enforcement Office, payments made to a third party such as a rental agency in lieu of or in addition to child support, whether based on a court order or a mutual voluntary agreement between the Medicaid applicant/enrollee and the responsible person, are NOT counted as unearned income to the child or to the parent-caretaker.

E. Payments Received for Child Not Living in Home

Child support payments received by a parent-caretaker for a child who is not living in the home are counted as income to the parent-caretaker if the parent-caretaker does NOT give the payment to the child when it is received.

M0730.500 DIVIDENDS AND INTEREST

A. Policy Dividends and interest are only counted as unearned income when earned on a countable resource. Dividend and interest income payments on countable resources are counted as income in the month received or anticipated to be received (even if paid quarterly, annually, etc.), unless the interest is earned on an excluded savings account for education, home purchase or establishing a business per M0630.125.

B. Definition Dividends and interest are returns on capital investments such as stocks, bonds, certificates of deposit, or savings accounts.

C. Procedure Verify the amount that is received or is anticipated to be received by documents in the applicant/recipient's possession or through contact with the financial institution where the account or other financial instrument is located.

M0730.505 RENTAL/ROOM AND BOARD INCOME

A. Policy Net rental/boarder income from the rental of real property, or rooms, or board paid when the applicant/recipient is not engaged in a business enterprise or actively involved in management is unearned income. Rental/room and board income is counted in the month in which it is received.

B. Definitions

1. Rent Rent is a payment which an individual received for the use of real or personal property, such as land or housing.

2. Net Rental Income Net rental income is the total amount received less the allowable costs.

3. Board Board is the amount paid for the provision of meals only.

4. Room Room is the amount paid to rent a room only.

5. Room and Board Room and board is the amount paid for room rent and the provision of meals.

C. Calculation of Net Rental/Boarder Income

1. Real or Personal The net rental income is the total amount received less the tax on the property.

Verify the anticipated income by documents in the applicant's possession or by a statement from the tenant.

Verify the anticipated cost by a tax receipt for the property owned.

2. Room Rent

The net rental income is 65% of the total rent received if heating fuel is furnished by the applicant/recipient. The net rental income is 75% of the total rent received if heating fuel is not furnished.

Verify the rent paid by documents in the applicant/recipient's possession or a statement from the tenant.

3. Boarders

The net rental income is the total board received less the standard food allowance for one person at 100% per boarder. Contact your Medicaid Consultant for the current standard food allowance.

Verify anticipated income from documents in applicant/recipient's possession or statement from boarder.

4. Roomer/ Boarders

The net rental income is the total rent received less the standard food allowance for one person at 100% per boarder AND the room rental costs: 65% of the total rent received if heating fuel is furnished or 75% of the total rent received if heating fuel is not furnished.

Verify anticipated income by documents in the applicant/recipient's possession or by a statement from the boarder.

M0730.520 GIFTS

A. Policy

The first $30 received by each individual in the assistance unit per calendar quarter for special occasions, such as birthdays, Christmas, etc., is excluded.

B. Definition

Calendar quarters are:

January - March;
April - June;
July - September;
October - December.

C. Procedure

Any amount in excess of the $30 per calendar quarter anticipated to be received will be counted as unearned income in the month in which it is anticipated to be received.

M0730.522 CONTRIBUTIONS

A. Policy

1. Contribution from agencies or organization

Any cash contribution made directly to the FU/BU by an agency or organization must be counted as unearned income to the FU/BU if such contribution is for any of the following:

- food, including special diets
- clothing
- personal care
- household supplies and equipment
- insurance
- school supplies and expenses
- laundry
- utilities (including telephone)
- housekeeping and personal services
- obligations incurred within the month of application
- guardianship fees
- average shelter costs appropriate to the locality in which the assistance unit resides (including rent, house payments, taxes, fire or comprehensive insurance repairs, installations, water sewage and trash disposal

NOTE: If the contribution to the assistance unit is for one of the items listed above, it is unearned income and counted dollar for dollar. If it is not for one of the items listed above, it is not unearned income.

2. All Other Cash Contributions

All other cash contributions are counted in amount received as unearned income.

B. Procedure

- Verify with the administering agency or person contributing, the purpose of the contribution; AND

- Verify the amount of the contribution.

M0730.600 HOME ENERGY ASSISTANCE

A. Policy

Payments made directly to a household for home heating or cooling provided by suppliers of home energy, such as electric and gas companies and fuel oil dealers, must be counted as income.

B. Value of Assistance

When payments are received jointly by a household composed of Medicaid and non-Medicaid applicants/recipients, the FU/BU's pro rata share, based on the total number of persons in the household, must be considered as unearned income to the Medicaid FU/BU.

M0730.800 TREATMENT OF LUMP SUM INCOME

A. Policy

The receipt (on or after the month of application for Medicaid) of a nonrecurring lump sum payment is counted as income of the individual who received it. It is counted as income to the individual who received it in the month of receipt. If any of the lump sum is retained beyond the month of receipt, the retained portion is counted as a resource to the individual.

The lump sum is earned income if it meets the definition of earned income, such as an earnings bonus paid annually to an employee. If the lump sum does not meet the definition of earned income, it is unearned income. Most lump sum payments are unearned income.

In the month of receipt, the countable portion of the lump sum (lump sum minus directly related expenses) is added to the individual's other income and counted as income to the individual's family unit and/or budget unit. The countable lump sum amount is also added to all other earned and unearned income in calculating the amount of the deemor parent's income to deem to the F&C child.

B. Definition

A lump sum is one of the following:

- accumulation of benefits for a prior period, including Social Security and Workman's Compensation benefits;
- payments in the nature of a windfall, e.g., inheritances or lottery winnings;
- personal injury awards;
- any portion of a casualty property loss payment which is not used for repair or replacement of the damaged/lost resources;
- life insurance settlement when the policy is owned by someone other than a member of the family/budget unit;
- child support identified as payments paid in excess of public assistance; or
- income from any other nonrecurring source.

NOTE: Money received from the sale or conversion of any real or personal property is not considered a lump sum (see M0610.100, Distinction Between Assets and Resources).

NOTE: A lump sum is a resource if it was received before the month of application for Medicaid or if any amounts are remaining after the period of time it is counted as income. If counted as income, it cannot be counted as a resource even if placed in a savings account for education, home purchase, or establishing a business as described at M0630.125.

C. Procedure

1. Determine Countable Amount of Lump Sum

The gross amount of the lump sum minus directly related expenses, equals the countable amount of the lump sum. The countable amount of the lump sum is income in the month of receipt.

a. Definition of Directly Related Expenses

Directly related expenses are items such as funeral expenses, medical bills, legal fees, or liens against insured property. Expenses for day-to-day living incurred pending receipt of a lump sum are not directly related expenses.

Lump sum payments received as a result of an accumulation of benefits for a prior period, such as Social Security benefits, will have no directly related expense deduction.

b. Documentation of Directly Related Expenses

The applicant/recipient must promptly provide documented evidence of directly related expenses which were incurred prior to or are anticipated to be incurred within 30 days after receipt of the lump sum.

If verification of the payment of directly related expenses is not provided promptly, the lump sum is counted in full. Subsequent provision of verification of the lump sum payment or the payment of directly related expenses will not change the countable amount of the lump sum. The agency must advise the applicant/recipient of the requirement to count the lump sum in full unless the directly related expenses are actually paid.

2. Determine Total Income

Add all countable earned and countable unearned income to the countable portion of the lump sum to determine the individual's total amount of income for the month of receipt.

3. Evaluate Asset Transfer

Evaluate the spending of a lump sum under the asset transfer policy in subchapter M1450 and document the case record with the amount(s) of compensation received.

D. Example--Lump Sum Received By Adult In Family

EXAMPLE #1: Mr. Fox , who lives in a Group II locality, receives a $5000 lump sum on August 2, 1997. There are 5 members of the family unit. Their other countable earned and unearned income for that month is $200. *The family unit's income for August is $200 + $5000 = $5200.*

$1,730 of the lump sum remains in September. The $1,730 is counted as a resource to Mr. Fox in September.

E. Example--Lump Sum Received By *Adult, Stepparent* In Family

EXAMPLE #2: *Mrs. Bear lives in a Group II locality with her husband, Mr. Bear, and her son from a previous relationship, Baby Bear. Baby Bear has been receiving Medicaid as a Medically Indigent Child Under 6. The parents had not requested Medicaid for themselves. On September 3, 1997, Mrs. Bear receives a $5000 lump sum payment (after directly related expenses are deducted). The family has no earned income, but has unearned income of $1300 per month (retirement for Mr. Bear). Mrs. Bear has no other income. The family unit's income for September is $1300 + 5000 = $6300.*

The countable income of the family unit is compared to the MI income limit for three people. $6300 exceeds the MI limit for three people ($1477). Since Baby Bear has a stepparent in the home, budget units must be formed. One budget unit contains Mr. and Mrs. Bear; the other budget unit contains Baby Bear.

Deem a portion of Mrs. Bear's income to Baby Bear:

$5000.00	*Mrs. Bear's lump sum income*
- 128.50	*deeming standard (1/2 of 100% standard of assistance for 2 in Group II)*
$4871.50	*deemable income*

Baby Bear's monthly income for September is $4871.50. That amount exceeds the MI Child Under 6 income limit for a budget unit of one ($874) so Baby Bear is not eligible for Medicaid in September. For October, Baby Bear has no countable income because his mother has no income in October; he is eligible for Medicaid again in October as an MI child under age 6.

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CHAPTER S08
ABD INCOME
SUBCHAPTER 10

GENERAL--ABD INCOME RULES

M0810 Changes

Changed With	Effective Date	Pages Changed
UP #5	7/1/11	page 2
TN #95	3/1/11	pages 1, 2
TN #93	1/1/10	pages 1, 2
Update (UP) #1	7/1/09	page 2

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GENERAL

M0810.001 INCOME AND ELIGIBILITY

A. Introduction

The following sections explain how to treat income in the Medicaid program. This chapter explains how we count income.

B. Policy Principles

1. Who is Eligible

An individual is eligible for Medicaid if the person:

- meets a covered group; and
- meets the nonfinancial requirements; and
- meets the covered group's resource limits; and
- meets the covered group's income limits.

2. General Income Rules

- Count income on a monthly basis.
- Not all income counts in determining eligibility.
- If an individual's countable income exceeds a classification's monthly limit, a medically needy spenddown may be established, if appropriate.

M0810.002 INCOME LIMITS

A. Income Limits

The Medicaid covered group determines which income limit to use to determine eligibility.

1. Categorically Needy

Supplemental Security Income (SSI) and State Supplement (Auxiliary Grant) recipient's money payments meet the income eligibility criteria in the ABD Categorically Needy covered group.

2. Categorically Needy Non-Money Payment-Protected Cases Only

Categorically-Needy Non-Money Payment Protected Covered Groups Which Use SSI Income Limits		
Family Unit Size 1 2	*2011* Monthly Amount $674 1,011 (no change in *2011*)	*2010* Monthly Amount $674 1,011
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size 1 2	*2011* Monthly Amount $449.33 674.00 (no change in *2011*)	*2010* Monthly Amount $449.33 674.00

3. Categorically Needy-Non Money Payment (CNNMP) – 300% of SSI

For the covered groups that use the 300% of SSI income limit, all income is counted (even excluded income) when screening at 300% of SSI. Do not count any monies which are defined as "what is not income" in S0815.000.

Categorically Needy-Non Money Payment 300% of SSI		
Family Size Unit 1	2011 Monthly Amount $2,022 (no change in 2011)	2010 Monthly Amount $2,022

4. Medically Needy (Effective July 1, *2011*)

a. Group I		
Family Unit Size 1 2	Semi-annual *$1,711.70* *2,179.46*	Monthly *$285.28* *363.24*
b. Group II		
Family Unit Size 1 2	Semi-annual *$1,975.04* *2,432.27*	Monthly *$329.17* *405.37*
c. Group III		
Family Unit Size 1 2	Semi-annual $*2,567.56* *3,095.78*	Monthly $*427.92* *515.96*

5. ABD Medically Indigent

For: ABD 80% FPL, QMB, SLMB, & QI with or without Social Security income, QDWI and MEDICAID WORKS, effective 1/20/11

ABD 80% FPL 1 2	Annual $8,712 11,768	Monthly $726 981
QMB 100% FPL 1 2	Annual $10,890 14,710	Monthly $908 1,226
SLMB 120% of FPL 1 2	Annual $13,068 17,652	Monthly $1,089 1,471
QI 135% FPL 1 2	Annual $14,702 19,859	Monthly $1,226 1,655
QDWI and MEDICAID WORKS 200% of FPL 1 2	Annual $21,780 29,420	Monthly $1,815 2,452

M0810.005 WHAT IS INCOME

A. Policy Principles

1. Definitions

Income is

- cash, or
- its equivalent, unless specifically listed in S0815 as not being income.

2. Amount

Sometimes income includes more or less than is actually received, for example:

- Expenses of obtaining income (less)
- Garnishment (more)
- Gross earnings, before any deductions (more).

B. References

- What is not income, S0815.001.
- Garnishment, S0810.025.
- Expenses of obtaining income, S0830.100.
- Wages, S0820.100.

S0810.007 INCOME EXCLUSIONS

A. Introduction

Medicaid eligibility is based on countable income. See S0810.300 B.1. for the definition of countable income (CI). In determining CI, consider any income exclusions.

Some exclusions totally negate the amount of income received. Other exclusions reduce the amount counted. For example, any income may be wholly excluded (not counted) if it meets the criteria for exclusion of income received infrequently or irregularly.

B. Definition

Excluded income is an amount which is income but does not count in determining eligibility.

C. Policy Principles

1. Income Exclusions under Other Federal Statutes

Some Federal laws other than the Social Security Act prohibit counting some income for Medicaid purposes. See S0830.099.

2. Exclusions under the Social Security Act

Section 1612(b) of the Social Security Act provides for several income exclusions in determining countable income for Medicaid purposes.

D. References

- Income exclusions applicable to both earned and unearned income, S0810.400.
- Earned income exclusions, S0820.500.
- Unearned income exclusions, S0830.001.
- Order of application of exclusions, S0830.100 C.

S0810.010 RELATIONSHIP OF INCOME TO RESOURCES

A. Operating Policy

In general, anything received in a month, from any source, is income to an individual, subject to the definition of income in S0810.005.

Anything the individual owned prior to the month under consideration is subject to the resource counting rules.

An item received in the current month is income for the current month only. (See exceptions to this general rule in S0810.030.) If held by the individual until the following month, that item is subject to resource counting rules (See exception in S1110.115)

B. Example

Mr. Jones receives a dividend check for $300 at the end of May. He spends $150 immediately and deposits the remaining $150 in his savings accounts. His income for May is $300. The June 1 evaluation of Mr. Jones' resources includes (for the first time) the $150 he saved.

C. References

- Definition of resources, S1110.100 B.1.
- Conversion or sale of a resource, S0815.200.
- Replacement of lost, damaged, or stolen resources, S1130.630.

S0810.015 TYPES OF INCOME

A. Policy Principles

1. Types of Income

Income is either earned or unearned, and different rules apply to each.

2. Earned Income

Earned income consists of the following types of payments:

- wages
- net earnings from self-employment
- payments for services performed in a sheltered workshop or work activities center.
- royalties earned by an individual in connection with any publication of his/her work and any honoraria received for services rendered.

3. Unearned Income

Unearned income is all income that is not earned income. Some types of unearned income are:

- annuities, pensions, and other periodic payments
- alimony and support payments
- dividends, interest, and royalties (except for royalties mentioned in 2. above)
- rents
- benefits received as the result of another's death to the extent that the total amount exceeds the expenses of the deceased person's last illness and burial paid by the recipient
- prizes and awards

B. References

- Definition of countable income, S0810.300.
- Earned income, S0820.001.
- Unearned income, S0830.001.

M0810.020 FORMS AND AMOUNTS OF INCOME

A. Operating Policies

1. Forms of Income

Income, whether earned or unearned, may be received in the form of cash--currency, checks, money orders, or electronic funds transfers (EFT), such as:

- Social Security checks
- unemployment compensation checks
- payroll checks or currency.

2. Amounts of Income

The value of cash income is generally the amount of the currency or the face value of checks, money orders or EFT's the individual receives. There are some exceptions listed in B. below.

B. References

- Expenses of obtaining income, S0830.100.
- Determining amount of wages, S0820.100.
- Amounts withheld to recover an overpayment, S0830.110.
- Garnishment or seizure, S0810.025.
- Income exclusions, S0810.400.

S0810.025 EFFECT OF GARNISHMENT OR SEIZURE

A. Definition

A **garnishment** or **seizure** is a withholding of an amount from earned or unearned income in order to satisfy a debt or legal obligation.

B. Policy Principles

Amounts withheld from earned or unearned income to satisfy a debt or legal obligation are income for Medicaid purposes.

C. Related Policy

1. Earned Income

Wages are what an individual receives (before any deductions) for working as someone else's employee. See S0820.100.

2. Unearned Income

See S0830.115 for instructions on determining the amount of unearned income if garnishment or other withholding is involved.

S0810.030 WHEN INCOME IS COUNTED

A. Policy Principles

Generally, we count income at the earliest of the following points:

- when it is received; or,
- when it is credited to an individual's account; or
- when it is set aside for his or her use.

We determine income monthly and count it the month it is received.

B. Operating Policy

1. Exceptions

Occasionally, a regular periodic payment (e.g., wages, Title II, or VA benefits) is received in a month other than the month of normal receipt.

As long as there is no intent to interrupt the regular payment schedule, consider the funds to be income in the normal month of receipt.

The most common situations where this policy applies appear in 2. and 3. below.

2. Advance Dated Checks

When a payor advance dates a check because the regular payment date falls on a weekend or holiday, there is no intent to change the normal delivery date.

Whenever such an advance dated check is received, consider it income to the recipient in the month of normal receipt.

3. Electronic Funds Transfers (EFT)

When an individual's money goes to a bank by direct deposit, the funds may be posted to the account before or after the month they are payable.

Whenever this occurs, treat the electronically transferred funds as income in the month of normal receipt.

C. Related Policy

1. Counting Advance Dated Checks and EFT's and Resources

Such funds are first subject to evaluation as resources in the month following the month of normal receipt.

See S1130.600 for SSI and RSDI retroactive payments as resources.

2. Counting Net Earnings from Self-Employment

Counting net earnings from self-employment (NESE) varies from the general income-counting rule. NESE is allocated evenly into all months of an individual's taxable year. See S0820.200.

3. Replacement of Income Already Received

See S0815.450 if income is lost, stolen, or destroyed, and a replacement is received.

4. Recipient Returns a Check He/She Is Not Due

See S0815.460 when the recipient is aware that he/she is not due a payment and returns the money.

5. Reissued Title II Funds in Change of Payee Situations

See S1120.022 when conserved title II benefits are reissued as a result of a change in payees.

WHOSE INCOME IS IT?

S0810.120 INCOME DETERMINATIONS INVOLVING AGENTS

A. Introduction

This section deals with the actions of agents who conduct financial transactions on behalf of others, and the policies that apply in making determinations of countable income as a result of such transactions.

A Medicaid recipient may be an agent for another person **or have an agent** acting on his or her behalf. Whenever an agent takes part in a financial transaction, the EW must determine whether the transaction was conducted on the agent's behalf or on behalf of the person he or she represents.

NOTE: References in this section to a "Medicaid recipient" also include a Medicaid applicant and individuals whose income and/or resources are subject to deeming.

B. Definition

An "agent" is a person or organization acting on behalf of and/or with the authorization of another person or organization. The term "agent" applies to all individuals who act in a fiduciary capacity, whether formal or informal, regardless of their titles (representative payees, guardians, conservators, etc.)

C. Operating Policies Medicaid Recipient Is an Agent

1. General

Monies received by a Medicaid recipient in his/her capacity as an agent are not income to him/her. Regular income rules (S0810.001) apply for counting income a Medicaid recipient receives which is not paid on behalf of another.

2. Agent With Bank Account for Another

a. Account Correctly Titled
When a Medicaid recipient acts as an agent for another and the title or designation of a bank account for the other person reflects the agency relationship, deposits to the account are not income to the Medicaid recipient.

b. Account Incorrectly Titled
If the account is incorrectly titled, deposits to the account are income to the Medicaid recipient--unless the Medicaid recipient makes the deposits for another person and disburses or intends to disburse the money on the other person's behalf. (See S1120.020 for instructions concerning the treatment of resources when an agent is involved.)

3. Fees Received by an Agent

There may be situations where agents are authorized to keep a part of the funds they receive on behalf of another. **Fees**, commissions, or contributions for services rendered **are unearned income** to a Medicaid recipient acting as an agent.

4. Misuse of Benefits

A Medicaid recipient acting as an agent may misuse another's funds. Monies misused by a Medicaid recipient are unearned income in the month received unless restitution is made.

When misused funds are refunded by a Medicaid recipient acting as an agent, these funds are not counted as income to the recipient.

5. Recipient and Use of Funds From an Absent Household Member

Frequently an individual leaves home (e.g., is confined to a Medicaid facility) and all or part of his/her income is turned over to someone maintaining the home. When funds are turned over to a Medicaid recipient, the guidelines below apply for determining if the recipient is acting as an agent.

a. **Absent evidence to the contrary, the Medicaid recipient is assumed to be acting as an agent** if he/she alleges that the funds received are being used to maintain the home **or** on behalf of the absent household member in some other manner (e.g., paying the absent individual's life insurance premiums).

NOTE: An example of evidence contrary to the assumption in a. above is a Medicaid recipient who is living at home and who has an absent spouse in a Medicaid facility. If a certain amount of the institutionalized person's income should be "assigned" to the spouse at home and the "assigned" amount is actually made available to the Medicaid recipient, the amount of money available as cash income is unearned income to the Medicaid recipient. (The terms for this income is "spousal monthly income allowance.") In this situation, the Medicaid recipient is not acting as an agent because the money has been assigned to meet the at-home spouse's needs. If a "spousal monthly income allowance" has not been assigned from the institutionalized person's income to the at-home spouse, the presumption in a. above applies.

The amount of money used by a Medicaid recipient on behalf of the absent individual is not cash income to the Medicaid recipient.

b. If the Medicaid recipient alleges that all or part of **funds received** from an absent household member **are for the recipient's personal use**, the amount of cash income diverted to personal use is income to the Medicaid recipient.

D. Operating Policies-Medicaid Recipient has an Agent

1. General

Treat monies received by an agent acting on behalf of a Medicaid recipient as if the recipient received the monies directly. These monies are counted as income to the recipient when received by the agent, following the income-counting rules in S0810.010.

2. Misuse of Benefits by the Agent

If a Medicaid recipient's agent has been charged with misuse of funds and restitution has not been made, the **amount of funds misused by the agent is not counted as income** to the recipient. If restitution is made by the agent directly to the recipient, the amount restored is income in the month received.

E. Development and Documentation

1. General

When an agent relationship exists between a Medicaid recipient and another individual, the file must be clear as to the relationship between the two parties. In cases where the agent is chosen by a court or governmental agency, retain a copy of any documents verifying the appointment. If no document exists, contact the source of the appointment and record the information in the file. When financial transactions involving an agent take place, the file must reflect why income was or was not counted to the Medicaid recipient.

2. Fees Received By an Agent

Verify fees, commission, or contributions provided to a Medicaid recipient for services rendered as an agent. (See S0820.100 if there is an employer-employee relationship.)

3. Misuse of Benefits

Develop misuse and document case record. Adjust the Medicaid recipient's file to remove income counted which represent funds misused by the recipient's agent. If the agent restores the misused funds to the Medicaid recipient, the recipient will have income counted in the month he/she received the repaid monies.

If restitution of misused funds is made by Medicaid recipient acting as an agent, adjust the recipient's to remove income counted which represent the repaid monies.

4. Receipt of Funds From an Absent Household Member

Document the Medicaid recipient's allegation regarding the use of an absent household member's funds. If evidence is presented which rebuts the presumption that the Medicaid recipient is acting as an agent, keep a copy of the evidence in file.

F. Examples

1. Agent Uses Money for Self and on Another's Behalf

Clara Dalloway, a Medicaid recipient, is legal guardian for her elderly sister. A friend of the family gives Mrs. Dalloway $120 and tells her that a third of it is for her sister. Mrs. Dalloway keeps $80 for herself and uses the rest to buy clothing for he sister. $80 represents unearned income to Mrs. Dalloway in the form of a gift. The $40 which was paid on her sister's behalf is not income to Mrs. Dalloway because she used this money in her capacity as an agent.

2. Monies From an Absent Household Member Used to Maintain Home and for Personal Use

Christine Duncan, Medicaid recipient, rents an apartment with her cousin who goes into the hospital for an extended stay. Ms. Duncan reports to the EW that her cousin sent $200 to help with the rent and utility bills. Of the $200, Ms. Duncan needed only $175 for the household bills and used the remaining $25 to buy a birthday present for her brother. Because Ms. Duncan was acting as an agent for her cousin, the EW counts only $25 in income since she made personal use of that portion of the $200.

S0810.130 INCOME DERIVED FROM JOINT BANK ACCOUNTS

A. Introduction

This section explains how to count income in different situations involving the joint bank account of a Medicaid recipient/applicant and/or deemor.

When a Medicaid recipient or applicant has a joint bank account with another individual, **deposits made to the account by other account holders or interest posted to the account are income** to the Medicaid recipient. See B.2. below for an exception.

References in this section to a "Medicaid recipient" also include a Medicaid applicant and individuals whose income and/or resources are subject to deeming.

See S1140.205 for resource determinations involving bank accounts.

B. Operating Policies

1. General

a. **When a joint bank account is held by a Medicaid recipient and an ineligible** individual who is not a deemor, income to the Medicaid recipient includes:

- the full amount of any interest posted to the account and
- the full amount of any deposit made by a third party or by the ineligible bank account holder unless the Medicaid recipient is acting as an agent (see S0810.120 C.1.).

b. **When two or more Medicaid recipients are joint account holders,** deposits made by one individual are not income to the other. Allocate interest equally among the joint holders.

2. Rebuttal Situations

a. If a Medicaid recipient successfully **rebuts ownership of a portion of funds in a joint account** (see S1140.205 C.2.), deposits made by the other account holder are not income to the Medicaid recipient. Interest is counted to the Medicaid recipient in proportion to the percentage of funds that are a resource to the recipient.

b. If a Medicaid recipient successfully **rebuts ownership of all the funds** held in a joint bank account, deposits by the other account holders or interest posted to the account are not income to the recipient.

COMPUTING COUNTABLE INCOME

S0810.300 GENERAL

A. Introduction

An individual's monthly income is one of the factors which determines eligibility for Medicaid.

B. Definitions

1. Countable Income (CI)

CI is the amount of income that remains after:

- eliminating all amounts that are **not income** (S0815.001.); and
- applying all appropriate **exclusions** (S0810.400.)

CI is the sum of a month's countable earned and countable unearned income.

2. Countable Earned Income

Countable earned income is the amount of earned income (S0810.015 A.2.) remaining after applying all appropriate income exclusions.

3. Countable Unearned Income

Countable unearned income is the amount of unearned income (S0810.015 A.3.) remaining after applying all appropriate income exclusions.

S0810.310 HOW TO COMPUTE COUNTABLE INCOME

A. Operating Procedure

1. Evaluate Income

Evaluate all reported or estimated income for the month.

2. Determine What is Not Income

Do not consider certain kinds of payments, property, or services which are not income for Medicaid purposes. See S0815.001.

3. Deduct Income Excluded Under Other Federal Statutes

See S0830.055 for these exclusions which are not in title XVI of the Social Security Act. Exclude any of this income in determining countable income.

4. Compute Countable Unearned Income

Subtract applicable exclusions (S0830.100.) from unearned income to determine countable unearned income.

5. Compute Countable Earned Income

Subtract applicable exclusions (S0820.500.) from earned income to determine countable earned income.

6. Compute Countable Income

Add countable earned income and countable unearned income to arrive at total countable income.

B. References

- Order of application of exclusions, S0830.100 C.

INCOME EXCLUSIONS WHICH APPLY TO BOTH EARNED AND UNEARNED INCOME

S0810.400 GENERAL

A. Policy Principle

Some statutory exclusions apply only to earned income, some apply only to unearned income, and a few apply to both earned and unearned income.

B. References

The following sections address those exclusions which can apply to both earned and unearned income:

- Infrequent or irregular income exclusion, S0810.410.
- $20 per month general income exclusion, S0810.420.
- PASS exclusion, S0810.430.

S0810.410 INFREQUENT OR IRREGULAR INCOME EXCLUSION

A. Policy

1. The Exclusion

We can apply an exclusion to income which is received either infrequently or irregularly provided the total of such income does not exceed:

- $10 per month of earned income; and/or
- $20 per month of unearned income.

2. Infrequent or Irregular Income--Definition

In order for this exclusion to apply, income need only be one or the other of:

- **infrequent**--An individual receives income on an infrequent basis if he/she receives it no more than once in a calendar quarter from a single source; or
- **irregular**--An individual receives income on an irregular basis if he or she could not reasonably expect to receive it.

3. Interpretation of the Exclusion

a. **Applicable to Both Earned and Unearned Income**--This exclusion can apply to both earned and unearned income in the same month provided the total of each does not exceed the limits in 1. above. Thus it is possible to exclude as much as $30 in a month under this provision.

b. **Total Exceeds the Limit**--This exclusion does not apply to any income received on an infrequent or irregular basis if the total of such income exceeds the amounts in 1. We exclude all infrequent or irregular earned and/or unearned income or none of it, depending on the amount involved. (See G. below concerning income subject to other exclusions.)

c. **Limit as it Applies to Couples**--The dollar amount of the exclusion does not increase even if both an eligible individual and spouse (eligible or ineligible) have infrequent or irregular income.

d. **To Whom Applicable**--The exclusion is applicable to income received infrequently or irregularly by an eligible individual, eligible or ineligible spouse, and parent of blind or disabled child.

4. Unearned Income--Specific Considerations

In evaluating frequency of receipt of unearned income, we look at receipts of the same type of income from a single source.

B. Definitions

1. Single Source of Income

a. A single source of earned income is an employer, a trade, or a business.

b. A single source of unearned income is an individual, a household, an organization or an investment.

- A household in which an individual lives is a single source even if the household composition changes due to a move by the individual or by other household members (see C.2. below).
- An organization is the Federal Government, a single State or local government, a business or corporation, a charitable agency, or a similar entity which provides an individual with income.
- An investment is a single financial account, life insurance policy, rental property, or any other resource providing a return to its owner. Two separate accounts, even if with a single financial institution, are two different investments.

2. Two Payments from a Financial Institution -- Not a Single Source

An individual may occasionally receive an irregular interest payment by reason of a financial institution's own internal "housekeeping" rules. For example, a bank's rules may require an extra payment when someone closes an account or there may be a special "adjustment" payment due to a change in the accounting system or to closing the books at the end of a fiscal year. These kinds of irregular payments are from the financial institution itself and not from an individual's account with that institution. Therefore, they do not cause a regular (but infrequent) interest payment from an account to be considered "frequent" in that one quarter (see C.3. below).

NOTE: Determinations involving sources of income are only necessary when determining whether income is infrequent (see D.1. and D.2. below).

3. Types of Unearned Income

For purposes of this exclusion, types of unearned income are those listed in S0830.200 - S0830.560.

C. Example of Unearned Income

1. Regular Source Makes Unexpected Payment

An individual has a savings account that pays interest of $15 in the second month of each quarter. The interest has been routinely excluded as infrequent as the individual has no other infrequent or irregular income.

In 1989, without any advance notice to depositors, the bank changes its accounting system. As a result, in June the individual receives a $2.03 one-time payment in addition to his/her regular $15 interest payment in May.

The bank does not intend to interrupt its usual quarterly interest schedule, so the EW correctly views the one-time payment in June as being from a separate source than the regular quarterly payments; i.e., it is a bank adjustment. Therefore, the regular $15 payment is still excludable as infrequent while the unexpected $2.03 payment is irregular. The total is within the $20 limit in the month of receipt and is excludable.

D. Process--Identifying Infrequent or Irregular Income

1. Unearned Income Total cannot exceed $20 per month.

If someone receives unearned income....	**and...**	**then its receipt is...**
no more than once in a calendar quarter from a single source	_____	infrequent.
no more than once in a calendar quarter from each of several sources	it is the same type of income in each instance,	infrequent.
no more than once in a calendar quarter from each of several sources	it is a different type of income in each instance,	infrequent.
more than once in a calendar quarter from the same source	it is a different type of income in each instance,	infrequent.
more than once in a calendar quarter from the same source	it is the same type of income in each instance,	**not** infrequent.
any number of times in a month	he could not reasonably have expected or budgeted for it,	irregular.
any number of times in a month	he could reasonably have expected or budgeted for it (even if he did not know the exact amount),	**not** irregular.

2. Earned Income Total cannot exceed $10 per month

When someone receives earned income....	then its receipt is...
no more than once in a calendar quarter from a single source,	infrequent.
no more than once in a calendar quarter from each of several sources,	infrequent.
more than once in a calendar quarter from each of several sources,	**not** infrequent.
any number of times in a month and he could not reasonably have expected or budgeted for it,	irregular.
any number of times in a month and he could reasonably have expected or budgeted for it (even if he did not know the exact amount).	**not** irregular.

E. Process --Applying The Exclusion

The following process is for any earned income but only for unearned income which is not subject to other exclusions (see F. below).

When someone receives infrequent or irregular...	**and...**	**then this exclusion...**
unearned income	the total in a month does not exceed $20	applies.
unearned income	the total in a month exceeds $20,	does not apply.
earned income	the total in a month exceeds $10,	does not apply.
earned **and** unearned income	the monthly earned income total does not exceed $10 and the monthly unearned income total does not exceed $20,	applies to **both** earned and unearned income.
earned **and** unearned income	the monthly earned income total exceeds $10 but the monthly unearned income total does not exceed $20,	applies to the unearned income but not to the earned.
earned **and** unearned income	the monthly earned income total does not exceed $10 but the monthly unearned income total exceeds $20,	applies to the earned income but not to the unearned.
earned **and** unearned income	the monthly earned income total exceeds $10 and the monthly unearned income total exceeds $20,	does **not** apply.

F. Procedure

1. Initial Applications

a. **Infrequent**--If income is regular but may qualify for exclusion as infrequent, evaluate its receipt for the three months prior to the month of application.

b. **Irregular**--If income may qualify for exclusion as irregular, evaluate the predictability of its receipt beginning with the month of application.

2. All Situations

a. **Individual's Allegation**
Obtain a statement over the individual's signature concerning the type, amount, frequency, or predictability of income. The statement or similar information on the application or redetermination form, is sufficient documentation. Absent evidence to the contrary, accept the individual's allegation.

b. **Evidence Disagrees with Allegation**
If there is evidence which disagrees with the individual's allegations, develop and document under the appropriate income rules.

c. **Frequency of Receipt**Even though infrequent income has a monthly dollar limit, evaluate the frequency of receipt over a calendar quarter.

d. **Evaluating Income Received From More Than One Source--Some on a Monthly Basis, Some Only Once in a Calendar Quarter**
Compare only the income received **once in a calendar quarter** against the $10/$20 monthly limits (see e. below).

e. **Amount of Income**
- Add all of the **earned** income received on an infrequent or irregular basis and compare the total against the $10 monthly limit; and/or

- Add all of the **unearned** income received on an infrequent or irregular basis and compare the total against the $20 monthly limit.

G. Examples

1. Infrequent Income--Quarterly Income Only

a. **Situation:** The recipient owns two bank accounts, both of which pay interest only in the last month of each calendar quarter. The combined interest does not exceed $20 in the month of payment.

b. **Analysis:** Since interest on each account is received no more than once a quarter, its receipt is infrequent. Since the total of all the unearned infrequent income does not exceed $20 in a month, all the interest may be excluded under the infrequent income provision.

c. **Situation:** An individual opens up a checking account on February 27. The account pays interest on a monthly basis. The individual applies for Medicaid the next month, in March, and receives his first checking account interest payment on March 31 in the amount of $10.

d. **Analysis:** The $10 interest payment is excludable as infrequent in **March only**, since it was received only once in the January-March quarter.

The monthly interest received in April and subsequent months is not excludable as infrequent or irregular since the interest is received more often than once in a calendar quarter.

2. Infrequent/ Irregular Income-- Monthly and Quarterly Income

a. **Situation:** The recipient owns two bank accounts, a checking account that pays interest of $2 a month and a savings account that pays interest of $19 once a quarter.

b. **Analysis:** The checking account interest is received more than once a quarter and is therefore not infrequent and not excludable under this provision. The savings account interest is received only once a quarter and is, therefore, infrequent. Since the total of all the unearned infrequent income does not exceed $20 in a month, the savings account interest may be excluded under this provision.

Note that in determining whether any interest income in this situation can be excluded as infrequent, we consider only the amount of income received **once in a calendar quarter** and compare that amount to the $20 unearned income limit for the infrequent/irregular income exclusion. Accordingly, in this situation, we do **not** add the $2 monthly checking account interest to the $19 savings account interest.

Also note that if the individual in this example has no income other than the savings and checking account interest, the checking interest is excludable under the $20 general income exclusion. See S0810.420 for a discussion of the general income exclusion.

c. **Situation:** An eligible couple owns the three bank accounts which pay interest in the month of September 1992 as described below.

Type	Interest is …	Paid in 9/92
Time deposit	compounded quarterly paid annually	$10
Savings	compounded monthly, paid quarterly	$2.50
Checking	compounded daily, paid monthly	$1.50

The wife receives a monthly title II check of $150. The husband received an unexpected birthday gift of $7 in cash in 9/92 from his daughter as a birthday gift.

d. **Analysis:** The time deposit interest and savings interest are received only once (or less) per quarter. Therefore they are both infrequent. The $7 gift is irregular income. Since the total of the irregular/infrequent income received by the couple in 9/92 does not exceed $20 ($10 + $2.50 + $7), the income from these sources may be excluded.

Both the checking interest and the title II benefit are paid monthly. Therefore, neither type of income is excludable as infrequent or irregular.

NOTE: The frequency with which interest is **compounded** is not material to how often it is paid. Daily, monthly, or quarterly compounding are methods of **computing** (not paying) interest.

3. Infrequent/ Irregular Income-- Amount Exceeds Limit

a. **Situation:** The recipient owns a savings account which pays interest of no more than $8 in the first month of each quarter. Also in the first month of every quarter, the recipient's sister gives her $16 in cash to help her pay utility bills.

b. **Analysis:** Although both the income from her savings account and the income from her sister are received infrequently, the total of the infrequent income exceeds $20 in a month. Therefore, none of the income is excludable under this provision.

Note that were the sister to give the recipient $16 in the second or third month of every quarter (i.e., not in the same month the interest income is received), **both** types of income could be excluded under the infrequent income provision.

H. References

Relation of the infrequent/irregular exclusion to other income exclusions, S0830.050.

S0810.420 $20 PER MONTH GENERAL INCOME EXCLUSION

A. Policy

1. Unearned Income

We exclude the first $20 per month of any unearned income other than income based on need (IBON).

Do not increase the dollar amount of this exclusion when both an eligible individual and his/her eligible spouse have income. An eligible couple receives one $20 exclusion per month.

2. Income Based on Need

Income based on need is a benefit that uses financial need as measured by income as a factor to determine eligibility.

The $20 exclusion does **not** apply to a benefit based on need that is totally or partially funded by the Federal Government or by a nongovernmental agency.

3. Earned Income

If an individual (or couple) has less than $20 of unearned income (other than IBON) in a month and also has earned income in that month, the remainder of the $20 exclusion reduces the amount of the earned income.

B. References

- Income Based On Need (IBON), S0830.170
- Assistance Based On Need (ABON), S0830.175

*M*0810.430 PLAN FOR ACHIEVING SELF-SUPPORT (PASS)

A. Policy

Income, whether earned or unearned, of a blind or disabled recipient may be excluded if such income is needed to fulfill a plan for achieving self-support (PASS). The Social Security Administration determines if an SSI recipient is entitled to a PASS exclusion.

This exclusion does not apply to a blind or disabled individual age 65 or older, unless he/she was receiving SSI or State disability or blind payments for the month before he/she became age 65.

B. How PASS Works In Brief

PASS is an income and resource exclusion that allows a disabled or blind person to set aside income and/or resources for a work goal such as education, vocational training, or starting a business. Individuals can *also* set aside funds to purchase work-related equipment.

PASS can help an individual establish or maintain SSI eligibility and can also help increase or help maintain the individual's SSI payment amount. *The PASS exclusion applies to the individual's SSI eligibility and is not evaluated by the Medicaid eligibility worker.*

C. References

- IRWE and PASS exclusions both apply, S0820.545 B.3.

VERIFYING AND ESTIMATING INCOME

S0810.500 INCOME VERIFICATION

A. Policy Principles

1. Why Verification is Necessary

Medicaid does not determine Medicaid eligibility solely on the basis of statements concerning eligibility factors by applicants and recipients. We verify relevant information from independent or collateral sources, and obtain additional information as necessary to be sure that eligibility is determined correctly.

2. Applicants/ Recipient's Responsibility

A person applying for or receiving Medicaid must give the local Department of Social Services (LDSS) any requested information and show necessary documents or other evidence to establish the amount of the individual's income.

B. Operating Policy

1. Burden of Proof

Applicants and recipients (or their representative payees) are responsible for providing LDSS with proof of income and for reporting any changes in income.

2. Additional Verification Requirements

See the instructions for the particular type of income involved for additional verification requirements.

3. Initial Applications Versus Posteligibility Situations

Unless instructions dealing with particular types of income state otherwise, verification requirements for initial applications also apply in posteligibility situations.

C. References

- Estimating future wages, S0820.150.
- Verification Requirements:
  Unearned income, S0830.005.
  Wages, S0820.135.
  Self-employment, S0820.220.
  Sheltered workshop earnings, S0820.300.
  Sick pay, S0820.005.

M0810.600 PERIOD FOR WHICH AN ESTIMATE IS REQUIRED

A. Operating Policy

1. Period for Which Estimate is Required

Develop and record the best possible estimates of anticipated income, month-by-month, for the month of application or for the month of redetermination and for the next 11 months.

2. Exceptions

a. **Earlier Redetermination or Review of Income**
Some applications or cases will undergo a review of income sooner than the period mentioned in 1. above.

- **For initial applications**
estimate future income for the month of application through the month the next review of income will be completed.

- **For redeterminations, or reviews of income,** estimate future income through the month the next review of income will be completed.

b. **Net Earnings from Self-Employment**
Estimate net earnings from self-employment on the basis of a taxable
year. See S0820.230 for more information on estimating net earnings from self-employment.

B. Documentation

If the period for estimating income is shortened because of one of the exceptions in A.2. above, show in the file the basis for using these procedures (e.g., that a critical birthday is upcoming or that an individual's estimated earned income for each month never exceeds $65).

C. Examples

1. Initial Application Deferred Development

Mr. Sam Polk files for Medicaid in March based on disability. His only income consists of rental income which varies from month-to-month. The EW obtains estimates of Mr. Polk's net rental income for the period from the month of application until a review of income will be completed (based on the EW's judgment).

2. Review of Income

Ms. Jennifer Wilks, an aged individual, undergoes a redetermination in October. Her only income consists of fluctuating wages from a part-time seasonal job. Since Ms. Wilks' job will end in January, the EW documents that and notes the case for a special review.

M0810.610 HOW TO ESTIMATE INCOME

A. Operating Policy

1. Monthly Estimates

Estimate future income monthly.

2. Fluctuating Income

When income fluctuates, use previous months' actual receipts to project future anticipated monthly income. The anticipated income should be an accurate indication of the individual's future income situation.

3. Income Expected Less Than Once a Month

Determine the specific month(s) of receipt and use the amount(s) estimated for the appropriate month(s).

4. Converting to Monthly Totals

To estimate income for Medically Needy Income evaluation convert to a monthly total, then multiply by number of months in the spenddown time frame.

- Weekly income is multiplied by 4.3,
- Biweekly income is multiplied by 2.15,
- dividing biweekly wages by 2 and multiplying by 4.3., or
- semi-monthly income multiplied by 2.

B. Operating Procedure

1. When a Change Occurs

An anticipated change in income occurs when you expect an individual's income to start, to stop, or to come in at a different rate in the future.

2. How to Develop a Change

When you anticipate an increase in income, use only that income which the individual is reasonably sure he will receive.

Except in self-employment situations (S0820.230), do not compute on the basis of an anticipated decrease in or termination of income unless that decrease or termination can be verified. Instead, tell the individual what income has been used in the computation and that he should report immediately when a decrease or termination can actually be verified so that appropriate adjustment can be made.

3. Example

Anticipated Decrease in Income
Mr. Danny Kelp, a student child, receives support payments from an absent parent. These payments are $160 a month. In March, Danny's father begins a new job which pays less money. Danny notifies his EW that, based on his father's decrease in salary, he expects his support payments to decrease to $125 a month. The EW includes $160 unearned income in Danny's countable income computation, and tells him to report immediately when it can be verified that the payments have decreased.

C. Documentation

1. What the File Must Contain

The file must contain the estimates used.

2. Who May Provide an Estimate

Estimates of income may come from the applicant/recipient, representative, worker, or deemor.

3. Resolve any Discrepancy

If information received from an employer concerning current or future rate of pay is discrepant with an estimate provided by the applicant/recipient, representative payee, worker, or deemor, you must resolve the discrepancy.

4. Additional Documentation Requirements

See the specific sections dealing with the type(s) of income involved to determine if there are additional documentation requirements.

INCOME OF MEMBERS OF RELIGIOUS ORDERS WHO TAKE A VOW OF POVERTY

M0810.700 GENERAL

A. Introduction

The policy and procedures in this section apply only to members of religious orders who have taken a vow of poverty. No other special provisions apply to Medicaid eligibility determinations for members of religious orders.

The existence of a vow of poverty is a factor in determining whether cash earnings are considered wages or net earnings from self-employment. The existence of a vow of poverty is also a factor in determining if payments made by a member to the order can be considered contributions for food, clothing, or shelter.

B. Policy

The treatment of income to members of religious orders who take a vow of poverty is determined by the source and nature of such income.

1. Earned Income -- Wages

Cash for members of religious orders who take a vow of poverty is considered wages in any of the following situations:

An individual receives compensation from the order as an active, working member of that order, whether or not the religious order has elected title II coverage.

EXAMPLE: A member of an order works at a hospital which is owned and operated by the order. The member's compensation of $150 per month from the order is earned income.

An active, working member of a religious order receives compensation for performing services from an agency of the church supervising the order or from an affiliated institution, whether or not the religious order has elected title II coverage.

EXAMPLE: A member of an order teaches at a school which is an affiliate of the order's supervising church. The school pays the member $300 per month which is turned over to the order. This amount is earned income.

A member of a religious order receives compensation from a third party for services performed as an employee.
EXAMPLE: A member of a religious order also works for a private firm which pays her $250 per month as a computer programmer. This amount is earned income.

2. Earned Income -- NESE

Remuneration for members of religious order who take a vow of poverty is considered earnings from self-employment only when a member engages in self-employment unrelated to his/her membership in the order.

EXAMPLE: A member of a religious order, who is a recognized ornithological expert, submits articles to a magazine, on a free lance basis, for publication. Any remuneration received is treated as net earnings from self-employment.

3. Unearned Income--From the Order

Any income provided by the order to a member who has taken a vow of poverty, which does not fall under 1. and 2. above, is unearned income to the member even if turned over to the order.

EXAMPLE: A cash stipend paid to an inactive member, or a payment unrelated to a member's work, that is made by the order to a member is unearned income.

Food, clothing, or shelter that is not considered part of a member's wages is in-kind support and maintenance and is not considered income.

Any income or resources turned over by the member to the order are considered to be in fulfillment of the vow of poverty and are **not** considered contributions for food, clothing, or shelter received from the order.

4. Unearned Income--From Outside the Order

Unearned income received by a member from any source other than the order (e.g., title II or VA benefits) is income to the member even if the member turns it over to the order.

C. Procedure

Use the following steps to process initial applications and post-eligibility changes involving income of members of religious orders who have taken the vow of poverty.

1. Vow of Poverty Allegation

Accept an individual's allegation that he/she has taken a vow of poverty unless there is a reason to doubt the allegation.

2. Wages--Performing Services For the Order

When a member is performing services for the order, contact the order and document the value of remuneration received in cash as wages per S0820.130.

3. Wages -- Performing Services Outside the Order

When a member is performing services for an affiliate of the order, and/or is employed by a third party, develop and document these earnings as wages per S0820.130.

4. Other Income

Apply the appropriate operating instructions pertaining to other types of earned and unearned income.

D. References

- Definition of wages, S0820.100
- NESE, S0820.200.
- Unearned income, S0830.001.
- Wage verification, S0820.130.

CHAPTER S08
INCOME
SUBCHAPTER 15

WHAT IS NOT INCOME

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WHAT IS NOT INCOME

M0815.001 WHAT IS NOT INCOME-GENERAL

A. Introduction

Some items that an individual receives are not income because they do not meet the definition of income in S0810.005 A. Other items are income but are excluded by statute (see S0830.099). In making income determinations, the eligibility worker (EW) must distinguish between an income exclusion and an item which is not income by definition. Only those items specifically listed in the law and regulations can be excluded from income.

B. Policy

An item received is not **income** if it is not cash, or its equivalent, or listed in this chapter. *Contributions of in-kind items are not income.*

An item which is not income when received by an individual, if retained until the following month, is subject to evaluation as a resource as of the first of the month after the month of receipt. (See S1110.600.)

C. Procedure

1. Is the Item Income?

In evaluating whether an item meets the definition of income, determine if it is:

- cash,
- **not** listed in this subchapter

If the item is **neither** of the above, consider it as not income.

2. Need to Document

Do not document the receipt of those items listed in this subchapter which are not income unless:

- Documentation is required by specific operating instructions elsewhere (e.g., rebates and refunds in S0815.250); or
- It is material to an eligibility computation.

D. References

- Treatment of income which is subject to garnishment, S0810.025.
- Treatment of contributions made to and benefits received from a cafeteria plan, S0820.102.

M0815.050 MEDICAL AND SOCIAL SERVICES, RELATED CASH AND IN-KIND ITEMS

A. General

Policy Principle: Medical and social services are **not income** for purposes of the Medicaid program. Under the circumstance specified in this section, cash and in-kind items received in conjunction with medical and social services are not income for Medicaid purposes.

1. Governmental Services

Assume that government medical and social service programs which provide cash or in-kind items are authorized to provide such items only in order to provide a medical or social service. Therefore, when an individual alleges receiving cash or in-kind items from a governmental medical or social service program, develop only the source of the item, not its purpose.

2. Non-governmental Services

Do not assume, however, that cash or in-kind items provided by a nongovernmental medical or social service organization can only be for medical or social service purposes. When a nongovernmental medical or social service organization is involved, develop both the source and the purpose of the cash or in-kind item. Subsection B. through E. explain the guidelines for determining whether or not the cash or item is income.

3. Do Count-Sheltered Workshop Income And Incentive Payments

Do not apply the rules in this section to two kinds of payments which, although commonly associated with medical or social services, are income, regardless of the source of payment.

1. Remuneration for work or for activities performed as a participant in a program conducted by a sheltered workshop or work activities center is earned income. See S0820.300.

2. Incentive payments to encourage individuals to utilize specified facilities or to participate in specified medical or social service programs are unearned income, to the extent that these payments are unrestricted as to use and are not reimbursement for medical or social services already received. Accept the individual's allegation as to the purpose and the amount of the payment; however, if the person does not know this information or if there is reason to question his statement, verify the information by obtaining documentary evidence or by contacting the source of the payment.

B. Medical Services

1. General

a. Definition

Medical services are those services which are directed toward diagnostic, preventive, therapeutic, or palliative treatment of a medical condition and which are performed, directed, or supervised by a State licensed health professional. The term "medical services" also includes any room and board (i.e., food and shelter) provided during a medical confinement as well as in-kind medical items such as prescription drugs, eyeglasses, prosthetics and their maintenance, etc. For Medicaid purposes, in-kind medical items also include devices intended to bring the physical abilities of a handicapped individual to a par with a nonhandicapped unaided individual (e.g., electric wheelchairs, modified scooters). Furthermore, for Medicaid purposes, in-kind medical items include specifically trained animals (e.g., seeing eye dogs) and their maintenance (e.g., dog food). Under the definition, an automobile or van intended for street use would not be considered wholly a medical item but any modifications made to an automobile or van in order to accommodate a physically handicap individual would be a medical item and there fore the modification would not be income upon receipt. (See S1120.110. for resource guidelines.) Transportation to and from medical treatment is also considered a medical services.

b. Sources of Medical Services

Medical services may be provided directly by treatment facilities or practitioners. They may also be made available indirectly through a variety of other sources. Some examples of Federal medical services programs are Medicare and CHAMPUS (Civilian Health and Medical Plan for the Uniformed Services). Similar medical services may be provided by or made available through other Federal programs, State and local government programs, private profit and nonprofit organizations (including charities, special funds benefiting an individual or a limited group of people, and medical insurers) and private individuals.

2. Treatment of Medical Services as Income

Medical services (which include in-kind medical items) are never income regardless of the source of the service or the source of payment for the service.

When cash or an in-kind item (other than a medical item, as defined above) is received by an individual in conjunction with a medical service, see D. below in order to determine whether the item is income.

NOTE: Payments by a third party or an individual's medical insurance premiums are not considered a medical service; however, these payments are not income per S0815.400. Also, items which do not qualify as a medical service may qualify as items received in conjunction with a social service and may not be income. See D. below.

C. Social Services

1. General

For Medicaid purposes, use the following definition for a social service: A social service is any service (other than medical) which is intended to assist a handicapped or socially disadvantaged individual to function in society on a level comparable to that of an individual who does not have such a handicap or disadvantage.

Cash received from a medical or social services program or organization is **not income** under the conditions described below.

2. Several Examples of Frequently Encountered Social Services Programs

a. Title XX of the Social Security Act provides services directed at the following goals:

1) Achieving or maintaining economic self-support to prevent, reduce, or eliminate dependency;

2) Achieving or maintaining self-sufficiency, including reduction or prevention of dependency;

3) Preventing or remedying neglect, abuse, or exploitation of children and adults unable to protect their own interests; or preserving, rehabilitating, or reuniting families;

4) Preventing or reducing in appropriate institutional care by providing for community-based case, home-based care, or other forms of less intensive care; and

5) Securing referral or admission for institutional care when other forms of care are not appropriate, or providing services to individuals for institutions.

b. Title IV-B of the Social Security Act, Child Welfare Services, provides for:

1) Public social services which supplement, or substitute for, parental care and supervision for the purpose of preventing, remedying, or assisting in the solution of problems which may result in the neglect, abuse, exploitation, or delinquency of children;

2) Protecting and caring for homeless, dependent, or neglected children;

3) Protecting and promoting the welfare of children working of mothers; and

4) Otherwise protecting and promoting the welfare of children.

c. Title V of the Social Security Act, Maternal and Child Health and Crippled Children's Services, provides:

1) Services of reducing infant mortality and otherwise promoting the health of mothers and children;

2) Medical, surgical, corrective, and other services; and

3) Care and facilities for diagnosis, hospitalization, and aftercare to children who are crippled or who are suffering from conditions leading to crippling.

d. The Rehabilitation Act of 1973 provides:

1) Vocational rehabilitation services to handicapped individuals;

2) Services that may improve their ability to live with greater independence by self-sufficiency;

3) Services to the handicapped individuals who are homebound or institutionalized; and

4) Services to promote and expand employment opportunities in the public or private sectors for handicapped individuals and to place such individuals in employment.

e. Some examples of governmental programs which may provide medical and social services in combination are: programs under the Lanterman Developmental Disabilities Services Act of 1976 (California), Texas State Mental Health and Mental Retardation Programs, programs under the Pennsylvania Juvenile Act, and State alcoholism programs. Typical or nongovernmental organizations that may provide medical and social services in combination are the Salvation Army and the American Red Cross. The above is not an al-inclusive list. There are social services similar to those described above that are provided by, or made available through, other Federal, State, and local government programs, private profit and nonprofit organizations (including charities) and private individuals.

3. Several Examples of What is Not a Social Services

a. Education such as that provided by the public schools and (and essentially similar programs by private and parochial schools) is generally accepted to be in a category of its own and is not considered to be a social services.

b. Training for a specific job skill or trade (vocational training) is not a social service. Do not confuse vocational training with vocational rehabilitation. Vocational rehabilitation refers to set of social services (not income) that is directed at bringing the abilities of the handicapped up to par with those of the nonhandicapped. However, if part of the vocational rehabilitation includes vocational training, treat both as a social service (i.e., not income).

c. Governmental income maintenance programs are not considered social services programs (e.g., Aid to Families with Dependent Children, Bureau of Indian Affairs General Assistance and/or Child Welfare Assistance, State general assistance, and Veterans Administration compensation or pension benefits).

d. Provision of food, shelter, laundry and recreational facilities in any combination is not by itself a social services.

D. Cash Received in Conjunction with Medical or Social Services

Cash received from a medical or social services program or organization is **not income** under the conditions described below:

1. Governmental Medical or Social Services Program

a. Rule

Any cash (other than remuneration for sheltered employment and incentive payments) provided by a governmental medical or social services program is not income. To be considered "governmental" in this context, the program must be authorized by Federal, State or local law to make payments for medical or social services purposes. Payment from a governmental program, which is disbursed by a nongovernmental agency, is considered a payment from a governmental program for purposed of this section.

b. Development

Document the file that the source of the cash is a governmental medical or social services program. Obtain evidence from the individual that the source of the cash is a governmental medical or social services program (e.g., program identification card, notice, or award letter). If the individual has no evidence available, contact the agency or organization alleged to be providing the cash and verify it is the source of the cash.

However, if it has been established that the program's fundamental purposed is medical or social services and the program agency or organization furnishes little or no documentary evidence to the claimant, then it is not necessary to contact the agency or organization. In these circumstances, obtain a signed statement from the individual indicating the source and amount of payments or in-kind items.

When it is not obvious that the governmental program is a medical or social services program (e.g., when medical and/or social services are provided in conjunction with other assistance or unrelated activities), look to the stated fundamental purpose of the program which is the direct provider of the cash as stated in its authorizing law, statute, or ordinance. (For the purpose o this section, an intervening vendor is not considered the direct provider of the cash.) If the fundamental purpose of the governmental program is to provide medical or social service assistance, the cash is not income.

If you are unable to determine the fundamental purpose of the governmental program (e.g., the authorizing statute provides more than one purpose, one of which is not medial or social services, and it does not identify which one is the fundamental purpose), make your determination based on the particular case facts and circumstances involved. If unable to make such a determination, refer the case facts to the Regional Specialist for a decision.

2. Nongovernmental Medical or Social Services Organization

a. Cash Provided for Medical of Social Services Already Received

1) Rule

Any cash provided by a nongovernmental medical or social services organization (including medical and liability insurers) for medical or social services already received by the individual and approved by the organization is **not income**. However, if the individual alleges (or evidence indicates) the receipt of amounts in excess of the medical or social services expenses incurred, count the cash received in excess of the expenses as unearned income.

2) Development

Document the file that the source of cash is a nongovernment medical or social services organization. Look to the fundamental purpose of the organization in its articles of incorporation or certification as a nonprofit organization under section 501 (c) of the Internal Revenue Code.

Also document the file with a statement by the organization as to the purpose of providing the cash. If you verify the source of the cash is a nongovernment medical or social services organization and the purpose of the cash is to provide a medical or social services, the cash is not income.

b. Cash Provided as a Payment Restricted to Future Use

1) Rule

Any cash provided by a nongovernment medical or social services organization (including medical and liability insurers) as a payment restricted to the future purchase of a medical or social services, or related excludable in-kind items, is not income.

2) Development

Document the file that the cash is provided by a nongovernment organization in accordance with the guidelines in a.2) above. Also document the file as to the purpose of a medical or social services) and that the providing program requires followup to verify that the funds were spent for the purpose given (e.g., the provider contacts the vendor or requests a receipt).

c. Flat Rate Benefit Payments from a Insurance Policy

1) Rule

Cash from any insurance policy which pays a flat rate benefit to the recipient without regard to the actual charges or expenses incurred is income. Examples of these types of insurance policies are per diem hospitalization or disability insurance, or cancer or dismemberment policies.

2) Development

When cash from a flat rate benefit insurance policy is received by a claimant/recipient, document the file as to the source and amount of the cash.

E. In-Kind Items Received in Conjunction with Medical or Social Services

1. Government Medical or Social Services Program

a. Rule

Any in-kind items (including food, clothing, or shelter) provided by a governmental medical or social services program (e.g., recreational equipment, magazines, toiletries) are not income unless provided as a remuneration for sheltered employment or as incentive payments. Note that in-kind medical items are **never income** regardless of their source (see B. above).

To be considered "government" in this context, the program must be authorized by Federal, State or local law, statute, or ordinance to provide medical or social services.

b. Development

Unless an in-kind medical item is involved, follow the general guidelines in D.1.b) above, and document the file that the purpose of the governmental program involved is to provide medical or social services. Do not count as income any in-kind items provided by the government medical or social services program. It is not necessary to develop for the reason the in-kind items are provided when a governmental medical or social services program is involved. It is necessary only to develop the source.

In-kind medical items are **not income** regardless of their source. If an item meets the definition of an in-kind medical item as defined in B. above, no further development is needed.

2. Nongovernment Medical or Social Services Organization

a. Rule

In-kind items (other than food, clothing or shelter) provided by a nongovernmental medical or social services program (e.g., recreational equipment, magazines, toiletries) for medical or social services purposes are **not income**.

b. Development

In-kind medical items are not income regardless of their source, if an item meets the definition of an in-kind medical item as defined in B. above, no further development is needed. When other in-kind items (not including food, clothing, or shelter) are alleged to be received in conjunction with a medical or social service, document the file that the item is provided by a nongovernmental medical or social services organization for medical or social services purposes in accordance with the guidelines in D.2.a.2) above. If you verify the source of the cash is a nongovernmental medical or social services organization and the purpose of the time is to provide a medical or social services, the item is **not income.**

F. Summary of Rules on Cash and In-Kind Items Received in Conjunction With Medical or Social Services

What follows is a summary of the rules for cash received in conjunction with medical or social services.

1. Cash Received in Conjunction with Medical or Social Services

a. Any cash provided by a governmental medical or social services program is **not income.**

b. Any cash from a nongovernmental medical or social services organization is **not income** when:

1. the cash is for medical or social services already received by the individual and approved by the organization; or

2. the cash is a payment restricted to the future purchase of a medical or social service.

c. Cash from any insurance policy which pays a flat rate benefit to the recipient without regard to the actual charges or expenses incurred is **income.**

2. In-Kind Items Received in Conjunction with Medical or Social Services

a. In-kind items which meet the definition of medical services in B. above are **not income** regardless of their source.

b. Room and board providing during a medical confinement is **not income.**

c. Any in-kind items (including food, clothing, or shelter) provided by a government medical or social services program are **not income**.

d. In-kind items (other than food, clothing, or shelter) providing a nongovernment medical or social services organization for medical or social services purposes are **not income**.

M0815.150 PERSONAL SERVICES

A. Policy

A personal service performed for an individual is not income.

B. Examples

Examples of personal services for an individual which are **not income are:**

- Mowing the lawn;
- Doing housecleaning;
- Going to the grocery; and
- Babysitting.

M0815.200 CONVERSION OR SALE OF A RESOURCE

A. Policy

Receipts from the sale, exchange, or replacement of a resource are **not income** but are resources that have changed their form.

This includes any cash or in-kind items that is provided to replace or repair a resource that has been lost, damaged, or stolen

Capital gains, which are profits made from the sale of capital assets (long-term assets such as land or buildings), are also not income. Any proceeds that remain the month after this type of sale must be evaluated as a resource.

B. Reference

See S1110.600 B.4. for a complete discussion of the policy.

C. Example

Jerry Wallace sells his 1974 Plymouth Satellite for $300. The money he receives is not income but a resource which has been converted from one form (a car) to another form (cash).

M0815.250 REBATES AND REFUNDS

A. Policy

When an individual receives a rebate, refund, or other return of money he or she has already paid, the money returned is **not income.**

CAUTION: The key idea is applying this policy is a return of an individual's own money. Some "rebates" do not fit that category. For example, if a cooperative operating as a jointly-owned business pays a "rebate" as a return on a member's investment, this money is unearned income similar to a dividend. Developmental guidelines for interest and dividends are in S0830.500.

B. Procedure

1. General

Unless you have reason to question the situation, accept an individual's signed allegation that a rebate or refund of money is a return of money already paid and do not count it as income.

2. Questionable Situation

In questionable situations, make copies for the file of any documents in the individual's possession, and contact the source of the payment, etc. to verify that the payment is a return of money already paid.

C. Example

Rose Woods, an elderly recipient, pays property taxes on the home she lives in. Because of her low income, the city government returns part of Mrs. Woods' property taxes in the form of a check. This return of money already paid by Mrs. Woods is not income.

D. References

See S0830.705 for rules on the exclusion of certain taxes.

M0815.270 INCOME TAX REFUNDS

A. Policy

1. General Any amount refunded on income taxes already paid is **not income**.

2. Tax Withheld Prior to Application Date Income tax refunds are not income even if the income from which the tax was withheld or paid was received in a period prior to application for Medicaid.

3. Tax Refunds and Blind Work Expenses Income tax refunds are **not income** even if the income taxes were included as work expenses of the blind. (See S0820.535 B.3.)

M0815.300 CREDIT LIFE OR CREDIT DISABILITY INSURANCE PAYMENTS

A. Definition of Credit Life/Disability Insurance Credit life and credit disability insurance policies are issued to or on behalf of borrowers, to cover payments on loans, mortgages, etc. in the event of death or disability. These insurance payments are made directly to loan or mortgage companies, etc. and are not available to the individual.

B. Policy

- Payments made under a credit life or credit disability insurance policy on behalf of an individual are **not income.**
- Food, clothing, or shelter received as the result of a credit life or credit disability payment is **not income.**

C. Example Frank Fritz, a Medicaid recipient, purchased credit disability insurance when he bought his home. Subsequently Mr. Fritz was in a car accident and became totally disabled. Because of his disability, the insurance company pays off the home mortgage. Neither the payment nor the increased equity in the home is income to Mr. Fritz.

M0815.350 PROCEEDS OF A LOAN

A. Introduction

Proceeds of a loan are **not income** to the borrower because of the borrower's obligation to repay.

B. Policy

1. Loan Not Income

Money that a person borrows or money received as repayment of the principal of a loan is **not income.**

2. Loan Not Bona Fide

If a loan is not bona fide, the proceeds are unearned income in the month received.

3. Interest on a Loan

Interest received on money loaned is **income.**
(See S830.500 C.)

4. Buying on Credit

Items bought on credit are treated as though the individual were borrowing money and are not income.

C. References

- Definition of Bona Fide loan, S1120.220.A.
- Resource policy when the Medicaid applicant/recipient is the lender, S1120.220.B., S1140.300.

M0815.400 BILLS PAID BY A THIRD PARTY

A. Policy.

Payment of an individual's bills (including supplementary medical insurance under title XVIII or other medical insurance premiums) by a third party directly to the supplier is **not income.**

B. Examples

1. Third Party Payment Does Not Result in Income

Joshua Hall, a Medicaid recipient, is unable to pay his phone bill so his sister pays the phone company with her money. Neither the payment to the phone company nor the telephone service received as a result of the payment is income because it is not food, clothing, or shelter.

C. References

- Gifts received as a result of another's payments of bills, S0830.520.
- Instructions on vendor payments which are a form of certain home energy assistance or support and maintenance assistance, S830.605.

M0815.450 REPLACEMENT OF INCOME ALREADY RECEIVED

A. Policy

- If an individual's income is lost, stolen, or destroyed and the individual receives a replacement, the replacement is **not income.**
- Once a payment has been issued and treated as income in determination an individual's eligibility for Medicaid, the reissuance of that same payment is **not income.** For instance, if one member of a couple receives income and dies before the check is cashed, the reissued check is not income to the surviving spouse.
- On the other hand, if the original payment is not used to determine the surviving spouse's eligibility (e.g., because the couple is separated), the reissued check **is income** to the surviving spouse. (See S830.545 for the treatment of death benefits.)

B. References

- Income rules regarding replacement of a resource, S0815.200.
- Rules on erroneous payment which the individual returns, S0815.460.

C. Example

Bob Akers, a Medicaid recipient, received a replacement title II check after his regular monthly title II check was damaged in the mail. The replacement check is not income to Mr. Akers. (Mr. Akers income was counted the month the regular title II check was paid.)

M0815.460 RETURN OF ERRONEOUS PAYMENTS

A. Policy

A payment is **not income** when the individual is aware that he/she is not due the money and returns the check uncashed or otherwise refunds all of the erroneously received money.

B. Procedure

1. Timely Return

If the individual returns or refunds an erroneous payment in the same or following month of receipt, accept the allegation that the money was returned and do not count the erroneous payment as income.

2. Delayed Return

If there is a delay in the return of an erroneous payment beyond the month following the month of receipt:

- verify return of the payment;
- document the reason for the delay (e.g., lengthy hospital stay) and any other relevant facts; and
- record your determination in the file.

C. Example

In August, Bob Brown states that he received his regular January VA pension check of $290. However, during the latter part of January, he received another $290 VA check along with a letter explaining that his January check had been delayed due to a computer error. Mr. Brown explains that he knew the second check was a duplicate and says he had not been able to return it sooner due to illness. The EW verifies the return of the $290 check in July as well as Mr. Brown's illness. The EW then makes a determination concerning Mr. Brown's income and records it in the file.

M0815.500 WEATHERIZATION ASSISTANCE

A. Policy

Weatherization assistance (e.g., insulation, storm doors, and windows, etc.) is **not income.**

B. Reference

- Treatment of certain home energy assistance and support and maintenance assistance, S0830.605.

M0815.600 WAGE-RELATED PAYMENTS

A. Introduction

Employers make various payments on behalf of their employees which are not earnings and are not available to meet the employee's needs of food, clothing, or shelter.

B. Policy

The following payments by an employer are **not income** unless the funds for them are deducted from the employee's salary:

- funds the employer uses to purchase qualified benefits under a cafeteria plan;
- employer contributions to a health-insurance or retirement fund;
- the **employer's** share of FICA taxes or unemployment compensation taxes, in all cases;
- the **employer's** share of FICA taxes or unemployment compensation taxes paid by the employer on wages for **domestic service in the private home of the employer or for agricultural labor only**, to the extent that the employee does not reimburse the employer.

C. References

- What is income, S0810.005
- What is not income, S0815.001
- Cafeteria plans, S0820.102

CHAPTER S08
INCOME
SUBCHAPTER 20

EARNED INCOME

S0820 Changes

Changed With	Effective Date	Pages Changed
TN #95	3/1/11	pages 3, 30, 31
TN #93	1/1/10	pages 30, 31
TN #91	5/15/09	Table of Contents pages 29, 30

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EARNED INCOME

GENERAL

S0820.001 EARNED INCOME

A. Policy

1. What Constitutes Earned Income

Earned income may be received in cash and consists of:

- Wages
- Net earnings from self-employment (NESE)
- Payments for services performed in a sheltered workshop or work activities center
- Earned Income Tax Credit (EITC) payments, excluded effective January 1, 1991
- Royalties earned by an individual in connection with any publication of his/her work and any honoraria received for services rendered, effective December 1, 1991.

2. Earned Income Exclusions

Although we must know the source and amount of all earned income, we do not count all of it in determining eligibility

B. References

- Wages, S0820.100.
- NESE, S0820.200.
- Sheltered workshop payments, S0820.300
- EITC payments, S0820.400.
- EITC exclusion effective January 1, 1991, S0820.570.
- Royalties/honoraria as earned income, S0820.450.
- Earned income exclusions, S0820.500.

S0820.005 SICK PAY

A. Definition

Sick pay is a payment made to or on behalf of an employee by an employer or a private third party for sickness or accident disability.

B. Policy

Sick pay is either wages or unearned income. (Payments to an employee under a workers' compensation law are neither wages nor sick pay.)

The following chart shows how to treat sick pay .

WHEN RECEIVED	ATTRIBUTABLE TO EMPLOYEE'S OWN CONTRIBUTION	TYPE OF INCOME
More than 6 months after stopping work	N/A	Unearned Income
Within 6 months after stopping work	No	Wages
	Yes	Unearned Income

C. Procedure

1. Development

To determine the 6-month period after stopping work:

- Begin with the first day of nonwork.
- Include the remainder of the calendar month in which work stops.
- Include the next 6 full calendar months.

EXAMPLE: If an individual stops work on May 5, the 6-month period begins on May 6 and runs through November 30.

2. Verification

a. **General**
Verify sick pay which is wages by using the wage verification procedure in S0820.135.

b. **Last Day (or Month) Worked**
Verify the last day (or month) worked with the employer or knowledgeable third party.

3. Documentation

Document the file with the employer/third party's statement or record contact showing the last day (or month) worked.

D. References

- Workers' compensation, S0830.235.
- Sick pay as unearned income, S0830.543.

WAGES

S0820.100 GENERAL

A. Definition

Wages are what an individual receives (before deductions) for working as someone else's employee.

NOTE: Under certain circumstances, services performed as an employee are deemed to be self-employment rather than wages (e.g., ministers, real estate agents, sharefarmers, *newspaper vendors*, etc.). *An S Corporation may pay wages to an individual who performs work-related services and is considered an employee of the S Corporation (i.e. President), even if the individual is a shareholder of the S Corporation.*

B. Policy

1. Kinds of Wages

Wages may take the form of:

a. **Salaries--**These are payments (fixed or hourly rate) received for work performed for an employer.

b. **Commissions--**These are fees paid to an employee for performing a service (e.g., a percentage of sales).

c. **Bonuses--**These are amounts paid by employers as extra for past employment (e.g., for outstanding work, length of service, holidays, etc.)

d. **Severance pay--**This payment made by an employer to an employee whose employment is terminated independently of his wishes.

e. **Military basic pay--**This is the service member's wages, which is based solely on the member's pay grade and length of service. See S0830.540 C.3.

f. **Special payments received because of employment.**

g. **Sick pay received within 6 months after stopping work, which is not attributable to the employee's contribution--**See S0820.005

2. When To Count

Wages for each month count at the earliest of the following points:

- when they are received, or
- when they are credited to the individual's account, or
- when they are set aside for the individual's use.

C. Procedure

Absent evidence to the contrary, if FICA taxes have been deducted from an item, assume it meets the definition of wages. If FICA taxes have not been deducted from an item, determine if it is wages per S0820.102.

D. References

- Work related unearned income, S0830.530.
- Advance dated checks, S0810.030 B.2.
- Wage advances and deferred wages, S0820.115.

M0820.102 CAFETERIA PLANS

A. Definitions

A cafeteria plan is a written benefit plan offered by an employer in which:

1. Cafeteria Plans

- all participants are employees; and
- participants can choose, cafeteria-style, from a menu of two or more cash or qualified benefits.

2. Qualified Benefits

A qualified benefit is a benefit that the Internal Revenue Service (IRS), by express provision of Section 125 of Chapter 1 of the Internal Revenue Code (IRC) or IRS regulations, does not consider part of an employee's gross income. Qualified benefits include, but are not limited to:

- accident and health plans (including medical plans, vision plans, dental plans, accident and disability insurance);
- group term life insurance plans (up to $50,000);
- dependent care assistance plans; and
- certain stock bonus plans under section 401(k)(2) of the IRC (but not 401(k)(1) plans).

Cash is **not** a qualified benefit.

3. Salary Reduction

A salary reduction agreement is an agreement between employer and employee whereby the employee, in exchange for the right to participate in a cafeteria plan, accepts a lower salary or forgoes a salary increase.

B. Background

1. IRS Authority

Section 125 of the IRC permits cafeteria plans.

2. Monitoring

IRS relies on employers to ensure that IRS-approved plans continue to meet the requirements of Section 125 of the IRC.

3. Funding

Most cafeteria plans are funded by salary-reduction agreements.

4. Significance for Tax Purposes

Because Section 125 of the IRC provides that qualified benefits and the amount of a salary-reduction agreement are not part of gross income, they are not subject to Social Security/Medicare and income taxes.

5. Cafeteria Plan Indicators

It can be difficult to tell whether payslip entries represent payroll deductions, which are part of gross wages, or cafeteria-plan itemizations, which are not. The following indicators suggest a cafeteria plan.

a. A payslip uses terms such as:
   - FLEX
   - CHOICES
   - Sec. 125
   - Cafe Plan

b. The Social Security/Medicare tax shown is less than the tax rate (7.65%) times the gross wages shown.
EXAMPLE: A payslip shows $402.07 gross and $26.73 withheld for Social Security/Medicare taxes, but 7.65% of $402.07 is $30.76.

NOTE: Another reason the Social Security/Medicare tax can be less is that part of the gross may not be covered wages for title II purposes. Examples include:

- earnings from noncovered employment;
- wages excluded from coverage because of quarterly or calendar-year minimums in such areas as agricultural labor, domestic employment, etc., and
- wages excluded from coverage because they are above the yearly maximum.

C. Policy

1. General

A plan is not a cafeteria plan unless it meets the requirements of Sec. 125 of the IRC.

2. Salary Reductions

Amounts used to purchase cafeteria-plan benefits under a salary-reduction agreement **are not** the employee's wages and **are not** earned income for Medicaid purposes.

3. Payroll Deductions

Payroll deductions used to purchase cafeteria-plan benefits in addition to or instead of as provided under a salary-reduction agreement **are** the employee's wags and **are** earned income.

IMPORTANT: Payslips that appear to show payroll deductions may actually show how funds from a salary reduction agreement have been allotted among qualified benefits.

4. Cash Received Under a Cafeteria Plan

a. **In Lieu of Benefits**
Cash received under a cafeteria plan in lieu of benefits is wages.

b. **Reimbursement for Expenses**
Cash received as reimbursement for qualified-benefit expenses, such as child care, is not income.

5. Qualified Benefits

Qualified benefits are neither earned nor unearned income.

D. Procedure

1. Assumption of Compliance

Assume that a cafeteria plan complies with IRS requirement, unless you become aware that IRS has determined otherwise.

2. How to Develop Cafeteria Plan Precedents

If a precedent is needed per 3. below, contact the employer (by phone, if possible) and ask if the employer offers a cafeteria plan. Proceed as follows:

a. **Employer Does Not Offer a Cafeteria Plan**

Prepare and retain in files a precedent showing:

- employer name, address, and phone number;
- name and title of person contacted; and
- a statement that the employer does not offer a cafeteria plan.

b. **Employer Offers a Cafeteria Plan**

Prepare and retain in the files a precedent showing:

- employer name, address, and phone number;
- name and title of person contacted;
- effective date of the plan;
- employee positions covered by the plan;
- benefits offered under the plan;
- which deductions on the payslips are nontaxable; and
- any additional information needed to determine countable gross wages from payslips.

NOTE: Precedents should be updated periodically.

3. Case Development and Documentation

Follow the steps below to:

- decide whether cafeteria-plan development is needed and, if so,
- establish whether a cafeteria plan is involved and, if so,
- determine countable wages.

NOTE: It is not necessary to separately document responses to the questions in the chart below, except where indicated.

STEP	ACTION
1	Are payslips available to verify wages? • If yes, go to step 2. • If no, verify wages with the employer per S0820.130. STOP.
2	Does a cafeteria-plan precedent exist for this employer? • If yes, use it to compute countable wages and go to Step 7. • If no, go to Step 3.
3	Ask the individual if he/she participates in a cafeteria plan. • **If yes or uncertain,** or there is any indicator of a cafeteria plan, such as those in B.5. above go to Step 4. • If **no**, and there is no other indication of a cafeteria plan, compute countable wages accordingly. STOP.
4	Is the employer's payroll office located in your service area? • If yes, go to Step 6. • If no, go to Step 5.
5	Request verification from the employer Upon receipt of the precedent, compute wages. Retain a copy of the precedent. Go to Step 7. **NOTE:** If a precedent cannot be established.
6	Document the case file with a statement that a precedent exists and that there is or is not a cafeteria plan.

E. Examples

1. Employee Chooses Not to Join a Cafeteria Plan

ABC, Inc. offers a cafeteria plan funded through a salary-reduction agreement. An employee who decides not to participate receives cash equal to or less than the amount the employer would have contributed as a premium on behalf of the employee. Mr. Green takes the cash. The cash is wages.

2. Salary Reduction

Mr. Black has the option of accepting a $100-a-month raise or participating in a cafeteria plan by entering into a salary-reduction agreement and allowing his employer to use $100 to help fund the plan. He enters into the salary-reduction agreement. The $100 is not part of his wages.

3. No Salary Reduction, But Contributions Allowed

The XYZ Company contributes $50 a week to fund basic benefit levels under a cafeteria plan that offers cash and a variety of insurance coverages. There is no salary-reduction agreement.

Employees who want more than the basic benefits may pay the additional cost through voluntary payroll deductions.

Mrs. Grey chooses health insurance and life insurance costing $83 per week. XYZ's $50 contribution is not wages. The $83 Mrs. Grey pays is part of her gross wages.

4. Cash in Lieu of Benefits

Same background as in 3. above. Mr. Brown selects insurance that costs $35 a week and opts for a weekly cash payment of $15 in lieu of additional coverage. XYZ's $35 contribution is not wages, but the $15 cash payment is.

5. Cash as Reimbursement for Plan-Approved Expenses

Same background as in 3. and 4. above. Mrs. White selects insurance that costs $30 a week and childcare benefits that cost $20 a week. Neither XYZ's contribution nor the reimbursements of childcare costs are wages.

S0820.115 WAGE ADVANCES AND DEFERRED WAGES

A. Definitions

1. Wage Advances — Advances are payments by an employer to an individual for work to be done in the future.

2. Deferred Wages — Wages are considered "deferred" if they are received later than their normal payment date. Types of wage payments which may be deferred include vacation pay, dismissal and severance pay, back pay, bonuses, etc.

B. Policy

1. Wage Advances — An advance is wages in the month received.

2. Deferred Wages

a. Wages that are deferred **due to circumstances beyond the control of the employee** are considered earned income when actually received.

b. Wages that are deferred **at the employee's request or by mutual agreement with the employer** are considered earned income when they would have been received had they not been deferred.

C. Procedure

1. Wage Advance — Assume that an advance on wages meets the definition of wages (as opposed to being a loan), absent evidence to the contrary. Count such advances on wages as income when received.

NOTE: Advance military pay is a cash loan. See S0830.540 B.9.

2. Deferred Wages — If the individual alleges or other evidence shows that wages were deferred, request from the employer an explanation of the reason for the deferment.

IF the employer . . .	**THEN . . .**
provides an explanation	document the file with the employer's explanation.
is uncooperative but the individual satisfactorily explains	document the file with the individual's signed statement.
is uncooperative and the individual cannot satisfactorily explain	document the file with a statement to that effect and assume that the wages were available to the employee when they would have been received had they not been deferred.

D. References

- Advance pay to members of the Uniformed Services, S0830.540 B.10.
- Loans, S0815.350.

S0820.125 WAGE VERIFICATION IS REQUIRED

A. Policy

1. When to Verify Wages

Verification of wage amounts and frequency of receipt is required whenever an individual alleges (or you believe) he received wages, sick pay, or temporary disability.

2. When Not to Verify Wages

Wage Verification Is Not Required When an Individual :

- Alleges he has not worked or received earnings (e.g., wage/sick pay) in any month from the first month of the retroactive period through the application month and you have no reason to question the allegation, or
- Is being denied Medicaid for reasons other than earnings/income.

M0820.127 PERIOD FOR WAGE VERIFICATION

Procedure

The following chart shows the period for which wages should be verified.

IF the situation is....	**THEN verify**
An initial application	• wages received in all retroactive months, (if a medical expense exists), • wages for the month of application, if the applicant alleges that wages have been paid. • wages received in the month of application, and • wages received after month of application but prior to processing the application **if** the applicant alleges that a change in wages has occurred. • wages used to estimate anticipated income.
A redetermination or review of income	all unverified wages through the month immediately preceding the month the redetermination or review of income is initiated, unless • employment began in current month.

NOTE: Obtain employer statement regarding wages (i.e., hourly wage, number of work hours per pay period, receipt of pay.

S0820.130 EVIDENCE OF WAGES OR TERMINATION OF WAGES

A. Policy

1. Primary Evidence of Wages

The following proofs, in order of priority, are acceptable evidence of wages:

a. Pay slips--Must contain the individual's name or Social Security number, gross wages, and period of time covered by the earnings.

b. Oral statement from employer, recorded in case record.

2. Secondary Evidence of Wages

If primary evidence is not available, the following proofs, in order of priority, are acceptable evidence of wages:

a. W-2 forms, Federal or State income tax forms showing annual wage amounts.

b. Individual's signed allegation of amount and frequency of wages.

3. Acceptable Evidence of Termination of Wages

The following proofs, in order of priority, are acceptable evidence of termination of wages:

a. Oral statement from employer, recorded in case record.

b. Written statement from employer.

c. Individual's signed allegation of termination of wages (including termination date and date last paid).

B. Procedure

1. Order of Priority

Seek type "a" evidence before type "b," etc.

2. Pay Slips

a. Stress to the individual that he/she is responsible for providing proof of wages and is expected to retain all pay stubs and provide them as requested.

b. Accept the individual's signed allegation of when earnings were received if it is not shown on the pay slip.

NOTE: If not all pay slips are available, but the wages attributable to the missing pay slip(s) can be determined by other evidence (e.g., year-to-date totals), it is not necessary to obtain the missing pay slip.

NOTE: Pay slips which do not contain all the required information may be used in conjunction with other evidence; however, any discrepancies must be resolved.

3. Employer Reports

If an employer returns a statement to the EW unsigned, do not recontact the employer for a signature unless the EW questions the statement's validity (e.g., the income verification form was handcarried to the LDSS by the applicant rather than mailed directly to the LDSS).

4. Evidence Reflects Only an Annual Wage Amount

If the evidence that can be obtained reflects only an **annual** wage amount, divide the annual amount by 12 to get monthly wage amounts.

C. References

- Military pay and allowances, S0830.540.

S0820.135 WAGE VERIFICATION

A. Procedure

1. Chart

This chart describes the procedure for verifying wages per month.

STEP	ACTION
1	Does the individual have acceptable pay slips for some or all of the period being verified? (See S0820.130 A. 1. a.) • If yes, go to Step 2. • If no, go to Step 8.
2	Were any wages deferred during the period covered by the pay slips? • If yes, go to Step 3. • If no, go to Step 4.
3	• Count deferred wages per S0820.115 B.2. • Document the file. • Go to Step 5.
4	• Count wages when received. • Go to Step 5.
5	Do the pay slips cover earnings for the entire period being verified or, if not, can the wages attributable to the missing pay slip(s) be determined by other evidence (e.g., year-to-date totals)? • If yes, go to Step 6. • If no, go to Step 7.
6	• Document the file with a copy or certification of the pay slips, and signed allegation (if necessary per S0820.130 B.2.) • STOP

A. Procedure

1. Chart (cont.)

STEP	ACTION	
7	• Document the file with a copy or certification of the pay slips, and signed allegation (if necessary per S0820.130 B.2.) • Go to Step 8 to verify any wages for which acceptable pay slips are unavailable.	
8	Phone employer to verify wages.	
	If the employer….	**THEN...**
	verifies wages and no deferred wages are involved	• count wages when received • document the file • STOP
	verifies wages and deferred wages are involved	• count deferred wages per S0820.115B.2. • count remainder of wages when received • document the file • STOP
	verifies wages but you believe an oral statement is sufficient	• go to Step 9.
	is uncooperative or unable to be reached by phone	• go to Step 9.

A. Procedure

1. Chart (cont.)

STEP	ACTION
9	Send Income Verification Form to employer. **IF the employer…** / **THEN…** verifies wages and no deferred wages are involved • count wages when received • document the file with the Income Verification Form • STOP verifies wages and deferred wages are involved • count deferred wages per S0820.115 B.2. • count remainder of wages when received • document the file with the Income Verification Form • STOP is uncooperative or cannot be located go to Step 10.
10	• Obtain the individual's signed allegation of amount and frequency of wages (and Form W-2, if available). **NOTE:** If the only evidence is an individual's signed allegation of **annual** wages and/or W-2 (e.g., migrant workers), divide the annual wage amount by the number of months for which work is alleged to arrive at a "verified" wage amount to be counted for each of those months. • Count wages as alleged in this step. • Document the file with the individual's signed statement and a copy of Form W-2 (if available). • STOP

2. Evidence Lacks Credibility

If you have serious reason to question the credibility of pay slips or an oral or written statement from any employer, use other acceptable evidence of wages and document the file to reflect your decision.

S0820.150 ESTIMATING FUTURE WAGES

A. Policy

You must obtain an estimate of future wages during an initial application, redetermination, or review of income. The period for which an estimate is required is set forth in B. below.

B. Procedure-- Estimating Period

Use the following chart to determine the period for which an estimate is required.

IF the action is ...	**THEN ...**
an initial application	estimate future wages for the month of application and for each of the following months until next month of review. For Medically Needy evaluations, estimate future wages for the month of application and the following 5 months (or prorated spenddown period). **EXCEPTIONS:** **Earlier Review of Income**-- When a review of income will occur before the next redetermination or before the spenddown period have elapsed , estimate future wages for the month of application through the month the next review of income will be completed. **All Wages Paid for Month**--When an individual alleges that all wages for a month have been paid, verify wages for that month (S0820.127).
a redetermination or review of income	estimate future wages for the month of initiation of redetermination or review of income and for each of the remaining months until the next review or until the end of the spenddown period.

M0820.155 HOW TO ARRIVE AT AN ESTIMATE

A. Procedure--General

1. Consider Known Facts

a. Consider any **recent work history,** unless inappropriate to the current situation (e.g., work stopped due to retirement or disability).

b. Try to establish a **logical wage pattern** by reviewing with the recipient, representative, or worker the

- rate of pay,
- hours worked per week, and
- number of pay periods in each month.

c. Be alert to individuals who perform **seasonal work** (e.g., school bus drivers).

d. Take into account any Blind Work Expenses/Impairment Related Work Expenses (**BWE/IRWE)** the individual anticipates he/she will incur.

2. Obtain More Information

Contact the employer by telephone, or by mail **only if you cannot establish an estimate using 1. above.**

3. Determine Estimate

Use the information obtained above and your own judgment to determine an estimate.

To convert to monthly income:

- multiply weekly wage by 4.3; or
- multiply biweekly wage by 2.15, or
- divide biweekly wage by 2 and multiply result by 4.3; or
- multiply semi-monthly wage by 2.

B. Procedure--Anticipated Decrease in Wages

If an employed person anticipates a decrease in wages which is not supported by evidence in the file, tell the individual to inform us as soon as the decrease can be verified. We will make any adjustments at that time. An example of this situation would be a wage cutback which is still being negotiated.

Meanwhile, use your judgment in selecting the verified period on which to base the estimate. For example, it could be the total period just redetermined, or a shorter period if there has been a pertinent change in circumstances such as a transfer.

C. Procedure--Documentation

1. General

Document the file to support the estimate.

2. Estimate Not Supported by Evidence

In any case where the estimate does not fall within the range indicated by the evidence of wages on file, document the file with an explanation of the basis for the estimate.

3. Examples—Estimate Not Supported by Evidence

- A worker estimates that wages for the coming year will differ from the total verified over the past 12 months. He states he will be switched in 2 months to a shift which pays a 10 percent differential payment. Document the file with this information.

- A worker states he anticipates a cost-of-living increase in his wages. Record this fact along with any other pertinent details (such as the expected adjustment percentage and effective date) for the file.

D. References

- General instructions on estimating income, S0810.600-.620.
- Anticipated changes in income, S0810.610 B.

NET EARNINGS FROM SELF-EMPLOYMENT

S0820.200 NET EARNINGS FROM SELF-EMPLOYMENT (NESE)

Definition NESE is the **gross income** from any trade or business **less allowable deductions** for that trade or business. NESE also includes any profit or loss in a partnership.

S0820.210 HOW TO DETERMINE NET EARNINGS FROM SELF-EMPLOYMENT (NESE)

A. Policy

1. Determining Monthly NESE NESE is determined on a taxable year basis. Then, the yearly NESE is divided equally among the months in the taxable year to get the NESE for each month.

2. Offsetting Net Loss Any verified net losses from self-employment are divided over the taxable year in the same way as net earnings. Then each month's net loss is deducted only from other earned income of the individual or spouse in that month.

3. Deduction for Taxable Years After 1989 For taxable years beginning after 1989, a 7.65 percent deduction is applied to net profit in determining NESE. Therefore, net profit is multiplied by .9235 to determine NESE. (See S0820.220 for where to find the correct NESE amount on the Federal income tax forms.)

NOTE: This deduction recognizes, as a business expense, part of the Social Security taxes paid. If Social Security tax is not paid (e.g., in situations involving less than $400 per year in NESE, net losses, and when no tax return was filed), the deduction does not apply.

4. Minimum/ Maximum Accounts Creditable NESE is earned income for Medicaid purposes without regard to the minimum and maximum amounts creditable for title II coverage purposes.

5. Computing NESE Only the actual net earnings are used in determining NESE for Medicaid.

6. Exemptions from Coverage NESE is earned income for Medicaid purposes regardless of whether the earnings are exempt from Social Security coverage.

7. Partnership Any distributive share (whether or not distributed) of income or loss from a trade or business carried on by a partnership is included in NESE.

B. Procedure

1. Determining Monthly NESE

Divide the entire taxable year's NESE equally among the number of months in the taxable year, even if the business:

- is seasonal;
- starts during the year;
- ceases operation before the end of the taxable year; or
- ceases operation prior to initial application for Medicaid.

2. Offsetting Net Loss

Divide any **verified** net loss for a taxable year evenly over the months in the taxable year. Subtract each resulting monthly amount from the individual's or couple's other earnings in the same month. Apply this procedure whether a couple filed a joint income tax return or separate returns, and regardless of which member of the couples listed below incurred the loss:

- an eligible couple;
- an eligible individual with an ineligible spouse;
- two parents.

3. Work Expenses

If an individual is self-employed (whether or not he/she is also a wage earner.), reduce his/her earned income by any allowable work expenses which have not already been used to compute NESE. (See S0820.545 B.1. for necessary work expense development.)

4. Withdrawals for Personal Use

When an individual alleges (or you discover) that cash or in-kind items are withdrawn from a business for personal use, proceed as follows:

a. Ask the individual whether the withdrawals were **properly accounted for** in determining NESE. That is, were they either deducted on the individual's Federal income tax return in determining the cost of goods sold or the cost of expenses incurred, or deducted on his business records?

b. Accept the individual's allegation of whether the withdrawals were properly accounted for.

IF THE WITHDRAWALS ARE…	THEN…
Properly accounted for	Do not count them again as income.
Not properly accounted for	• Ask the individual to estimate the value of the cash or in-kind withdrawals. Deduct that amount from the cost of goods sold or the cost of expenses incurred on the profit and loss statement to arrive at the proper NESE. • If the individual cannot or will not provide the profit and loss statement, but alleges an amount of NESE, add the value of the withdrawals to the individual's allegation of NESE.

C. References

- Properly essential to self-support, S1130.500.

S0820.220 HOW TO VERIFY NET EARNINGS FROM SELF-EMPLOYMENT (NESE)

A. Introduction

Acceptable evidence of NESE, in order of priority, is listed in B.1. through B.3. below. C.2. describes situations in which verification is not required.

B. Policy

The Federal income tax return contains evidence of NESE in the following schedules:

1. Federal Income Tax Return

a. **Schedule SE**

- Net earnings--Section A, line 4 or Section B, line 4.C.

  NOTE: If line 4 or 4.C. shows a positive amount of less than $400, then line 3 is used, even if the amount on line 3 is greater than $400. For example, line 3 shows $410 and line 4/4.C. shows $378. Line 3 should be used because no tax was due.

- Net loss--Section A, line 3 or Section B, line 4.C.

b. **Schedule C**--Line entitled "Net Profit or Loss."
c. **Schedule C--EZ**—Line entitled "Net Profit"
d. **Schedule F**--Line entitled "Net Profit or Loss."

2. Business Records

Business records are acceptable evidence of NESE.

3. Individual's Signed Allegation

The individual's signed allegation of NESE is acceptable evidence of NESE if no other evidence can be obtained.

C. Procedure

1. When to Verify

Verify NESE per 2. below whenever self-employment is alleged or otherwise indicated, unless the individual:

- alleges starting a new business, and that he/she was not self-employed in the prior taxable year.

- is being denied Medicaid for reasons other than income.

2. How to Verify

a. Priority Order
Attempt to secure the evidence in the order shown in B. above.

b. NESE of Less Than $400
Do not apply the 7.65 percent deduction in determining countable NESE if the NESE amount after the deduction would be less than $400.

c. Business Records
- Assume that any deductions taken on business records are allowable per IRS, absent evidence to the contrary.

- Do not apply the 7.65 percent deduction in determining countable NESE, unless you have evidence that a tax return was filed and Social Security taxes were paid on the NESE.

d. Schedule C, C-EZ or F
Do not apply the 7.65 percent deduction in determining countable NESE, unless you have evidence that Social Security taxes were paid on the NESE.

e. Individual's Signed Allegation
Do not apply the 7.65 percent deduction to the alleged amount of NESE in determining the countable NESE unless you have evidence that Social Security taxes were paid on the NESE.

4. Period for Which Verification Is Required

Follow the chart below when verification is required per 1. above.

SITUATION	VERIFICATION PERIOD
Initial Application	Verify NESE for the prior taxable year. **NOTE:** Accept the individual's signed allegation that self-employment terminated if: • the month of application is in the current taxable year, and • the individual alleges his/her self-employment ceased in the prior taxable year.
Redetermination or Review of Income	Verify all unverified NESE through the prior taxable year.

S0820.230 HOW TO ESTIMATE NESE FOR CURRENT TAXABLE YEAR

A. Procedure

1. When an Estimate Is Needed

Estimate NESE for the current taxable year for an initial application, redetermination, or review of income when an individual alleges (or you believe) he/she is (or has been) engaged in self-employment during the current taxable year.

2. Inform the Individual

Inform the individual:

- how his/her estimated NESE was determined and its effect on eligibility.
- to promptly contact the LDSS office if any change occurs which could affect the amount of his/her estimated NESE.
- to maintain business records until a Federal income tax return is available, so he/she can report any changes promptly (when any method other than the first two in the chart in 4. below is used).
- to provide a copy of his/her Federal income tax return when it becomes available.

3. Net Loss

Do not take into account an **estimated** net loss when estimating NESE for the current taxable year.

NOTE: A net loss can only be used to offset other earnings **after** it has been verified.

4. How to Estimate NESE

Use the first of the following methods in the sequence below, which is applicable.

When the estimate is obtained using business records or the individual's allegation, ask the individual if he/she plans to file a tax return.

- If **yes** and the estimated net profit is $400 or more after applying the multiplier, multiply the net profit by .9235 to determine the countable NESE estimate.
- If **yes** and the estimated net profit is less than $400 after applying the multiplier, do not apply the multiplier.
- If **no,** count the net profit as the NESE estimate. Do **not** apply the multiplier.

4. How to Estimate NESE (cont.)

WHEN TO USE	METHOD
When an individual: • has been conducting the same trade or business for several years; • has had NESE which has been fairly constant from year-to-year; and • anticipates no change or gives no satisfactory explanation of why current NESE would be substantially lower than past NESE	**Current Year's Estimate Based on Prior Year's Profit** Use the NESE from the prior year as an estimate for the current taxable year.
When an individual: • is engaged in the same business that he/she had **only** in the preceding taxable year; and • anticipates no change or gives no satisfactory explanation of why current NESE would be substantially different from what it has been in the past	**Gross-Net Ratio** • Calculate from the individual's tax return or business records the ratio between net profit and gross receipts for the last year. **EXAMPLE:** Net profit of $1,200 for $6,000 gross income or 20 percent. • Calculate from his/her records the actual gross receipts for the current taxable year and project it for the remainder of the year. **EXAMPLE:** $4,000 in current year's receipts for the first 6 months gives an assumed gross of $8,000 for the entire year. • Apply the previously calculated gross-net ratio to the current year's assumed gross to arrive at the estimated NESE. **EXAMPLE:** 20 percent of $8,000 is $1,600. **EXCEPTION:** Do not use this method for businesses which are seasonal, or have unusual income peaks at certain times of the year; go to next applicable procedure.
When an individual is engaged in a new business	**Projecting Partial Year's Profit for Whole Year** • Obtain the individual's profit and loss statement or other business records for his/her taxable year to date. • Ascertain his/her net profit to date. • Project that net profit for the entire taxable year. **EXCEPTION:** Do not use this method for businesses which are seasonal, or have unusual income peaks at certain times of the year; go to next applicable procedure.

4. How to Estimate NESE (cont.)

WHEN TO USE	METHOD
When: • an individual is engaged in a new business and records are not yet available; or • the business has been going on for some time but no records were kept	**Individual's Estimate** Use a signed allegation of the individual's best estimate.
When an individual: • alleges his/her NESE for the current year will vary from NESE for past years; and • gives a satisfactory explanation for the variation	**Current Year's Estimate Varies from Past Records** • Obtain a written statement from the individual explaining the basis for the variation. • If the individual's estimate of NESE for the current year is higher than that of the prior years, and the individual satisfactorily explains why, accept the individual's estimate of NESE. **EXAMPLE:** Individual recently added new products to his mail order sales catalog and sales have picked up dramatically. • If the individual's estimate of NESE for the current year is lower than that of prior years, and the individual satisfactorily explains why, request any relevant documentation for the file and accept the lower estimate. **EXAMPLES:** • Satisfactory Explanation--the business has suffered a heavy loss or damage due to fire, flood, burglary, serious illness or disability of the owner, or other catastrophic event. • Relevant Documentation--copies of newspaper accounts of the event, police reports, etc. **NOTE:** In some cases (e.g., downturns in the economy) there may not be any documentation of the event. In such cases, the individual's written statement explaining the basis for the variation in sufficient documentation.

5. Documentation Document the file sufficiently so that it supports the estimate made by the eligibility worker.

SHELTERED WORKSHOP OR WORK ACTIVITIES CENTER PAYMENTS

S0820.300 PAYMENTS FOR SERVICES PERFORMED IN A SHELTERED WORKSHOP OR WORK ACTIVITIES CENTER

A. Policy

Payments for services performed in a sheltered workshop or work activities center are what an individual receives for participating in a program designed to help him become self-supporting.

Payments for such services are a type of earned income.

Payments for such services are counted when received or when set aside for an individual's use.

B. Definitions

1. Sheltered Work-Shop

A sheltered workshop is a nonprofit organization or institution whose purpose is:

- to carry out a recognized program of rehabilitation for handicapped workers; and/or
- to provide such individuals with remunerative employment or other occupational rehabilitating activity of an educational or therapeutic nature.

2. Work Activities Center

A work activities center is :

- a sheltered workshop, or
- a physically separated department of a sheltered workshop having an identifiable program, and separate supervision and records.

A work activities center is planned and designed exclusively to provide therapeutic activities for handicapped workers, whose physical or mental impairment is so severe as to make their productive capacity inconsequential.

3. Therapeutic Activities

Therapeutic activities are custodial activities (such as activities where the focus is on teaching the basic skills of living), and any purposeful activity so long as work or production is not the main purpose.

C. Procedure

Follow S0820.115 - S0820.150 to develop, document, verify and estimate remuneration for services performed in a sheltered workshop or work activities center program.

NOTE: If there is any doubt that a sheltered workshop or work activities center is involved, contact the organization for verification.

For receipt of cash or items which are not remuneration for services and therefore are not earned income, see S0810.005 A. regarding whether items of this type meet the basic definition of income for Medicaid purposes. If so, develop such income as unearned income (S0830.001).

EARNED INCOME TAX CREDITS

S0820.400 EARNED INCOME TAX CREDITS

A. Definition

The earned income tax credit (EITC) is a special tax credit which reduces the Federal tax liability of certain low income working taxpayers. This tax credit may or may not result in a payment to the taxpayer. EITC payments can be received as an advance from an employer or as a refund from IRS.

B. Policy Effective January 1, 1991

Exclude from income any EITC payments received January 1, 1991 or later, either as an advance or as a refund, regardless of the tax year involved.

C. Procedure

No development necessary.

ROYALTIES AND HONORARIA

S0820.450 ROYALTIES AND HONORARIA

A. Definitions

1. Royalties

Royalties are payments to the holder of a copyright or patent. Royalties may also be paid to the owner of a mine, oil well, timber tract, or other resource, for extraction of a product, including proceeds from the direct sale of the product.

2. Honorarium

An honorarium is an honorary payment, reward, or donation usually received in consideration of services rendered (e.g., guest speaker), for which no payment can be enforced by law. However, the amount also may include payment for items other than services rendered (e.g., travel expenses and lodging).

B. Policy

1. Royalties

Royalties earned by an individual in connection with any publication of his/her work are earned income (e.g., publication of a manuscript, magazine article, artwork, etc.)

2. Honoraria

The portion of any honorarium **which is received in consideration of services rendered** is earned income. An honorarium which is **not** in consideration of services rendered (e.g., for travel expenses) is unearned income to the extent that it exceeds expense. (See S0830.100 B. for expenses of obtaining income.)

C. Procedure

1. Verification

a. Verify these payments by examining documents in the individual's possession which reflect:

- the amount of the payment,
- the date(s) received, and
- the frequency of payment, if appropriate.

b. If the individual has no such evidence in his possession, contact the source of the payment.

c. If verification cannot be obtained by the above means, accept any evidence permitted by either S0820.130 A. or S0820.220.

2. Assumption

Assume that any honorari*um* received is in consideration of services rendered, absent evidence to the contrary. Evidence to the contrary would include a statement or document indicating that part or all of the honorari*um* is for something other than services rendered (e.g., travel expenses or lodging).

3. Expenses of Obtaining Income

DO NOT DEDUCT any expenses of obtaining income from royalties or honoraria that are earned income. (Such expenses are deductible from royalties/honoraria that are unearned income.)

4. Documentation

Document the file by including copies of documents or indicating in the file information provided by the payment source concerning the amount and, if appropriate, frequency of payment.

D. References

- Royalties as unearned income, S0830.510.
- To determine deductible IRWE/BWE, see S0820.535 - .565.

EARNED INCOME EXCLUSIONS

*M*0820.500 GENERAL

A. Policy

1. General

The source and amount of all earned income must be determined, but not all earned income counts when determining Medicaid eligibility.

2. Other Federal Laws

First, income is excluded as authorized by other Federal laws.

3. *2010 Census Income*

Income paid by the U.S. Census Bureau to temporary employees specifically hired for the 2010 census is NOT counted when determining eligibility for medical assistance.

3. Other Earned Income

Then, other income exclusions are applied, in the following order, to the rest of earned income in the month:

a. Federal earned income tax credit payments.

b. Up to $10 of earned income in a month if it is infrequent or irregular.

c. For 2010 and *2011*, up to $1,640 per month, but not more than $6,600 in a calendar year, of the earned income of a blind or disabled student child.

d. Any portion of the $20 monthly general income exclusion which has not been excluded from unearned income in that same month.

e. $65 of earned income in a month.

f. Earned income of disabled individuals used to pay impairment-related work expenses.

g. One-half of remaining earned income in a month.

h. Earned income of blind individuals used to meet work expenses.

i. Any earned income used to fulfill an approved plan to achieve self-support.

4. Unused Exclusion

Earned income is never reduced below zero. Any unused earned income exclusion is never applied to unearned income.

Any unused portion of a monthly exclusion cannot be carried over for use in subsequent months.

6. Couples

The $20 general and $65 earned income exclusions are applied only once to a couple, even when both members (whether eligible or ineligible) have income, since the couple's earned income is combined in determining Medicaid eligibility.

B. References

For exclusions which apply to both earned and unearned income, see:

- S0810.410 for infrequent/irregular income
- S0810.420 $20 general exclusion
- S0810.430 amount to fulfill a plan for achieving self-support

For exclusions applicable only to earned income, see S0820.510 - S0820.570.

S0820.510 STUDENT CHILD EARNED INCOME EXCLUSION

A. Policy

1. General

For a blind or disabled child who is a student regularly attending school, earned income is excluded under this provision, limited to the maximum amounts shown below.

For Months	Up to per month	But not more than in a calendar year
In calendar years 2010 and *2011*	$1,640	$6,600

2. Qualifying for the Exclusion

The individual must be:

- a child under age 22; and
- a student regularly attending school.

3. Earnings Received Prior to Month of Eligibility

Earnings received prior to the month of eligibility do not count toward the yearly limit.

4. Future Increases

The monthly and yearly limits will be adjusted annually based on increases in the cost of living index. Under this calculation, these amounts will never be lower than the previous year's amounts. However, there may be years when no increases result from the calculation.

B. Procedure

1. Application of the Exclusion

Apply the exclusion:

- consecutively to months in which there is earned income until the exclusion is exhausted or the individual is no longer a child; and
- only to a student child's own income.

2. School Attendance and Earnings

Develop the following factors and record them:

- whether the child was regularly attending school in at least 1 month of the current calendar quarter, or expects to attend school for at least 1 month in the next calendar quarter, and
- the amount of the child's earned income (including payments from Neighborhood Youth corps, Work-Study, and similar programs).

Verify wages of a student child even if they are alleged to be $65 or less per month.

C. References

- Grants, scholarships and fellowships, S0830.455.
- Educational assistance with Federal funds involved, S0830.460.

D. Example *(Using April 2002 Figures)*

Jim Thayer, a student child, starts working in June at a local hardware store. He had no prior earnings during the year, and he has no unearned income. Jim earns *$1,600* a month in June, July and August. In September, when he returns to school, Jim continues working part-time. He earns *$800* a month in September and October. Jim's countable income computation for June through October is as follows:

June, July and August
$1600.00 gross earnings
- 1320.00 student child exclusion
$ *280.00*
- 20.00 general income exclusion
$ *260.00*
- 65.00 earned income exclusion
$ *195.00*
- *97.50* one-half remainder
$ *97.50* countable income

Jim has used up *$3,960* of his *$5,340* yearly student child earned income exclusion *($1,320* in each of the three months).

September
$800.00 gross earnings
- 800.00 student child exclusion
0 countable income

Jim has now used up *$4,760* of his *$5,340* yearly student child earned income exclusion.

October
$800.00 gross earnings
- 580.00 student child exclusion *remaining ($5,340-$4,760=$580)*
$220.00
- 20.00 general income exclusion
$200.00
- 65.00 earned income exclusion
$135.00
- *67.50* one-half remainder
$ *67.50* countable income

Jim has exhausted his entire *$5,340* yearly student child earned income exclusion. The exclusion cannot be applied to any additional earnings during the calendar year.

S0820.520 $65 PLUS ONE-HALF REMAINDER PER MONTH EARNED INCOME EXCLUSION

A. Policy

1. Amount Excluded — $65 per month of earned income plus one-half of the remaining earned income in the month is excluded.

2. Order of Exclusion — The exclusion is applied in the order shown S0820.500 A.3.

B. References — IRWE exclusions, S0820.540.

S0820.535 BLIND WORK EXPENSES (BWE)

A. Definition

BWE represent any earned income of a blind person which is used to meet any expenses reasonably attributable to earning the income.

B. Policy

BWE are deducted from earned income if the blind person:

1. Eligibility Requirements

- is under age 65; or
- is age 65 or older; and
- received Medicaid due to blindness (or received payments under a former State plan for aid to the blind) for the month before attaining age 65.

2. Application of Exclusion

a. The BWE exclusion applies only to earned income. BWE in excess of the earned income an individual receives during the month are never deducted from unearned income.

b. The BWE exclusion is applied to earned income immediately after applying:

- any portion of the general income exclusion which has not been deducted from unearned income; and
- all other earned income exclusion except the exclusion of income used to fulfill an approved plan for achieving self-support (PASS).

3. Deductible Items

a. Except for items in 4. below, the cost of any work-related item paid by a blind person may be deducted as BWE, regardless of:

- any nonwork benefit that may be derived from the item; **or**
- the item's relationship to the person's blindness.

b. A blind individual can claim the amount withheld for Federal, State, and local income taxes even though other factors may affect his or her tax liability (e.g., number of dependents, business loss, etc.).

c. Examples of items which may be deductible as BWE are identified in S0820.555.

4. Nondeductible Items

The following items cannot be deducted from earned income as BWE:

- In-kind payments
- Expenses deducted under other provisions (e.g., PASS)
- Expenses which will be reimbursed
- Life maintenance expenses. Although not all inclusive, life maintenance items include the following:

  meals consumed outside of work hours;

  self-care items (including items of cosmetic rather than work-related nature);

  general educational development;

  savings plan (e.g., Individual Retirement Accounts (IRA'S) or voluntary pensions);

  life and health insurance premiums

- Items furnished by others that are needed in order to work (the value of such items is not income)
- Expenses claimed on a self-employment tax return (see S0820.545B.1 for further discussion regarding this issue)

EXAMPLE: Mrs. Terry Peters, a blind individual, works as a typist. A community organization bought her a special typewriter that she needed to perform satisfactorily on the job. The value of the typewriter is not income to Mrs. Peters, nor is it deducted as a BWE since she did not pay for it.

S0820.540 IMPAIRMENT-RELATED WORK EXPENSES (IRWE)

A. Definition

IRWE are expenses for items or services which are directly related to enabling a person with a disability to work and which are necessarily incurred by that individual because of a physical or mental impairment.

B. Policy

1. General

We may deduct IRWE to determine countable earned income in both initial applications and posteligibility situations regardless of whether we previously established the person's eligibility without considering IRWE.

2. Eligibility Requirements

A payment for a service or item is excludable as IRWE for eligibility purposes when:

- the individual:

  is disabled (but not blind); **and**

  is under age 65; **or**

  received Medicaid as a disabled individual (or received disability payments under a former State plan) for the month before attaining age 65; **and**

- the severity of the impairment requires the individual to purchase or rent items and services in order to work; **and**

- the expense is reasonable; **and**

- the cost is paid in cash (including checks or other forms of money such as money orders, credit and/or charge cards) by the individual and is not reimbursable from another source (e.g., Medicare, private insurance); **and**

- the payment is made in a month the individual receives earned income for a month in which he/she **both** worked **and** received the services or used the item; **or**

  the individual is working but makes a payment before the earned income is received.

(See S0820.560 B. for instructions on deducting expenses paid while working. See S0820.560 C. for instructions on deducting expense paid prior to work. For instructions on deducting expenses paid after work has stopped, see S0820.560 D.)

3. IRWE Used for Other Daily Activities

Any expense may meet the criteria for an IRWE even if it also is used for daily activities other than work.

4. Application of Exclusion

a. The IRWE exclusion only applies to earned income. IRWE in excess of the earned income an individual receives during the month are never deducted from unearned income. (See S0820.560 for allocating expenses.)

b. The IRWE exclusion is applied to earned income in the sequence below:

- immediately **after** deducting:

  any portion of the general income exclusion which has not been deducted from unearned income; **and**

  the $65 earned income exclusion; **and**

- immediately **before** deducting one-half of the remaining earned income.

M0820.545 WORK EXPENSES – INTERACTION WITH OTHER POLICIES

A. Introduction

This section discusses the interaction of other policies with work expenses.

B. Policy-Items Deductible Under Other Provision

1. Self-Employment

If the cost of an item has been deducted in figuring net earnings from self-employment (NESE) as described in S0820.200, it cannot be deducted as a work expense.

2. Community Residence

When an individual resides in a community residence, the individual's payments for work related attendant care can be used to reduce countable earnings.

3. PASS

a. A PASS permits an individual to set aside income and resources for a limited period of time in order to reach a work goal. (For a more comprehensive discussion on PASS, see M0810.430)

b. Income used to pay for a particular work-related item may not be excluded from countable income under the PASS and the BWE or IRWE provisions simultaneously.

c. Unlike BWE or IRWE, a PASS may be used to reduce countable unearned income and resources.

C. Policy – Deeming

In determining how much of an ineligible spouse's or parent's income is subject to deeming, earnings which are used to meet work expenses are not counted, if the ineligible spouse or parent is blind or disabled. Accept the individual's allegation of blindness or disability. Work expenses should be documented and verified according to S0820.550.

S0820.550 WORK EXPENSE DEVELOPMENT AND DOCUMENTATION

A. Policy

All allegations and/or evidence of BWE and IRWE must be documented in file.

B. Procedure—Documentation

Document BWE and IRWE respectively per 1. and 2. below.

1. Allegation of BWE

Document BWE as described below:

STEP	ACTION
1	Assume that any working blind individual earning income more than $65 a month has BWE. For example, most earnings are subject to income taxes which qualify as BWEs.
2	If earnings are above $65 per month, obtain an allegation from the individual that either: • claims a BWE, specifying the type and amount of expense; or • explains why he/she has no BWE.
3	Record this statement in the case record.

2. Allegation of IRWE

Document IRWE according to the following steps:

STEP	ACTION
1	Ask about IRWE when: • a disabled individual's earned income exceeds $65 in any month; or • at least one member of an ineligible couple is disabled and has earned income, and the couple's total earned income exceeds $65 in any month; or • a disabled individual has earned income of $65 or less, the individual is subject to spouse-to-spouse deeming, and the couple's total earned income exceeds $65.
2	Record the individual's response with a statement describing the IRWE claimed or that no IRWE is alleged.

3. When to Develop

Develop work expenses per 1. and 2. above when you:

- complete an initial application or a redetermination; **or**
- receive a report that the recipient has started working; **or**
- receive a report that the expenses have changed.

NOTE: A change in the amount of earnings of a blind worker implies a change in expenses since the amount of taxes deducted probably changed.

4. Allocation of Work Expenses

Document the file to support your allocation of work expenses. (See S0820.560 for instructions on allocating work expenses.)

NOTE: You may use the worksheet in S0820.565, which may be reproducted locally, to document the type and allocation of BWE.

C. Procedure—Verification

1. Evidence of BWE

a. Verifying that criteria for BWE are met

- Stop file documentation when the expense is listed on the chart in S0820.555. The items listed on the chart meet the criteria for a BWE.
- Document the file to reflect how an item is reasonably attributable to the earning of income when the item is not listed on the chart.

b. Verifying cost of BWE

- Document the file with photocopies of bills, receipts, etc., from the individual to corroborate the allegations.

  Inform every working blind individual of the requirement to maintain records of work expenses and to produce such records when requested. Explain why we need to see these records.

- Accept the individual's allegation of the expense amount when:

  bills, receipts, etc., cannot be obtained (e.g., lack of receipts for food purchased for a dog guide, meals, transportation, etc.) **and**

  the allegation appears reasonable.

  NOTE: You may use the worksheet in S0820.565 as an aid in calculating BWE.

2. Evidence of IRWE

a. Document the need for an item or service

- Refer to the chart in S0820.555 for guidance in common types of expenses deductible as IRWE.

- Accept an allegation, as **verification of need**, that a prescription drug is used to control the disabling condition, enabling the individual to function at work, when:

  there is a paid bill for the drug; and

  the information on the container indicates that:

  a physician and a licensed pharmacist were involved in providing the drug; and

  the drug is for the individual.

b. Verifying cost of an item or service

- Accept the individual's allegation as to the recurring use and cost of an IRWE when:

  at least one available receipt of documenting the cost is submitted;

  additional receipts are unavailable for the recurring expense (e.g., hearing aid batteries, incontinence pads, etc.); **and**

  the allegation of use is consistent with the nature of the expense (e.g., the individual states that he has only a couple of receipts for the box of 60 incontinence pads he buys every month as his condition requires him to use two pads a day).

3. Posteligibility Situations

a. BWE/IRWE previously developed

If BWE/IRWE were developed previously, compare the recipient's (and spouse's, if applicable) responses with information in the case record. Then, proceed as follows:

IF	AND...	THEN...
the alleged amounts and dates of work expense information agree with the verified information	no changes are alleged	no further BWE/IRWE development is necessary.
	changes are alleged	develop and verify BWE/IRWE per 1 and 2 above.
information is unverified	------	develop and verify BWE/IRWE per 1 and 2 above.

b. BWE/IRWE not previously developed

Develop and verify per 1 and 2 above.

D. Procedure--Special Considerations

1. More Than One Employer Involved

Add total earnings from all employers. Deduct combined work expenses from this total.

NOTE: There is no need to relate a specific expense to a particular source of earnings.

2. Self-Employment

Carefully review records and/or the portion of the tax return used to determine NESE per S0820.210. Check that none of the expenses deducted in determining NESE are also being claimed as work expenses.

Determine what expenses can be excluded from earned income as work expenses. If necessary, refer the individual to the Internal Revenue Service (IRS) for information about permissible self-employment deductions.

D. Procedure—Special Considerations

2. Self-Employment (cont.)

EXAMPLE: Individual is self-employed and a wage earner.

FACTS: Mr. Griffin, a blind Medicaid recipient, is self-employed selling brushes. He also works one night a week as an employee typing transcripts from recordings. Mr. Griffin's self-employment requires him to travel by cab (at a cost of $60 per month) to the brush manufacturer to pick up samples. He also must travel by cab, at a cost of $40 per month, to the office where he is employed.

CONCLUSION: You determine that the $60 monthly cab fare to pick up samples has been used in arriving at his NESE and cannot be deducted from his earned income as a work expense. You deduct as a work expense the $40 monthly cabfare for travel to and from the office where he is employed.

3. Work Expenses of a Couple

If both members of a couple are eligible and both work, deduct from the couple's earned income each individual's work expenses to the extent that they do not exceed that individual's earnings. Do not deduct excess work expenses of one member of the couple from the earned income of his or her spouse. (See B.2. above when it is necessary to document IRWE in couple's cases and S0820.545C when deeming is an issue.)

4. Estimating Future Work Expenses

a. Estimate an individual's future expenses based on expenses paid in the most recent period per S0810.600-610. This could be the period just redetermined or a shorter period if there has been a pertinent change in circumstances, such as additional expenses.

   For example, if the individual had more expenses in the last 3 months than in previous months and those expenses are expected to continue, use that amount in your determination. Consider any expected decrease in expenses (e.g., installment payments on tools that will be paid off).

b. Do not estimate an anticipated expense in the near future (e.g., purchase of more equipment) until there is proof that the expense exists. Tell the individual to let you know as soon as a new expense develops so you can make any appropriate adjustments at that time.

S0820.555 LIST OF TYPE AND AMOUNT OF DEDUCTIBLE WORK EXPENSES

The following chart provides guidance on types of expenses which are deductible as BWE, IRWE, or both, and the amount deductible. The chart is not intended to be all-inclusive. Refer to the policy discussed in S0820.535, S0820.540.

TYPE OF EXPENSES	DEDUCTIBLE AS		AMOUNT OF DEDUCTIBLE
	BWE	IRWE	
Attendant care services which are rendered in the: • home; • process of assisting an individual in making the trip to and from work; or • work setting	X	X	The amount paid.
Drugs and medical services which are essential to enable the individual to work (e.g., medication to control epileptic seizures)	X	X	The amount paid.
Expendable medical supplies Examples • Bandages • Catherers • Face masks • Incontinence pads	X	X	The amount paid. See M0820.550 C.1 and C.2.
Federal, State and local income taxes and Social Security taxes	X		The amount withheld. Assume the amount withheld reflects the individual's tax liability.
Dog Guide	X	X	The cost of purchasing the dog and all associated expenses (e.g., its food, breast straps, licenses, veterinary services, etc.)
Fees Examples: • Licensee • Professional association dues • Union dues	X		The amount paid.

TYPE OF EXPENSES	DEDUCTIBLE AS		AMOUNT OF DEDUCTIBLE
	BWE	IRWE	
Mandatory contributions Examples: • Pensions • Disability	X		The actual amount of the mandatory contribution. For example, mandatory pension contributions are considered reasonably attributable to earning incomeand, therefore, deductible. Voluntary pension contributions are considered savings plans and, as such, are life maintenance expenses and not deductible.
Meals consumed during work hours	X		The actual value of the meals whether bought during work hours or brough from home.
Medical devices Examples: • Braces • Inhalers • Pacemakers • Respirator • Wheelchair	X	X	The cost of the items plus maintenance and repair of such items whether the individual works at home or at employer's place of business.
Nonmedical equipment/services Examples: • Air cleaners • Air conditioners • Child care costs • Humidifiers • Portable room heaters • Posture chairs • Safety shoes • Tools used on the job • Uniforms	X	*	The cost of the item plus maintenance and repair of such items whether the individual works at home or at the employer's place of business. *To be deductible IRWE, the item or service must impairment-related.
Other work-related equipment/services Examples: • One-handed typewriters • Special tools designed to accommodate an individual's impairment • Telecommunications devices for the deaf • Translation of materials into braille • Typing aids (e.g., page turning devices) • Vision and sendory aids for the blind	X	X	The cost of the item plus maintenance and repair of such item whether the individual works at home or at the employer's place of business.
Physical therapy	X	X	The amount paid.

TYPE OF EXPENSES	DEDUCTIBLE AS		AMOUNT OF DEDUCTIBLE
	BWE	IRWE	
Prosthesis	X	X	The cost of the item plus maintenance and repair of such item.
Structural modifications to the individual's home to create a work space or to allow the individual to get to and from work.	X	X	The cost of the modifications.
Training to use an impairment-related item or an item which is reasonably attributed to work Examples: • Braille • Cane travel • Computer program course for a computer operator • Grammar • Stenotype instruction for a typist • Use of one-handed typewriter • Use of special equipment • Use of vision and sensory aids for the blind NOTE: Training does not include general education courses. Such courses may be excluded under a PASS.	X	X	The cost of the training plus travel expenses to and from the training facility. Compute travel expenses to and from the training facility in the same manner as transportation to and from work (shown previously in this chart)

TYPE OF EXPENSES	DEDUCTIBLE AS		AMOUNT OF DEDUCTIBLE
	BWE	IRWE	
Transportation to and from work	X	X	• In own vehicle the rate is 28 cents per mile. • For other than in own vehicle the actual cost of the bus, car, pool, or cabfare.
Vehicle modification	X	X	Whatever seems reasonable.

S0820.560 ALLOCATING WORK EXPENSES

A. Policy--

1. IRWE For IRWE, the instructions in this section effective November 1, 1995.

2. BWE For BWE, the instructions below that pertain to the proration of expenses paid prior to starting work or after stopping work are effective November 1, 1995.

B. Procedure-- Expenses Paid While Working

1. Expenses Paid Prior to Receipt of Income Deduct (or begin allocating) the amount paid in the first month income is received.

2. Monthly Recurring Expenses

a. **No downpayment involved**

Deduct the amount of a monthly recurring work expense in the month in which the expense is paid.

b. **Downpayment involved**

- Have the individual decide whether the downpayment is to be deducted in the month paid; **or** prorated over a consecutive 12-month period.
- If the downpayment is to be deducted in the month paid, deduct the regular recurring monthly expense when paid.

3. Other Recurring Expenses

a. **Less frequently than monthly**

Have the individual decide whether the work expense is to be deducted in the month paid or prorated for the months in the billing period.

b. **Daily/Weekly/Biweekly**

- Use the submitted receipts, bills, etc., in conjunction with any allegation obtained per S0820.550C. to determine the number of days the expense is paid each month; **and** whether the expense fluctuates or remains the same.
- Multiply the amount of the expense by the number of days the expense is paid each month if the expense remains the same.
- Add the individual amounts paid in each month if the expense fluctuates.

NOTE: If the computation is being based on the individual's allegation, assume that the expense remains the same.

4. Expense Is One-Time Payment

Have the individual decide whether the work expense is to be:

- deducted entirely in the month of payment; or
- prorated over a consecutive 12-month period beginning with the month of payment.

5. Self-Employment

Deduct the work expenses related to a self-employed activity for an individual who is blind and self-employment, provided the expenses were not used to complete the net earnings from self-employment (NESE). If it is to the person's advantage, prorate the work expenses over all the months of the tax year; otherwise, follow 1-4 above, as appropriate.

C. Procedure-- Expenses Paid Prior to Work

Follow the steps below, whenever a work expense was paid before work began:

STEP	ACTION
1	Determine whether the item that was purchased: • is work-related; **and** • had a payment made on it in the 11-month period immediately preceding the first month of employment.
2	If the item meets all the criteria in step 1, go on to step 3. If not, stop. The expense cannot be deducted.
3	Determine the total amount paid towards the item during the 11 months preceding the month that work began.
4	Determine the **deductible portion** according to the following chart.

No. of Months Prior to Work That First Payment is Made	Deductible Portion of Payment
1	11/12 (.916)
2	5/6 (.833)
3	3/4 (.750)
4	2/3 (666)
5	7/12 (.581)
6	1/2 (.500)
7	5/12 (.415)
8	1/3 (.333)
9	1/4 (.250)
10	1/6 (.166)
11	1/12 (.083)

NOTE: See E. below for an example of how to use this chart.

5	Have the individual decide whether the deductible portion from step 4 is to be allocated: • only to the first month that earned income is received; **or** • over a consecutive 12-month period beginning with the first month that earned income is received. **NOTE:** The deductible amount is **in addition to** amounts actually paid after beginning work.

D. Procedure-- Expenses Paid After Work Stops

1. Expense Paid Before Earned Income Stops

Deduct a work expense that is paid in a month after work has stopped from earned income received in a month after work has stopped only when:

- the income is based on work activity (e.g., not income received as a silent partner in a business); and
- the work activity was performed in a period when the individual required the item or service.

2. Expense Paid After Earned Income Stops

Deduct the work expense from the earned income received in the last month of work when:

- the work expense is paid in a month after the individual last worked and received earned income; and
- the payment was for an item or service used while working.

E. Procedure— Expenses Paid by Credit Card

- Treat a credit/charge care purchase as a nonrecurring expense and follow the appropriate instructions in B.4, C or D above.

  EXCEPTION: You may treat the actual payments as a recurring expense per B.2-3 above when the IRWE was the only charge on the account during the time the charge was being paid; i.e., there was a zero balance when the IRWE was charged and no other charges were made before the payments were completed.

- Apply the credit card's annual interest rate to the cost of the IRWE purchase when:

  there is already a balance on the account when the IRWE is purchased;

  another purchase is made before the IRWE charge is paid off; or

  there is the likelihood of another purchase before the IRWE charge is paid off,

- Deduct the IRWE charge amount plus the calculated interest.

F. Procedure--Documenting Allocation Decision

Obtain a signed statement to document individual's decision regarding the allocation of expenses to one month or a 12-month period **only if** it would not be discernable from the file that the method of allocation is advantageous to the individual.

G. EXAMPLES

1. IRWE Charged While Working

Mr. Applegate, a disabled Medicaid recipient who is working, charges an IRWE which costs $240 (i.e., purchase price plus applicable tax) on a credit card that has an annual interest rate of 18%. Because there was already a balance on the account prior to the IRWE purchase, you treat the IRWE as a nonrecurring expense.

You calculate the interest on the IRWE purchase to be $43.20 ($240 x 18%). You determine the deductible IRWE amount to be $283.20.

You ask Mr. Applegate whether he wants the IRWE amount deducted entirely in the month charged or prorated over a consecutive 12-month period. He decides to have it prorated. You deduct a $23.60 ($283.20/12) a month as IRWE for 12 consecutive months beginning with the month the IRWE was charged.

2. IRWE Charged Before Working

Similar circumstances to the above example, except that Mr. Applegate charges the IRWE on his credit card 6 months before he begins working.

You use the chart in C. above to determine that only $141.60 is deductible as IRWE (one-half of $283.20)

You ask Mr. Applegate whether he wishes to have the IRWE deducted in the first month he receives earned income or during the 12 month period at $11.80 a month ($141.60/12). He elects to have it deducted in the first month.

S0820.565 BWE WORKSHEET

A. When to Use B. Exhibit

The BWE worksheet in B. below may be reproduced and used to develop blind work expenses. Refer to S0820.550 and S0820.555 for detailed instructions on the type of deductible expenses and the amount of deductible.

B. Exhibit

BLIND WORK EXPENSES WORKSHEET						
NAME PART I	AMOUNT($) OF TAXES			SSN PART III	TOTALS	
Month/ Year	Federal, State Local	FICA (Social Security)	Other Mandatory Deductions (e.g., mandatory pension contri-butions)	A (Add Columns Part I)	B (from Part II)	C (Combine A and B)

PART II	Amount ($) by Type of Other Expenses							
	Medical		Nonmedical					Total
Month/ Year	Drugs and Other Expendable Supplies	Other see* below) (List Item)	Attendant care services	Dog Guide	Food Eaten During Work Hours (e.g., lunch)	Transpor-tation To and From Work	Other (see** below) (List Item)	Add Columns and Transfers to Part III

* Other
- Medical Devices (e.g., wheelchair, respirator)
- Medical Services
- Physical Therapy
- Prostesis

** Other nomedical BWE:
- Fees (e.g., union dues, licenses)
- Modifications to vehicle and/or structure of home
- Nomedical equipment/services (e.g., uniforms, child care)
- Other work related equipment/services/ (e.g., one-handed typewriters, translations into Braille)
- Training (e.g., use of one-handed typewriter)

NOTE: The above items do not reflect an all-inclusive list of deductible expenses.

S0820.570 EARNED INCOME TAX CREDIT (EITC) PAYMENTS EXCLUSION

A. Definition

The earned income tax credit (EITC) is a special tax credit which reduces the Federal tax liability of certain low income working taxpayers. This tax credit may or may not result in a payment to the taxpayer. EITC payments can be received as an advance from an employer or as a refund from IRS.

B. Policy

Exclude from income any EITC payments received as an advance or as a refund, regardless of the tax year involved.

C. References

- EITC resource exclusion S1130.675.
- EITC, S0820.400

S0830 Changes

Transmittal Number	Effective Date	Pages Changed
TN #94	09/01/2010	page 29
TN #93	01/01/2010	Table of Contents, page iv pages 28, 67, 119-120 pages 122-125
TN #91	05/15/2009	Table of Contents, page i page 29

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UNEARNED INCOME

GENERAL

S0830.001 INTRODUCTION TO UNEARNED INCOME

A. Policy

Unearned income is all income that is not earned income.

B. Description of the Subchapter

The instructions in this subchapter apply to unearned income and unearned income exclusions.

The subchapter is organized so that payments which are similar in nature are grouped together. Unearned income exclusions and counting rules are not all in one place. Those related to a specific type of payment are discussed in sections about the payment itself.

C. References

Users should be familiar with the general income rules found in subchapters 10 and 15, particularly:

What is income (S0810.005);

What is not income (S0815.001.);

Whose income is it (S0810.120.);

When income is counted (S0810.030)

Income verification (S0810.500); and

How to estimate income (S0810.600-620).

S0830.005 GENERAL RULES FOR DEVELOPING UNEARNED INCOME

A. Procedure

Some types of income require particular development as explained in later sections in this subchapter. Apply the instructions in this subsection where no specific instructions exist.

1. Clearly Ineligible

Do not develop unearned income where the individual is clearly ineligible for a non-financial reason or excess resources.

2. File

Document the case file so that it **fully** supports every eligibility decision.

3. Allegations

Document any **material** allegation. **.**

You do not need to document an attempt to obtain information from **other sources**

5. Verification

- In general, verify the **amount, frequency** of receipt and **source** and/or type of unearned income.
- Unless required elsewhere, verify only the source and/or type of a **totally excluded** payment.
- **Request evidence first** from the recipient and then, if necessary, from other sources.

6. Evidence Not Readily Available

When evidence is not readily available, and if the individual has cooperated:

a. obtain a **signed statement** from the individual as to the amount, source and frequency of receipt of the payment;
b. **process the case** on the basis of the individual's statement if all other eligibility factors are met and there is no reason to doubt the allegation;
c. **clearly document** the file as to why the information is not readily available; and
d. obtain the evidence **postadjudicatively.**

7. Evidence In Doubt Or Contradictory

a. Request **supporting evidence** from the individual or the source of the income.
b. If all available evidence leaves a question, weigh the evidence and **make a decision**. The file must reflect the basis for this decision.

8. Classification Unknown

a. If you are unable to determine whether an item or amount should be classified as income or whether income is earned or unearned, **contact the regional office.**

9. Mailing Time

When a payment is mailed, assume that the payment is received 5 days after the payment or mailing date unless the individual alleges a different date, in which case accept any credible allegation.

B. References

Developmental rules for posteligibility situations, S0830.007

S0830.007 DEVELOPMENTAL RULES IN POSTELIGIBILITY SITUATIONS

A. Introduction

Some types of income and income exclusions have special rules that apply in posteligibility (PE) situations. For example, in the section on rental income, if a Medicaid recipient with rental income reports a new expense, the remaining income estimates may need to be recalculated.

When no specific instructions exist, however, the general rules in this subsection apply.

B. Procedure

1. General

Unless specific instructions indicate otherwise, the general rules for developing unearned income found in S0830.005 also apply in PE situations.

C. References

General rules for developing unearned income, S0830.005

Rental Income, S0830.505

S0830.010 WHEN TO COUNT UNEARNED INCOME

A. Policy -- General

Unearned income is counted as income in the earliest month it is:

- received by the individual;
- credited to the individual's account; or
- set aside for the individual's use.

B. Policy--When to Count Retroactive RSDI Benefits

Other than the following exceptions (1.- 2. below), retroactive RSDI benefits, whether paid in one lump sum or by installment, are counted as unearned income in the month payment is received.

NOTE: Reissued conserved funds, whether paid in a lump sum or in installments, are not considered unearned income in the month of reissuance since such funds were previously considered in the month of original receipt (S1120.022.B.2.).

1. Retroactive RSDI Benefits Paid By Installment When DAA is Material

Retroactive RSDI benefits must be paid in installments when paid to representative payees of individuals who are eligible because of drug addiction or alcoholism (DAA). In such cases involving DAA beneficiaries, the total of retroactive RSDI benefits paid in installment is treated as if paid in a lump sum in the usual manner. The total of such benefits paid in installments is considered unearned income in the month in which the first installment is made.

In certain posteligibility situations involving DAA beneficiaries, a subsequent amount of retroactive RSDI benefits to be paid in installments cannot be paid because the beneficiary is receiving installment payments

from a previous retroactive RSDI benefit. In such situations, the total of the subsequent retroactive RSDI amount is counted as unearned income in the month such total would have normally been paid (i.e., as if the lump sum had been paid in the usual manner.)

NOTE: For resource purposes, each installment is subject to regular resource rules in the month following receipt (see S1130.600 for exclusion of RSDI underpayments).

2. Retroactive RSDI Benefits Paid By Installment At Recipient's Request

In certain situations, SSA will agree **at the recipient's request** to pay by installment retroactive RSDI benefits that would otherwise be paid in one lump sum. In such cases, the total of retroactive RSDI benefits (except for amounts considered paid in a windfall offset period per 1. above) is counted as unearned income in the month such benefits were set aside for the individual's use.

C. References

- Counting advance dated checks and electronic fund transfers, S0810.030
- Reissuance of conserved finds, S1120.022B.2.
- Resource exclusion of RSDI underpayments, S1130.600

UNEARNED INCOME EXCLUSIONS - GENERAL

S0830.050 OVERVIEW OF EXCLUSIONS

A. Definition

An **exclusion** is an amount of income which does not count in determining eligibility.

B. Policy

Exclusions never reduce unearned income below zero. Except for the $20 general exclusion (S0810.420), no unused unearned income exclusion may be applied to earned income.

C. Procedure

First, determine whether what is received is income. Next apply any appropriate exclusions to unearned income as discussed in this subchapter.

1. Exclusions in Relation to the Infrequent/ Irregular/ Exclusion

Apply the exclusions in this subchapter separately from the infrequent or irregular exclusion (S0810.410). However, do not apply the infrequent or irregular exclusion to an amount remaining after another exclusion has been applied to a particular type of income (e.g., the remaining amount of child support after one third has been excluded).

You may apply the infrequent or irregular exclusion to an individual's total unearned income if the entire amount can be excluded under that provision.

2. Application of Other Exclusions

After applying the specific exclusions discussed in this subchapter, apply the $20 general income exclusion (S0810.420). If there is also earned income, apply the earned income exclusions after the $20 general income exclusion.

D. Reference

What is not income, S0815.001.

S0830.055 EXCLUSIONS UNDER OTHER FEDERAL STATUTES

A. Introduction

1. General

Federal statutes other than the Social Security Act sometimes provide that the Medicaid program must exclude from income (or income and resources) assistance provided under those statutes.

2. New Exclusions

Be aware that new or different assistance programs may have Federal involvement and be subject to an exclusion. (Central office does not always immediately know when exclusions are enacted if they are handled by another agency.) Follow the guidelines in B. below when a program is questionable or someone alleges a new exclusion or type of assistance.

B. Procedure - Exclusion New or Questionable

1. Contact RO

Contact the regional office (RO) if there is reason to believe an exclusion exists for a program with Federal involvement or if you learn of a new exclusion.

2. Helpful Information

The name of the local program or agency may not be sufficient information to make a determination. As possible, provide the RO with the following information:

- the name of the program and what it does;
- the public law (name and number) which authorizes the program (e.g., P.L. 99-498, the Higher Education Amendments of 1986);
- the section number(s) in the public law which pertain to the program; and
- the Federal agency which is responsible for Federal involvement in the program.

C. Reference

List of exclusions under other Federal statutes and related instructions, S0830.099.

S0830.099 GUIDE TO EXCLUSIONS

A. Introduction

The following provides a list of those instructions which address a partial or total exclusion of unearned income. Those in **bold print** involve an exclusion under another Federal statute.

B. List of Instructions About Unearned Income Exclusions

Action Programs **S0830.610**
Agent Orange Settlement Payments S0830.730

Austrian Social Insurance Payments S0830.715
BIA Student Assistance S0830.460
Capital Gains *M0815.200*
Child Support S0830.420
..... S0830.425
Disaster Assistance S0830.620

Educational Assistance S0830.450
Energy Assistance S0830.600
..... S0830.605

Farmers Home Administration Housing Assistance (FMHA) S0830.630
Food/Meal Programs S0830.635
Food Stamps S0830.635
Foster Grandparents Program S0830.610

General Assistance (General Relief) S0830.175
German Reparation Payments S0830.710
Gifts Occasioned by a Death S0830.545
Gifts of Domestic Travel Tickets S0830.521
Grants, Scholarships, and Fellowships S0830.455

HUD Subsidies S0830.630
Home Energy Assistance S0830.600
..... S0830.605
Home Produce S0830.700
Hostile Fire Pay from the Uniformed Services S0830.540
Housing Assistance S0830.630
Interest on Excluded Burial Funds S0830.501

Japanese-American and Aleutian Restitution Payments S0830.720

Low Income Energy Assistance S0830.600

Meals for Older Americans S0830.635
Milk Programs S0830.635

National Defense Student Loans (NDSL) S0830.460

Pell Grants S0830.460
Private Non-profit Assistance S0830.605

Radiation Exposure Compensation Trust Fund (RECTF) Payments S0830.740
Refunds of Taxes Paid on Real Property or Food S0830.705
Relocation Assistance S0830.655
Retired Senior Volunteer Program (RSVP) S0830.610

School Breakfasts S0830.635
School Lunches S0830.635
Senior Companion Program S0830.610
Supplemental Education Opportunity Grant (SEOG) S0830.460
Special and Demonstration Volunteer Program S0830.610
State Student Incentive Grants (SSIG) S0830.460
State Assistance Based on Need S0830.175

University Year for Action (UYA). S0830.610

Victim's Compensation Payments S0830.660
Volunteers in Service to America (VISTA) S0830.610

Walker v. Bayer Settlement Payments *M0830.760*
Women, Infants, and Children Program (WIC) S0830.635

AMOUNT OF UNEARNED INCOME

S0830.100 EXPENSES OF OBTAINING INCOME

A. Definition

An **expense** as used in this section is one that is an essential factor in obtaining a particular payment(s).

B. Policy

Unearned income does not include that part of a payment which is for an essential expense incurred in getting the payment.

1. Treatment of Expenses

- From a payment received for damages in connection with an accident, we subtract **legal, medical, and other expenses** connected with the accident.

- From a retroactive check from a benefit program other than SSI, we subtract **legal fees** connected with that claim.

2. How to Deduct Expenses-- General

Except as noted in 3. below, expenses are deducted from the first and any subsequent amounts of related income until you have completely eliminated all expenses.

3. Expense Money -- Assumption

You may assume that the following payments for expenses do not exceed the expenses and thus do not result in income:

- payments by a government agency for expenses related to obtaining a service or participating in a program (e.g., $10 expense money provided to jurors); and

- lump sum advances or reimbursements by employers to cover expenses of employment paid by the employee (e.g., employee receives a per diem allowance, school bus driver is paid $100 per month allowance to pay for gas and maintenance).

NOTE: See C.2. below for verification requirements when this assumption is applied.

4. Repayment of Legal Fees When Equal Access to Justice Act Payments are Involved

An attorney who receives duplicate fees under the Equal Access to Justice Act (EAJA) and section 206(b) of the Social Security Act is obligated to return the smaller fee to the recipient. Any such payment to the recipient is income, provided that the amount of the fee previously had been deducted from income.

C. Procedure

Use bills, receipts, contact with the provider, etc., to verify all essential expenses.

1. Verifying Expenses -- General

If an expense has been incurred but not paid, assume that the individual will pay the expense unless you have reason to question the situation.

NOTE: You do not need to follow up if this assumption applies.

2. Verifying Expenses -- Assumption in B.4. Applies

If the assumption in B.3. above applies, be aware that you do not need to verify expense or follow up on how the money was spent.

3. Deducting Allowable Expenses

Deduct any expenses which have been verified as essential from the first and any subsequent amount(s) of related income. Deduct even those verified expenses which the recipient has **previously** paid (e.g., a partial payment to an attorney made from the individual's savings account) as long as the expenses are essential.

NOTE: The remainder is unearned income subject to the general rules pertaining to income and income exclusions.

D. Examples -- Essential Expenses

A fee to acquire documentation to establish that an individual has a right to certain income (e.g., a fee for a birth certificate or medical examination) is an essential expense.

1. Document Fees

2. Guardianship Fees

A guardianship fee is an essential expense **only** if the presence of a guardian is a requirement for receiving the income.

NOTE: Guardianship fees are **never** an essential expense for obtaining title II or title XVI benefits because the appointment of a legal guardian is never an SSA requirement.

E. References

- Medical and social services, S0815.050.
- Receipts from the sale, exchange, or replacement of a resource, S1110.600 B.4.
- Treatment of gambling losses, S0830.525 A.

S0803.105 PAYMENTS IN FOREIGN CURRENCY

A. Introduction

Occasionally, an individual receives income tendered to him/her in a monetary unit other than U.S. dollars. This usually will be in the form of a check or a direct deposit to a bank.

B. Policy

1. Amount of Income

The U.S. dollar value of a payment made in foreign currency, less expenses, is income.

2. When Counted

We count foreign currency payments when received unless the individual alleges and can establish that the payment was received too late in the month for conversion prior to the following month.

C. Procedure

1. Verify Receipt and Amount

Use a check or documents in the individual's possession to verify receipt of a foreign payment and the amount in foreign currency. If the payment is made directly to a bank, the bank may provide a statement of the amount received.

2. Evidence Not Available

If the evidence is not readily available, or if translation of the documents would require a delay beyond the receipt of the next payment, then:

- adjudicate the case based on the individual's signed allegation (if there is not reason to doubt the allegation); and
- ask the individual to present his next check before cashing it.

3. Conversion to U.S. Dollars

Verify the exchange rate for conversion of the foreign currency into U.S. dollars using:

- A receipt for the individual's last exchange; or
- A telephone call to a local bank or currency exchange.

4. Changes in Exchange Rate

Presume that an established exchange rate remains constant until the next redetermination, at which time verify the rate again. If at this point, the exchange rate has changed, presume the change occurred in the month of verification and that it remains constant until the next redetermination.

EXCEPTION: If the individual reports that the exchange rate has changed, verify the change and adjust the income counted to reflect the new rate.

D. References

Annuities, pensions, retirement or disability payments--General, S0830.160

German reparations payments, S0830.710

S0830.110 OVERPAYMENT INVOLVED

A. Policy

1. General Rule

Unearned income includes that part of another benefit payment (such as RSDI) which has been withheld to recover a previous overpayment.

2. Exception

The amount withheld is not income when the payment is received if:

- the individual received both Medicaid and the other benefit at the time the overpayment of the other benefit occurred; **and**
- the overpaid amount was included in figuring the Medicaid eligibility at that time.
- This exception applies only if the eligible individual actually received Medicaid while the overpayment was occurring (even if the payments were erroneous). It does **not** apply if the overpayment was used to determine eligibility and the individual was determined to be ineligible.

The exception avoids counting the income twice or "double counting."

3. Which Benefits are Affected

This policy applies to the following benefits:

- annuities and pensions;
- retirement or disability benefits (including veterans' pensions and compensation);
- workers' compensation;
- social security benefits;
- railroad retirement annuities;
- unemployment insurance benefits; and
- black lung benefits.

NOTE: A reduction of title II due to workers' compensation offset or work deductions, is not an overpayment and is **not affected** by this policy.

4. Overpayment--Definition

Overpayment for purposes of this section means overpayment as defined by the entity paying the benefit and includes overpayments made to someone other than the individual whose benefits are withheld.

5. Unable to Determine Double--Counting

Unearned income does not include the amount being withheld to recover an overpayment if, after all development is completed, we are unable to determine whether the exception in A.2. above applies.

6. Multiple Overpayments

When two or more overpayments are being recovered at the same time, we assume the amounts are first withheld to repay any overpayments not subject to the exception in A.2. above. This is regardless of the chronological order in which the overpayments occurred.

B. Procedure

1. Ask About Overpayments

When someone receives benefits under a program listed in A.3. above, ask him/her whether any benefits otherwise due are being withheld to recover an overpayment.

If the answer is	Then
No	Stop. No written documentation or further development is required.
Yes	Explain the policy and exception. Ask if the Medicaid recipient/applicant was receiving Medicaid at the time of the overpayment. • If no, go to B.2. • If yes or unknown, go to B.3.

2. Medicaid Not Received at Time of Overpayment

Accept the individual's allegation that Medicaid coverage was not being received at the time of the overpayment. Obtain a signed statement that:

- Medical assistance was not being received when the overpayment occurred;
- the policy and the exception have been explained; and
- the individual understands that the amounts withheld from the other benefit are considered part of the recipient's/applicant's income.

3. Medicaid Received at Time of Overpayment (or Unknown)

If the individual alleges that medical assistance was being received at the time of overpayment, or the individual does not know, verify Medicaid coverage. Use documents in the individual's possession or contact with the appropriate office or agency to verify:

- when the overpayment occurred;
- the rate of recovery; and
- the period of time of recovery.

C. Examples

1. Exception Applies

Joe Jones received title II benefits and Medicaid beginning January 1987. In November 1988, Mr. Jones learned he was overpaid $100 on his title II claim from April 1988 through August 1988. From January 1989 through May 1989, $20 is withheld from his title II benefit to recover the overpayment. Since the overpayment was already included in unearned income, the EW does not count the $20/month being withheld from January 1989 through May 1989.

2. Overpayment Makes Person Ineligible

Alex Martin received Medicaid payments and VA benefits starting in August 1987. His monthly VA benefit increased to $300 in August 1988. The VA benefit increase, combined with other income, caused Mr. Martin to become ineligible for Medicaid beginning in August 1988. He continued to be ineligible until January 1989 when VA determined his benefit should have been $200 since August 1988. Therefore, Mr. Martin was overpaid a total of $500 by VA for August 1988 through December 1988. Mr. Martin began receiving Medicaid in January 1989. To recover the VA overpayment, Mr. Martin's VA benefit is reduced by $100/month from March 1989 through July 1989. Since Mr. Martin received no Medicaid coverage during the time he was overpaid, the $100/month withheld to recover the overpayment is included in Mr. Martin's current income.

3. Another Person's Overpayment Included in Deeming Computation

Alice Brown has been receiving Medicaid since December 1986. Carl Brown is her ineligible spouse whose income is subject to deeming. In April 1989, Mr. Brown learns he incurred a $250 title II overpayment in November 1988. SSA recovers the overpayment by withholding $50 a month from the benefits Mr. Brown receives in June 1989 through October 1989. For deeming purposes, Mr. Brown's current income does not include the $50/month withheld from his title II since it has already been used in deeming computation for a prior period.

4. Another Person's Overpayment Not Previously Used in Deeming Computation

Mary Smith has been receiving Medicaid since December 1986. Harry Smith, her ineligible spouse, was separated from Mary Smith when he died in 1989. His income was never subject to deeming. Mr. Smith incurred a $100 title II overpayment in November 1988. Since Mrs. Smith is also a title II beneficiary, SSA recovers Mr. Smith's overpayment by withholding $50 a month from Mrs. Smith's benefit in July and August 1989. Since none of Mr. Smith's income was subject to deeming when the overpayment occurred, the EW includes in Mrs. Smith's current income the $50/month withheld from her title II benefit.

D. References

For office or agency addresses see:

- OPM, S0830.220 C.4.
- VA, S0830.320.
- DOD, S0830.240 C.2.

S0830.115 GARNISHMENT OR OTHER WITHHOLDING

A. Policy

Unearned income includes amounts withheld from unearned income because of garnishment or to make certain other payments.

Unearned income includes amounts withheld from unearned income whether the withholding is:

- purely voluntary;
- to repay a debt; or
- to meet a legal obligation.

NOTE: This policy does not apply to amounts withheld to pay the expenses of obtaining the income since such amounts are not income. See S0830.100.

B. Kinds of Withholding

Some items for which amounts may be withheld but considered received are:

- Federal, State, or local income taxes;
- health or life insurance premiums;
- SMI premiums;
- union dues;
- penalty deductions for failure to report changes;
- loan payments;
- garnishments;
- child support payments (court ordered or voluntary (exception-deemors));
- service fees charged on interest-bearing checking accounts;
- inheritance taxes;
- guardianship fees if presence of a guardian is not a requirement for receiving the income (see S0830.100).

C. Procedure

Use documents in the individual's possession or contact the source of the payment to verify the amount withheld. Add the amount withheld to the amount received and consider the total as unearned income from that source.

D. Reference

Overpayment involved, S0830.110

S0830.115 GARNISHMENT OR OTHER WITHHOLDING

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- purely voluntary;
- to repay a debt; or
- to meet a legal obligation.

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- SMI premiums;
- union dues;
- penalty deductions for failure to report changes;
- loan payments;
- garnishments;
- child support payments (court ordered or voluntary (exception-deemors));
- service fees charged on interest-bearing checking accounts;
- inheritance taxes;
- guardianship fees if presence of a guardian is not a requirement for receiving the income (see S0830.100).

C. Procedure

Use documents in the individual's possession or contact the source of the payment to verify the amount withheld. Add the amount withheld to the amount received and consider the total as unearned income from that source.

D. Reference

Overpayment involved, S0830.110

BROAD CATEGORIES OF UNEARNED INCOME

S0830.160 ANNUITIES, PENSIONS, RETIREMENT, OR DISABILITY PAYMENTS

A. Definitions

1. Annuity

An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer. *For Medicaid purposes, an annuity is a contract reflecting payment to an insurance company, bank or other registered or licensed entity by which one receives fixed, non variable payments on an investment for a lifetime or a specified number of years. Payments received from an annuity are counted as unearned income.*

2. Pensions and Retirement Benefits

Pensions and retirement benefits are payments to a worker following his retirement from employment. These payments may be paid directly by a former employer, by a trust fund, an insurance company, or other entity.

3. Disability Benefits

Disability benefits are payments made because of injury or other disability.

B. Policy

1. General Rule

Annuities, pensions, retirement, and disability benefits are unearned income.

2. Exceptions

Certain accident disability benefit paid within the first 6 months after the month an employee last worked are earned income. For a further explanation of sickness and accident disability payments, see S0820.005.

A Qualified Domestic Relations Order (QDRO) is a court order, usually the result of a divorce or separation proceeding that changes the ownership of the pension asset and the income stream from one individual to another. To be valid, a QDRO must:1) be a decree issued by a state court; 2) provide the names and addresses of participants and the amount or percentage of the benefit; and 3) be approved by the pension plan administration.

When a QDRO splits the income between a Medicaid applicant/recipient and the spouse, count only the income that is ordered to go to the Medicaid applicant/recipient as his income. If the plan administrator has not approved the QDRO or disapproved it, the income should be calculated without regard to the court order.

C. List of Payments

The following provides a list of instructions which address particular payments:

Black Lung Benefits..... S0830.215
Foreign Payments..... S0830.105
German Reparations Payments S0830.710
Military Pensions S0830.240
Office of Personnel Management (Civil Service and
Federal Employment Retirement System) Payments..... S0830.220
Railroad Retirement Payments..... S0830.225
Title II Payments S0830.210
VA Payments S0830.300
Worker's Compensation Payments S0830.235

D. Procedure

1. Initial Applications

In initial applications, be alert for clues which may indicate a receipt of or potential eligibility for an annuity, pension, or similar payment; e.g., long employment with a particular industry or a government agency, military service, membership in a union.

2. Check Specific Instructions

Check for specific policy instructions pertaining to the payment involved. (See C. above.)

3. Overpayment Question

Ask if any benefits otherwise due are being withheld to recover an overpayment. If the answer is yes, see S0830.110.

4. Verification/ General

If there are no specific policy instructions for the payment, use award letters or other documentation in the individual's possession or contact the source to verify:

- the type, source, and amount of payment;
- if necessary, the frequency of payment.

5. Verification/ Frequency

It is not necessary to verify the frequency of the payment if you are familiar with the type of payment involved either through direct experience or a precedent.

6. Verification/ Use of Check

If the individual does not possess an award letter or other document, a **check** may be used to verify the payment amount if it is clear that the amount shown represents the gross amount.

7. Contact with the Source

If the individual has no evidence in his/her possession, contact the source of the payment.

E. References

Determining the amount of unearned income, S0830.100

Contributions by an employer into a retirement fund, S0815.600

Retirement funds as resources, S1120.210 E.

S0830.165 ASSISTANCE PROGRAMS WITH GOVERNMENTAL INVOLVEMENT -- GENERAL

A. Introduction

Federal, State, and local governments are involved in a number of programs which provide assistance (cash or in-kind goods and services) to Medicaid recipients. For Medicaid purposes, treatment of this assistance will vary depending on the nature of the program and the payment. Sections S0830.170, S0830.175 and S0830.180 provide guidelines for determining the nature of these programs and the income, if any, to count when program specific instructions do not exist elsewhere. A guide is provided in B. below.

B. Programs-Specific Instructions

Use this table to locate specific instructions pertaining to frequently encountered programs with governmental involvement.

Adoption assistance S0830.415
Action Programs S0830.610
Aid to Families with Dependent Children (AFDC) S0830.400
Bureau of Indian Affairs General Assistance (BIAGA) ... S0830.800
Community Services Block Grant S0830.615
Community Work Experience Program (CWEP) S0830.185
Cuban/Haitian Entrant Cash Assistance S0830.645
Disaster Assistance S0830.620
Educational Assistance S0830.450
Emergency Assistance Under Title IV A S0830.405
Federal Emergency Management Agency (FEMA) S0830.625
Food Stamps S0830.635
Foster Care S0830.410
Foster Grandparents Program S0830.610
General Assistance, Home, Relief, etc. S0830.175
Housing Assistance S0830.630
Job Training Partnership Act (JTPA) S0830.535
Low Income Home Energy Assistance Program (LIHEAP) S0830.600
Older Americans Act S0830.640
Refugee Cash Assistance S0830.645
Refugee Reception and Placement Grants S0830.650
Refugee Matching Grants S0830.650
Rehabilitation Act of 1973 ..... S0815.050
Relocation Assistance S0830.655
School Lunches S0830.635
Social Service Block Grant (Title XX) S0815.050
State Assistance Based on Need S0830.175
VA Benefits S0830.300
Work Relied (Workfare) Programs.. ..... S0830.185

S0830.170 INCOME BASED ON NEED (IBON)

A. Definition

Income based on need (IBON) is assistance:

1. provided under a program which uses income as a factor of eligibility; and

2. funded wholly or partially by the Federal government or a nongovernmental agency (e.g., Catholic Charities or the Salvation Army) for the purpose of meeting basic needs (i.e., the funds are provided specifically for a formalized program whose general purpose is similar to that of the SSI program).

EXCEPTION: State supplementary payments made to refugees are not IBON (S0830.175), despite involvement of Federal funds.

B. Policy Principle

Income based on need is counted as income dollar for dollar, unless it is totally excluded by statute (e.g., food stamps) or excluded under a PASS (S0810.430.). The $20 general income exclusion (S0810.420) does not apply to IBON.

NOTE: If a nongovernmental agency is involved, consider whether the assistance qualifies for exclusion as Home Energy Assistance and Support and Maintenance Assistance (HEA/SMA, S0830.605) or meets the definition of a social service (S0815.050).

C. Operating Procedures

NOTE: These instructions apply when there are no separate instructions pertaining specifically to the program in question.

1. Verify with the administering agency personnel and/or program descriptions that the assistance meets the definition of income based on need.

2. Verify the amount of the assistance for each month with the administering agency or through documents in the individual's possession.

3. If income based on need is paid to or on behalf of a group of people, determine one individual's income by the incremental method (i.e., the individual's income is the difference between the amount paid and the amount which would have been paid had the individual not been included).

S0830.175 ASSISTANCE BASED ON NEED (ABON)

A. Definitions

ABON is assistance:

1. Assistance Based on Need (ABON)

- provided under a program which uses income as a factor of **eligibility**; and
- funded **wholly** by a State (including the District of Columbia, Indian tribes and the Northern Mariana Islands), a political subdivision of a State, or a combination of such jurisdictions.

EXCEPTIONS: State supplementary payments, made to refugees are considered to be ABON even if the Federal government reimburses the State.

NOTE: If a program uses income to determine payment amount but not eligibility, it is not ABON (e.g., some crime victims compensation programs).

2. Federal Funds

For purposes of this section, Federal funds means monies supplied and directed by the Federal government for a specific use or specific type of program (e.g., community service block grants, Federal matching funds for AFDC). Monies not allocated for specific purposes are not considered Federal funds.

EXAMPLES: Nonspecific Funding

Revenue sharing funds are not "Federal funds" for purposes of this section and programs using these funds are considered wholly Sate funded.

B. Policy

Assistance based on need is excluded from income.

C. Procedure

1. Precedent Exists

If a precedent exists:

- **Accept** the claimant's **allegation** as to the type and source of assistance and exclude it without further development.
- **Document** the file to show that a precedent exists **only** if you use a local precedent.

2. No Precedent Exists

If a precedent does not exist:

- Use **documents** in the individual's possession or contact the administering agency to **determine** the program under which the assistance is provided.
- **Verify** with agency personnel and/or program descriptions that no

Federal or private funds are involved and that the program uses income in arriving at eligibility determinations.

- **Retain** the evidence (either written material or oral statements documented).

NOTE: If evidence establishes that the assistance is excludable under this provision, it is not necessary to verify the amount of assistance and when it was received.

- **Document the file** with copies of the original evidence, or mention that a local precedent exists.

D. References

Income based on need, S0830.170.

S0830.180 OTHER ASSISTANCE INVOLVING GOVERNMENT FUNDS

A. Policy Principle

Assistance which is neither IBON nor ABON, but which involves government funds, is subject to the general rules pertaining to income and income exclusions.

NOTE: See section S0830.625, S0830.615 and S0830.405 for examples of this type of assistance.

B. Operating Procedures

1. Determine that the assistance is neither IBON (S0830.170) nor ABON (S0830.175). Remember:

   a. assistance involving Federal funds which are not provided by the Federal government for the purpose of meeting ongoing basic needs is not IBON;

   b. State supplementary payments, including those made to refugees, are always ABON; and

   c. assistance involving funds which have been supplied and directed by the Federal government for use solely in the type of assistance provided is not ABON.

2. Determine the nature of the assistance and apply the appropriate operating instructions pertaining to income and income exclusions. Related sections include:

   S0815.050 (Medical and Social Services)
   S0810.420 ($20 General Income Exclusion)
   S0830.605 (Home Energy Assistance and Support and Maintenance Assistance)

S0830.185 WORK RELIEF (WORKFARE) PROGRAMS

A. Background

Many governmental assistance programs require that certain recipients work in exchange for the assistance provided. Most often the amount of the assistance payment is divided by the minimum wage and the recipient required to perform some service for the resulting number of hours. Usually a participant in such a work program is given money to cover any expenses incurred (e.g., carfare, special clothing, miscellaneous, etc.). Programs connected with general assistance have various locally established names. Programs connected with AFDC include the Community Work Experience Program (CWEP), and the Work Incentive Program (WIN). Programs are often run as demonstrations or pilot projects.

B. Policy Principle

The fact that an individual is required to work in exchange for an income based on need (S0830.170) or assistance based on need (S0830.175) payment does not change the nature of the payment. For Medicaid purposes, the payment in such situations is an assistance payment and is not earned income.

NOTE: Do not confuse work supplementation programs connected with AFDC with programs which require an individual to work in exchange for income based on need. Work supplementation programs pay wages which are earned income. The family may or may not receive an AFDC payment in addition to the earned income.

C. Operating Procedures

1. Verify the assistance according to the appropriate instructions. Follow the instructions in S0830.170 if IBON is involved; S0830.175 if ABON is involved; S0830.400 if AFDC is involved.

2. Assume that any expense money provided in connection with a governmental work program equals the expenses incurred and does not result in any income. Verify with the paying agency or through documents in the individual's possession that any alleged expense money is provided as such. A precedent may be used. If a precedent has been established, document the file to show this.

MAJOR BENEFIT PROGRAMS

M0830.200 BENEFITS PAID UNDER TITLE XVI OF THE SOCIAL SECURITY ACT

A. Policy Principles

Supplemental Security Income (SSI) payments are monthly unearned income. SSI monthly payments and SSI lump sum payments are totally excluded when determining financial eligibility for Medicaid.

SSI recipients who meet the more restrictive Medicaid resource criteria are eligible for Medicaid as categorically needy.

S0830.210 BENEFITS PAID UNDER TITLE II OF THE SOCIAL SECURITY ACT

A. Policy Principles

1. Retirement, survivors, and disability insurance (RSDI) monthly benefits are unearned income. Special age 72 payments are also unearned income. (See S0830.545 for treatment of lump-sum death payments.)

2. The amount of premiums deducted for Supplementary Medical Insurance (SMI) under Medicare from RSDI benefits is included in unearned income.

3. Unearned income includes the amount withheld to recover an overpayment (unless the exception in S0830.110 applies).

B. Operating Policies

1. Reductions, Deductions, and Rounding

At different points in the computation process, the title II benefit, if not already an even dime amount, is rounded to the next lower dime. The final benefit payment is then rounded to the next lower dollar. Rounding does not apply to special age 72 (Prouty) payments or transitionally insured benefits. If a beneficiary is entitled to more than one benefit (dual or triple entitlement), each benefit is rounded to the next lower multiple of a dollar.

Count as income for Medicaid purposes the amount of title II after reductions, deductions, and dollar rounding, but before the collection of any obligations of the beneficiary (e.g., SMI premium or prior overpayment).

If a monthly benefit payment has been reduced because of a workers' compensation offset, count the net amount of the benefit received (plus any SMI premium withheld) as unearned income.

2. Prior Overpayment

If all or part of a title II benefit is being withheld to recover an overpayment, count as income the amount of title II before deduction for the overpayment unless the exception in S0830.110 applies. If the exception applies (i.e., the overpayment occurred when the individual was receiving Medicaid and the overpaid amount was included in unearned income at that time), do not include the amount deducted for an overpayment in calculating countable title II income. Also do not count as income monies received as a result of a waiver approval when the money was previously withheld to recover a title II overpayment and was counted as income for Medicaid when originally withheld.

3. SMI Premiums

Do no count refunded SMI premiums as unearned income.

EXAMPLE: An individual's title II benefits for January 1987 through May 1987 are withheld because of expected work and earnings. He reports in June 1987 that he quit working in February 1987. He paid

SMI premiums for January - March 1987, April - June 1987, and July - September 1987. A title II check sent in July 1987 includes full benefits for January - June 1987 and refunds SMI premiums for August - September 1987, which will be withheld from future checks. For Medicaid purposes, the part of the check which represents full benefits for January - June 1987 is unearned income in July 1987 and the refunded SMI premiums for August - September 1987 are not income.

4. Retroactive State Buy-In

When a State "buys-in" for Medicare on behalf of an individual, a different amount of title II income may be posted because of the title II rounding provisions.

5. Underpay-ments

Title II benefits can be received in regular monthly checks (or by direct deposit) or in retroactive payments. If an individual receives a check because of an underpayment, charge the amount of the check (plus any SMI premiums withheld) as unearned income in the month received; do no look back and allocate an underpayment being made in the current month to prior months. See S0830.010 B. on counting retroactive RSDI benefits for an offset period. See S1120.022 for the treatment of reissued title II monies in change-of-payee situations.

6. Facility of Payment Provisions

When a title II auxiliary or survivor beneficiary who is subject to work deductions receives title II benefits in his name because of the facility (something that makes an operation or action easier) of payment provisions but the benefits are those of other beneficiaries, the amount of title II benefits of each of the involved beneficiaries must be determined separately. Count the benefits as income to the appropriate beneficiaries.

M0830.211 SPECIAL EXCLUSION OF TITLE II COLA FOR ABD MI

A. Policy

The cost-of-living adjustment (COLA) in the individual's Social Security Title II benefit is excluded through the month following the month in which the new federal poverty limits (FPLs) are published when determining the income eligibility of an individual in the following ABD medically indigent (MI) covered groups:

- Qualified Medicare Beneficiary (QMB
- Special Low-income Medicare Beneficiary (SLMB),
- Qualified Individual Group 1 (QI-1),
- Qualified Individual Group 2 (QI-2), or
- *ABD with Income ≤ 80% FPL (ABD 80% FPL).*

B. Procedure

Exclude the COLA in the individual's SSA Title II benefit until the first day of the second month following the publication month of the new FPL. Local agency staff are notified of the FPL publication via the Department of Social Services' Central Office broadcast system

C. Example

A QMB-only Medicaid recipient who receives SSA Title II benefits receives a COLA in the benefit amount received in January 1998. The worker does not take any action on this change in income until the

broadcast system notifies the worker of the new FPLs and their publication month. On March 26,1998, a broadcast is sent which indicates that the FPLs were published on March 9,1998. The worker recalculates the recipient's income for May 1, 1998 based on the recipient's increased Title II benefit and the new QMB income limit which was effective May 1, 1998.

S0830.215 BLACK LUNG BENEFITS

A. Introduction

1. Types of Black Lung Benefits

Black Lung (BL) benefits are paid to miners and their survivors under the provisions of the Federal Mine Safety and Health Act (FMSHA).

Benefits under **Part B** of the FMSHA are paid by the **Social Security Administration** (SSA) and benefits under **Part C** of the FMSHA are paid by the **Department of Labor** (DOL).

2. Payment Dates

In general, Part B benefits are paid on the third of the month while Part C benefits are paid on the fifteenth of the month.

3. Reduction of BL Benefits

Both Part B and Part C BL benefits are subject to offsets (e.g., workers' compensation) and can be reduced due to the recovery of an overpayment. In addition, Part C benefits may be reduced because of liens imposed by other Federal agencies (such as the Internal Revenue Service).

B. Policy

1. Unearned Income

BL benefit payments are unearned income.

2. Deductions

The amount deducted from a Part C BL benefit because of garnishment (e.g., liens imposed by other Federal agencies) is unearned income (see S0830.115). (See 0830.110 if an overpayment is involved.)

3. Countable BL Income

The amount of the BL benefit to count as income is the amount paid after application of an offset (i.e., workers compensation offset or work deductions) but before the collection of any obligations of the recipient (unless the exception in S0830.110 applies).

C. Procedure Part B

a. **Verify the receipt of Part B BL benefits**

You may use the individual's award notice or actual check.

b. Use the monthly payment amount **(MPA)** in the PAYMENT section of the Maximum Benefit Rate **(MBR) to calculate BL income**.

NOTE: The MPA is the amount paid to the individual after deduction for an offset or collection of an overpayment.

c. **Document the file** so that it is clear how countable BL income was determined.

D. Procedure Part C

a. **Verify the receipt of Part C BL benefits** with the individual's own records (such as an award notice or check), if available.

b. **Call the appropriate DOL office** if information from the applicant/recipient is unavailable or incomplete. DOL can also resolve questions about overpayments or liens.

c. **Calculate the amount of countable BL income** from the actual payment amount.

d. **Document the file** so that it is clear how countable BL income has been determined.

S0830.220 OFFICE OF PERSONNEL MANAGEMENT (CIVIL SERVICE AND FEDERAL EMPLOYEE RETIREMENT SYSTEM) PAYMENTS

A. Introduction

1. General

The Office of Personnel Management (OPM) makes U.S. Civil Service and Federal Employee Retirement System (FERS) payments because of disability, retirement, or death.

2. Annuitants Retired Before July 1, 1960

OPM provides annuitants under the Retired Health Benefits (RHB) program free coverage under Part B of Medicare. At the employee's option, the Part B premium may instead be paid to another health insurance plan or paid directly to the annuitant for use in purchasing health insurance coverage privately. All annuitants covered by the RHB program retired before July 1, 1960.

B. Policy

1. General Rule

U.S. Civil Service and FERS payments are **unearned income** to the entitled retiree or individual survivor.

2. Certain Disability Benefits

Certain disability benefits paid within the first 6 months after an employee last worked are earned income.

NOTE: For an explanation of benefits falling under this exception, see S0820.005.

3. Retired Health Benefit (RHB) Payments

RHB payments to annuitants are **not** income.

NOTE: An RHB payment is shown as a **positive** amount on the health benefits line of the OPM notice.

C. Procedure

1. Overpayment Question

Ask if any benefits otherwise due are being withheld to recover an overpayment. If the answer is "yes," see S0830.110.

2. Use Documents Other Than a Check

Use notices or other documents in the individual's possession (other than a check) to verify the **gross amount** of the payment.

3. Do Not Use Check Alone

Do not use a check alone to verify the amount of the payment because a check is not reliable evidence of the gross amount.

4. Contact with OPM

If the individual has no acceptable documents, write or telephone OPM. Provide the individual's name and civil service annuity claim identification number (a seven-digit number with a "CSA" or "CSF" prefix). If the claim number is not available, provide the individual's date of birth and Social Security number.

The OPM telephone number is (888) 767-6738. Direct written inquiries to:

U.S. Office Personnel Management
Retirement Operations Center
P.O. Box 45
Boyers, PA 16017

S0830.225 RAILROAD RETIREMENT PAYMENTS

A. Introduction

1. Categories of Payment

There are three basic categories of payments made by the Railroad Retirement Board (RRB):

- Life and survivor annuities
- Social Security benefits certified RRB
- Unemployment, sickness, and strike benefits

2. Life and Survivor Annuities

- Life annuities for retirement and disability are paid under the Railroad Retirement (RR) Act to the railroad employee and his/her spouse. Children of a living annuitant are not entitled to benefits.
- Survivor annuities are payable to widows, widowers, children, and dependent parents of railroad employees. A small number of widows receive two annuities, a regular widow's check and a check payable to them as designated survivors of retired railroad employees who elected to receive reduced benefits during their lifetimes.
- RR annuity payments are similar to Title II benefits in that a check for one month is paid the next month. Also, cost of living adjustments (COLA) for RR annuities are effective the same month as Title II COLA's.

3. Social Security Benefits Certified by RRB

SSA may authorize the payment of Social Security benefits for RR employees to RRB instead of directly to Treasury. In these situations, RRB *is* responsible for certifying Title II benefits to Treasury, *but* they remain Title II benefits.

RR benefits are not necessarily Title II benefits. Individuals entitled to this type of benefit receive two award notices. The first notice, from SSA, informs the beneficiary that RRB has responsibility for making Social Security payments. The final notice, from RRB, specifies the amount of the first check.

RR annuity payments and Social Security benefits certified by RRB may be paid as a single check. In these cases, RRB may issue an interim notice before the final notice which specifies the amount of the first check.

4. Unemployment Sickness, and Strike Benefits

Unemployment, sickness, and strike benefits are computed on a daily basis with each check covering a period of up to 2 weeks. These claims are usually filed through the railroad employer or directly with RRB in Chicago.

B. Policy

1. Unearned Income

Payments made by the RRB are unearned income**.**

2. Reduction of RR Benefits

The amount deducted from a RR benefit for supplementary medical insurance (SMI) premiums is unearned income. See S0830.110 if an overpayment is involved.

3. Countable RR Income

The amount of the RR annuity to count as income is the amount before the collection of any obligations of the annuitant (unless the exception in S0830.110 applies).

C. Procedure - Life and Survivor Annuities

1. General Development -- All Cases

a. Be alert to the possibility of the receipt of, or potential entitlement to, RR benefits in every case where:

- the individual's social security number begins with a "7"
- the individual alleges or other evidence indicates railroad employment by the individual or his/her spouse.

b. Verify allegations of receipt of RR annuities by obtaining a copy of the individual's most recent award notice.

c. If the notice is unavailable**,** record in the file the information from the individual's next check.

NOTE: RR checks bear beneficiary symbols that identify the type of RR benefit involved.

D. Procedure for Social Security Benefits Certified By RRB

The applicant should have notices issued by SSA and RRB indicating that the benefit is a Title II benefit. If Title II status cannot be determined from the available documents, verify with the RRB that RR benefits are Title II benefits.

E. Procedure - Unemployment, Sickness, and Strike Benefits

Obtain evidence of unemployment, sickness, and strike benefits from the individual's own records, such as an award letter or actual check. If this evidence is unavailable, contact the RRB headquarters by telephone *toll-free at 1-877-772-5772* or by mail at:

Railroad Retirement Board
844 North Rush Street
Chicago, IL 60611-2092

Local RRB offices do not maintain this information.

M0830.230 UNEMPLOYMENT COMPENSATION BENEFITS

A. Definition

Unemployment Compensation payments are received under a State or Federal unemployment law and additional amounts paid by unions or employers as unemployment benefits.

B. Procedures

1. General Procedures

Unemployment Compensation benefits are counted as unearned income

2. Special $25 Weekly Exclusion

The American Recovery and Reinvestment Act of 2009 (P.L. 111-5) authorized *increased* payments, *called Federal Additional Compensation (FAC), of $25.00 per week* to certain individuals receiving Unemployment Compensation payments. *FAC* increased payments *are* authorized for Unemployment Compensation payments made through *December 4, 2010, provided that the initial claim for compensation was filed on or before May 23, 2010. Claims filed after May 23, 2010 are not subject to the increased payments.*

The individual's entitlement to Unemployment Compensation is not affected—the individual will only receive the number of payments to which the individual would normally be entitled.

FAC increased payments are excluded from countable income. If the individual's Unemployment Compensation claim was filed on or before May 23, 2010, exclude the first $25.00 of Unemployment Compensation for payments made through December 4, 2010.

If the claim was filed after May 23, 2010, the individual does not receive the additional weekly $25.00. DO NOT exclude the FAC payments from countable income.

S0830.235 WORKERS' COMPENSATION

A. Introduction

Workers' compensation (WC) payments are awarded to an injured employee or his/her survivor(s) under Federal and State WC laws, such as the Longshoremen and Harbor Workers' Compensation Act. The payments may be made by a Federal or State agency, an insurance company, or an employer.

B. Policy

1. Income

a. General

The WC payment less any expenses incurred in getting the payment is unearned income.

b. Amounts Designated for Expenses by Authorizing or Paying Agency

Any portion of a WC award payment **that the authorizing or paying agency designates** for medical expenses or legal or other expenses attributable to obtaining the WC award is not income (S0830.100). The expenses may be **past, current,** or **future**. The WC payments designated for such expenses may be received in a lump sum or as a continuing payment.

c. Other Amounts Claimed for Expenses

If an individual alleges having incurred expenses that exceed amounts designated for expenses as in b. above, or for which no amount was designated, the normal rules pertaining to the expenses of obtaining income apply (see S0830.100).

2. Resources

There is no resource exclusion that applies specifically to WC payments that have been deducted from income under b. or c. above. Normal resource rules apply to WC payments retained after the month of receipt.

C. Procedure

1. Checking for Possible WC Overpayment Withholding

Ask if any WC benefits are being withheld to recover an overpayment. If yes, see S0830.110.

2. Verifying WC Payments

If possible, use an award notice to verify WC payments. If such a notice is not available, obtain information from the Federal or State agency, insurance company, or employer. (The address of the local Federal Employee's Compensation agency or the State Workers' Compensation Office should be in the local phone directory.)

3. Verifying Amounts Designated by Authorizing or Paying Agency

If the WC award notice includes monies designated for expenses listed in B.1.b. above, but does not specify the amount designated, contact the paying agency (i.e., the Federal or State agency, insurance company, or employer) to verify the amount of the WC award that is designated for such expenses.

4. Verifying Other Amounts Claimed for Expenses

Follow the instructions in S0830.100 C. to verify expenses that exceed the designated amounts or for which no amounts are designated.

D. References

- Expenses of obtaining income, S0830.100.
- General resource rules, S1110.001.
- Liquid resources, S1110.300.

S0830.240 MILITARY PENSIONS

A. Introduction

1. General

The Air Force, Army, Marine Corps, and Navy pay military pensions to military retirees and survivors normally on the first day of the month.

2. Categories of Beneficiaries

There are three categories of beneficiaries who may be entitled to military payments:

- **RETIREE** - A person with 20 years of service who meets the requirement for entitlement;
- **ANNUITANT** - A survivor who is designated by the retiree to receive benefits upon the death of the retiree under the Retired Serviceman's Family Protection Plan **(RSFPP)**, Survivor's Benefit Plan **(SBP)**, or both;
- **ALLOTTEE** - Anyone other than an annuitant of the RSFPP or SBP who is designated to receive money out of the service member's or retiree's check. Entitlement as an allottee terminates upon the death of the retiree. However, an allottee can become an annuitant when the retiree dies.

3. Types of Annuitants

The RSFPP and SBP annuitant programs pay money to surviving spouse(s) and children.

The SBP program also pays:

- "Insurable interest" person: i.e., someone other than a surviving spouse or child that a service member designated to receive survivor benefits based on monies withheld from his or her retirement payment under the provisions of the SBP program; and
- Minimum income level widows (MIW) who are certified by the VA as having low income and are referred by the Department of Defense (DOD).

B. Policy

1. Basic Policy

Military pensions are unearned income.

Payments to MIW's are income based on need not subject to the $20 general income exclusion.

2. Income Exclusion - SBP

Any portion of a retiree's pension that is withheld as a contribution to participate in the SBP is excluded from income. To participate in SBP in conjunction with their retirement, military members must elect to receive reduced retirement pay for their lifetime so that a percentage of their

retirement pay can continue to be paid to their survivors following their death. Once SBP is elected, retirees cannot discontinue the deductions from their pensions.

C. Procedure

1. General

Obtain evidence from the individual's own records, if available. If the individual does not have sufficient evidence, contact the appropriate Military Finance Center as shown in 2. below.

2. Contacting the Military Finance Centers

a. If information must be requested from a Military Finance Center, send a request with the individual's authorization to release the information.

b. Include the following information on the request form:

- The service member's given name, middle initial and surname;
- The service member's service identification number (if available);
- The service member's SSN;
- The annuitant's or allottee's name; and
- The annuitant's or allottee's SSN.

c. **Specify the period** for which payment information is needed and identify the pay plan (e.g., RSFPP, SBP).

d. The following is a listing of the mailing address for each Military Finance Center.

Military Service Branch	Military Finance Center Mailing Addresses
ARMY	USAFAC Director, Retired Operations Indianapolis, IN 46249 ATTN: Management Support Office
NAVY	Defense Finance Accounting Service Code 305 Navy Finance Center Anthony J. Celebrezze Building Cleveland, OH 44199
AIR FORCE	DFAF/DE/CIDM Denver, CO 80279-5000
MARINE CORPS	Marine Corps Finance Center 1500 E. Bannister Street Kansas City, MO 64197

D. References

- Income based on need, S0830.170

DEPARTMENT OF VETERANS AFFAIRS PAYMENTS

S0830.300 DEPARTMENT OF VETERANS AFFAIRS PAYMENTS

A. Introduction

The Department of Veterans Affairs (VA) has numerous programs which make payments to Medicaid recipients and their families. For Medicaid purposes, treatment of those VA payments depends on the nature of the payments. The most common types of VA payments are explained in the following sections:

- PENSION - S0830.302
- COMPENSATION - S0830.304
- EDUCATIONAL ASSISTANCE - S0830.306
- AID AND ATTENDANCE ALLOWANCE - S0830.308
- HOUSEBOUND ALLOWANCE - S0830.308
- CLOTHING ALLOWANCE - S0830.310
- PAYMENT ADJUSTMENT FOR UNUSUAL MEDICAL EXPENSES - S0830.312
- INSURANCE PAYMENTS - S0830.160 (for disability insurance) and S0830.545 (for life insurance).

B. Procedure

Explore the possibility of receipt of, or potential eligibility for, a VA payment, whenever it comes to your attention that an applicant or recipient is:

- a veteran;
- the child or spouse of a disabled or deceased service person or veteran;
- an unmarried widow or widower of a deceased service person or veteran;
- the parent of a service person or veteran who died before January 1, 1957 from a service connected cause.

NOTE: Eligibility for Other Program Benefits: The Social Security Act requires that an applicant or recipient who is potentially eligible for some VA benefits must apply for those benefits.

S0830.302 VA PENSION PAYMENTS

A. Introduction

1. Basis for Payments

Pension payments are based on a combination of service and a nonservice-connected disability or death. With a few rare exceptions noted below, VA pension payments are also based on need.

2. Payments for Dependents

VA may take dependents' needs into account in determining a pension. However, normally VA will not make a pension payments directly to a dependent during the lifetime of the veteran. Instead, the amount of the veteran's basic pension is increased if the veteran has dependents.

A VA pension payment that has been increased for dependents is an augmented VA payment. A VA pension payment made directly to the dependent of a living veteran is an apportioned payment. (See S0830.314 for a discussion of augmented and apportioned payments.)

3. Frequency

Pension payments are usually paid monthly; however, when the monthly payment due is less than $19, VA will pay quarterly, biannually or annually. VA may also make an extra payment if an underpayment is due.

4. Unusual Medical Expenses

When computing some needs-based pension payments, VA deducts unusual medical expenses from any countable income. This computation may result in an increase in a pension payment or in an extra payment. **An increase or extra payment resulting from this computation is not income**. (See S0830.312 for a discussion of VA payments resulting from unusual medical expenses.)

B. Policy

1. Basic Policy -- Needs - Based

All VA pension payments except those listed in 2. below are federally funded income based on need. As such, these payments are unearned income to which the $20 general income exclusion does not apply.

2. Policy Exceptions

a. Pension Payments Resulting from Aid and Attendance or Housebound Allowances

VA aid and attendance housebound allowances are not income. (See S0830.308.) All or part of a VA pension may be subject to this rule.

b. Pension Payments Resulting from Unusual Medical Expenses

VA payments resulting from unusual medical expenses are not income. (See S0830.312.) All or part of a VA pension payment may be subject to this rule.

c. Pensions Not Based on Need

Certain pensions paid to veterans or their dependents are not needs based. These pensions are unearned income and the $20 general exclusion (S0810.420) applies. This exception applies to pensions paid on the basis of:

- a Medal of Honor; or
- a special act of Congress.

3. Assumption

Assume that a VA pension is partly or entirely needs based unless there is evidence to the contrary.

C. Procedure

Follow the procedure below for developing and verifying VA pensions.

Step	Action
1	Screen for unusual medical expenses per S0830.312.
2	Develop for augmentation (per S0830.314) if dependents may be involved.
3	Screen for an aid and attendance or housebound allowance per S0830.308.
4	Are unusual medical expenses, augmentation, or an aid and attendance or housebound allowance at issue in the case? • If yes, go to Step 5. • If no, go to Step 6.
5	Verify the gross amount and frequency of payment. STOP.
6	Verify the gross amount and frequency of payment using (in order of priority): • a VA award letter or comparable document in the individual's possession; • a benefit check in combination with a signed statement from the individual that provides the frequency of payment and affirms that VA makes no deductions (such as insurance premiums, loan payments, and overpayment deductions); or • Verification from VA Regional Office (VARO).

D. References

- Applying Income Rules, S0810.030.

S0830.304 VA COMPENSATION PAYMENTS

A. Introduction

1. Basis for Payments

Compensation payments are based on service-connected disability or death. VA compensation payments may also be based on need.

2. Payments for Dependents

VA may take dependents' needs into account in determining a compensation payment. Compensation payments may be paid directly to dependent parents on the basis of a service-connected death.

A VA compensation payment that has been increased for dependents is an augmented VA payment. A VA compensation payment made directly to the dependent of a living veteran is an apportioned payment. (See S0830.314 for a discussion of augmented and apportioned payments.)

3. Frequency

Compensation payments are paid monthly.

4. Unusual Medical Expenses

For needs-based compensation payments, VA may deduct unusual medical expenses from any countable income. (See S0830.312.)

B. Policy

1. Surviving Parent Compensation

Compensation payments to a surviving parent of a veteran are federally funded income based on need. As such, these payments are unearned income to which the $20 general income exclusion (S0810.420) does not apply.

EXCEPTIONS: Compensation payments resulting from unusual medical expenses, aid and attendance allowances, and housebound allowances are not income (S0830.308 and S0830.312). All or part of a VA compensation payments may be subject to this rule.

2. All Other Compensation

Compensation payments to a veteran, spouse, child, or widow(er) are unearned income subject to the $20 general income exclusion (S0810.420).

EXCEPTION: Any portion of a VA compensation payment that is a VA aid and attendance allowance or housebound allowance is not income. (See S0830.308.)

C. Procedure

- Follow the pension instructions in S0830.302 C.
- Do not screen for unusual medical expenses unless a needs-based payment is involved.

S0830.306 VA EDUCATIONAL BENEFITS

A. Introduction

VA provides educational assistance under a number of different programs including vocational rehabilitation. The Medicaid income and resource policies that apply depend on the nature of the VA program.

1. General Information

a. **Period of Eligibility**--Generally, veterans have 10 years after leaving the service to complete their education and 12 years after leaving the service to complete a program of vocational rehabilitation.

b. **Frequency of Payment** -- Payments are usually made monthly only for those months the veteran is in school. If school attendance is less than full time, the payments may be made less frequently.

c. **Other Eligibles** -- Dependents and survivors of veterans may also be eligible for educational benefits.

d. **"Contributory" Programs** --Some VA educational benefits are based on contributions by the veteran. That is, the veteran contributed to the educational fund while in the service and VA matches the money when the veteran withdraws it to pursue an education. The veteran also has the right to withdraw, as a lump sum, the funds he/she contributed.

2. Specific Educational Programs

a. **Chapter 30 (Active Duty Educational Assistance Program ("new" GI Bill))** --VA makes payments under this noncontributory program to veterans who:

- entered active service on or after July 1, 1985; or
- meet the qualification in 2 c. below, serve 3 years after June 30, 1985 and have had their military pay reduced for 12 months during their active service due to the individual participating in this program.

Payments under this program are not augmented for dependents if the veteran entered active service after June 30, 1985.

b. **Chapter 31 (Training and Rehabilitation for Veterans with Service Connected Disabilities)** --- VA pays benefits under this noncontributory vocational rehabilitation program to veterans who served in the military after August 1, 1940.

Chapter 31 benefits may be augmented for dependents.

c. **Chapter 32 (Veterans Educational Assistance Program (VEAP))** -- VA pays benefits under this contributory program to veterans who entered active service between January 1, 1977 and June 30, 1985.

The benefits are not augmented for dependents.

d. **Chapter 35 (Survivors and Dependents Educational Assistance Program)** -- VA makes payments under this noncontributory program to:

- children (between ages 18 and 26) and surviving spouses of veterans who died in the service; or
- children and spouses of living veterans who are 100 percent disabled due to a service-connected injury.

NOTE: Survivors and dependents have 10 years from the date of the veteran's service-connected death or date of 100 percent disability to participate in this program.

e. **Chapter 106 (Selected Reserve Program)**--VA pays benefits under this noncontributory program to reservists who have a 6-year commitment while they are in the reserves. Payments under this program are not augmented for dependents.

B. Policy

1. What is Not Income

a. **Vocational Rehabilitation** -- Payments made as part of a VA program of vocational rehabilitation are not income (S0815.050 C.). This includes any augmentation for dependents.

b. **Withdrawal of Contributions** -- Any portion of a VA educational benefit which is a withdrawal of the veteran's own contribution is conversion of a resource and is not income (S0815.200).

2. What is Income

VA educational benefits other than those in 1.a. and b. above are unearned income. However, any portion of a grant, scholarship, or fellowship used for paying tuition, fees, or other necessary educational expenses is excluded from income (S0830.455).

NOTE: The $20 general exclusion (S0810.420) applies to VA educational assistance and the payments are subject to deeming.

3. Augmented Benefits

The policy for augmented VA benefits as explained in S0830.314 applies to augmented educational benefits.

EXCEPTION: Subsistence allowances received during vocational rehabilitation may be augmented, but the dependent's portion is not income per 1.a. above.

Only that portion of an educational payment which is income to the individual obtaining the education is subject to the exclusion for educational expenses as described in S0830.455. The augmented portion which is income to the dependent is not subject to this exclusion.

C. Procedure

Accept the following, in the order listed, as documentation of type, amount, and frequency of payments:

1. Acceptable Evidence

a. A VA award letter or comparable document in the individual's possession; or
b. Verification from the VARO.

2. Noncontrib-utory/ Contributory Programs

a. ....**Service Began Prior to January 1, 1977 or After June 30, 1985** -- If there is evidence in file that the veteran's active service began prior to January 1, 1977 or after June 30, 1985, assume that the educational benefits are paid under a noncontributory program. (A signed statement from the veteran or the veteran's surviving spouse or child is sufficient evidence of service dates).

b. **Service Began Between January 1, 1977 and June 30, 1985** -- If there is evidence that the veteran's active duty service began between January 1, 1977 and June 30, 1985, assume that the educational benefits (other than Chapter 31 benefits) paid to a veteran are paid under a **contributory** program. (A signed statement from the veteran or the veteran's surviving spouse or child is sufficient evidence of service dates). Verify the portion of any VA educational benefit that is a withdrawal of the veteran's contributions to the fund.

Verify this information with the VARO and obtain the following information:

- For each periodic payment of educational benefits, provide the dollar amount representing a return of the veteran's own contribution.

S0830.308 VA AID AND ATTENDANCE AND HOUSEBOUND ALLOWANCES

A. Introduction

VA pays an allowance to veterans, spouses of disabled veterans, and surviving spouses who are in regular need of the aid and attendance of another person or who are housebound. This allowance is combined with the individual's pension or compensation payment.

B. Policy -- Income Treatment

- VA aid and attendance and housebound allowances are not income for Medicaid purposes. (See S0815.050 for rules on medical and social services payments.)

- If the veteran pays his/her own spouse or deemor to provide medical or social services, the payment is not income to the eligible spouse or deemor.

- If a veteran without a spouse or child or a surviving spouse without a child is covered by a Medicaid plan for services furnished him/her by a nursing facility, the maximum pension that can be paid to or for the veteran or surviving spouse for any month after the month of admission to such nursing facility is $90. This reduced pension is an aid and attendance allowance in all cases, and not income.

C. Policy -- Public Income Maintenance (PIM) Payments

A VA payment consisting entirely of an aid and attendance or housebound allowance is not a PIM payment for living arrangement and deeming purposes.

D. Procedure

Contact the VARO for verification of a pension or compensation payment amount whenever the veteran, spouse or a disabled veteran, or surviving spouse;

- alleges an aid and attendance or housebound allowance; or
- is housebound; or
- is blind; or
- is unable to dress or care for him/herself; or
- is a patient in a nursing home; or
- is single and severely and permanently disabled or otherwise appears to require the assistance of someone else on a day-to-day basis.

Do not use a VA check or award letter to verify the amount of income if an aid and attendance or housebound allowance is involved. (When the VARO provides the amount of the pension or compensation payment, they will not include a household or aid and attendance allowance). Do not ask the VARO about the amount of the aid and attendance or housebound allowance because this information is not needed.

S0830.310 VA CLOTHING ALLOWANCE

A. Introduction

A lump sum clothing allowance is payable in August of each year to a veteran with a service-connected disability for which a prosthetic or orthopedic appliance (including a wheelchair) is used. The allowance is intended to help defray the increased cost of clothing due to wear and tear caused by the use of such appliances.

B. Policy

A VA clothing allowance is not income (S0815.050, Medical and Social Services).

C. Procedure

Accept the individual's allegation concerning a VA clothing allowance. No further development is required

S0830.312 VA PAYMENT ADJUSTMENT FOR UNUSUAL MEDICAL EXPENSES

A. Introduction

VA considers unusual medical expenses when determining some needs-based pension and compensation payments (S0830.302 and S0830.304). Expenses which exceed 5 percent of the maximum annual VA payment rate are considered unusual. The amount of the unusual medical expenses is deducted from countable income when computing the VA payment. As a result, the veteran, survivor, or dependent may receive a higher monthly VA payment, an extra payment, or an increase in an extra payment.

B. Policy -- Income Treatment

1. Effective July 1, 1994

VA payments resulting from unusual medical expenses are not income.

2. Prior to July 1, 1994

Any VA increase or extra payment resulting from unusual medical expenses was income.

C. Policy -- Public Income Maintenance (PIM) Payments

If a VA payment to an individual is entirely attributable to unusual medical expenses, then it is not a public income maintenance (PIM) payment for living arrangement and deeming purposes.

D. Policy Resources

Any unspent VA payments resulting from unusual medical expenses are resources if retained into the calendar month following the month of receipt.

E. Procedure -- General

1. When to Consider

Consider the issue of unusual medical expenses in all cases involving a VA payment based on need. Develop the issue only if indicated in 2. and 3. below.

2 When Not to Develop

Do not routinely develop the issue of unusual medical expenses for an ineligible spouse or parent (unless you believe the payment may be entirely attributable to such expenses per C. above).

NOTE: If the payment is entirely attributable to unusual medical expenses, other income of an ineligible spouse or parent is subject to deeming.

3. When to Develop

Develop the issue of unusual medical expenses (unless precluded by 2. above) as indicated in the chart below.

SITUATION	INDIVIDUAL IS...	ACTION NEEDED
Medicaid application filed or VA benefits begin	veteran or widow	Develop per F. below.
	VA dependent	Develop per F. below only if you believe the expenses may affect the dependent's portion per F.7. below.
Redetermination or other income review	veteran or widow	Develop per F.3 below
	VA dependent	Develop per F. below only if you believe the expenses may affect the dependent's portion per F.7. below.

F. Procedure -- Development and Documentation

1. Examine Documents

If documents show that VA considered unusual medical expenses, go to F.3. below. If not, go to F.2. below.

2. Question the Individual

Question the individual following the steps below. You need not document responses.

STEP	ACTION
1	Did the individual or any member of his/her family report any income to VA? • If yes or unknown, go to Step 2. • If no, STOP. No further action is necessary.
2	Did VA ever notify the individual (or the VA claimant) that medical expenses were considered in the VA payment? • If yes, go to F.3. below. • If no, STOP. No further action is necessary. • If unknown, go to Step 3.
3	Has the individual (or the VA claimant) ever reported medical expenses to VA?

- If yes or unknown, go to F.3. below.
- If no, STOP. No further action is necessary.

3. Contact VA

Contact the VARO:

- See S0830.320 A. for VARO addresses.
- On verification form, complete only the identifying information for the applicant and the veteran unless you are requesting other information.
- Inquire what date payments due to unusual medical expenses began.

4. Unusual Medical Expenses Involved

If VA reports payments due to unusual medical expenses:

- deduct the amount from the total VA payment to determine countable income, and adjudicate the case.

NOTE: If payments due to unusual medical expenses exceed the amount attributable to the veteran/widow(er), see 5. below.

5. Unusual Medical Expenses and Augmentation Involved

If augmentation is involved (S0830.314):

- deduct the payments due to unusual medical expenses first from the veteran/widow(er)'s portion, and
- deduct any remaining amount from the dependent's portion.

NOTE: If more than one dependent is involved, prorate the remaining amount equally among the dependents

S0830.314 AUGMENTED VA BENEFITS

A. Introduction

The Department of Veterans Affairs (VA) often considers the existence of dependents when determining a veteran's or a veteran's surviving spouse's eligibility for pension, compensation, and educational benefits. If dependents are involved, the amount of the benefit may be larger.

B. Definitions

1. Absent Dependent

An absent dependent is a dependent who does not reside with the veteran or surviving spouse. Residency is determined as of the first moment of the month.

2. Apportionment

Apportionment is direct payment of VA benefits to a dependent. VA decides whether and how much to pay by apportionment on a case-by-case basis. Apportionment reduces the amount of the augmented benefit payable to the veteran or surviving spouse.

3. Augmented Benefit

An augmented benefit is a benefit that is increased, or which has higher income eligibility limits, because of a dependent. An augmented VA benefit, which for Medicaid purposes includes a designated beneficiary's portion and a dependent's portion, usually is issued as a single payment to the veteran or the veteran's surviving spouse.

4. Child

For purposes of this section, a child is a son or daughter (biological, adoptive, or by marriage) who is:

- under age 18, or
- age 18-22 (inclusive) and a student, or
- age 18 or older, and disabled since before age 18.

5. Dependent

For purposes of this section, a dependent is a veteran's child or spouse (other than a surviving spouse) who is or was dependent on the veteran for financial support, as determined by VA.

6. Dependent's Portion

The dependent's portion is that part of an augmented benefit that is attributable to the dependent.

7. Designated Beneficiary

A designated beneficiary is the veteran or surviving spouse who receives an augmented benefit.

8. Designated Beneficiary's Portion

The designated beneficiary's portion is that part of an augmented benefit that is attributable to the veteran or surviving spouse.

C. Policy

1. Apportioned Benefit

A benefit paid by apportionment (per B.2. above) is VA income to the dependent to who (or for whom) it is paid. It does not constitute a support payment from the designated beneficiary.

2. Designated Beneficiary's Portion

The designated beneficiary's portion is VA income to the designated beneficiary.

3. Dependent's Portion

The dependent's portion is VA income to the dependent, provided the dependent resides with the designated beneficiary. It does not constitute a support payment from the designated beneficiary.

4. Absent Dependent's Portion--Prior to 11/17/94

An absent dependent's portion of augmented benefit received by the designated beneficiary prior to November 17, 1994 was VA income to the absent dependent, unless VA had previously denied an application for apportionment. If apportionment had been denied, the absent dependent's portion, less any amount provided by the designated beneficiary to the absent dependent, was income to the designated beneficiary.

EXAMPLE:
Susan Baker, age 17, is an absent dependent whose application for apportionment has been denied. Her father, Joseph Baker, is also a Medicaid recipient. He receives an augmented monthly VA pension of $450 on the first of each month. He has no other dependents. During 1993, Mr. Baker sends Susan $25 per month. The VA regional office (VARO) verified that Susan's portion of the VA benefit is $50. $25 is child support payment for Susan ad $425 is income for Mr. Baker.

5. Absent Dependent's Portion--Effective 11/17/94

An absent dependent's portion of an augmented VA benefit, received by the designated beneficiary on or after November 17, 1994, is **not income** to **either** the dependent or the designated beneficiary. This is true even if the designated beneficiary continues to receive the absent dependent's portion. See C.6. below for the policy on payments made to an absent dependent by the designated beneficiary.

6. Other Payments to Absent Dependents--Effective 11/17/94

A payment from a designated beneficiary to an absent dependent on or after November 17, 1994 is not VA income to the absent dependent. It is a gift, a support payment, in-kind support and maintenance, or another kind of income, unless it is not income per SI 00815.001.

EXAMPLE: Robert Jones, age 17, and his father Raymond Jones are both Medicaid recipients who do not reside together. Mr. Jones' VA pension is $450 per month, which includes a portion for Robert as his only dependent. Mr. Jones sends Robert a money order for $25 per month. The $25 is child support for Robert. The EW verified that Mr. Jones' portion of the VA benefit is $400. The $400 is VA pension based on need for Mr. Jones.

D. Procedure--Initial Application and Posteligibility Development

Use this procedure to determine how to develop for augmentation in initial applications.

Step	Action
1	If the claimant is: • a VA beneficiary (veteran or veteran's surviving spouse), go to step 2. • a VA beneficiary (spouse or child paid by apportionment per B.2. above), go to step 5. • a VA beneficiary 's spouse or child who resides with the beneficiary, go to step 4. • a VA beneficiary's spouse or child who does not reside with the beneficiary, STOP. No income development is required.
2	Ask the applicant whether the benefit includes money for any dependents. If the answer is: • **yes,** go to step 4. • **unknown,** go to step 3. • **no,** go to step 5.
3	Does the applicant have a living spouse or child (including an adult child disabled since childhood)? • If **yes,** go to step 4. • If **no,** go to step 5.
4	Verify the VA income for each month in the period covered by the application.
5	Verify pension or compensation per S0830.302 C. step 6, and educational benefits per S0830.306 C. STOP.

E. References

- Gifts, S0830.520
- Support Payments, M0830.420

M0830.320 VA REGIONAL OFFICE

A. List of VA Regional Offices

This list shows the VARO mailing address for each geographic area:

STATE	ADDRESS
District of Columbia	941 North Capitol Street, NE. Washington, DC 20421
Virginia (all counties, except Fairfax, Arlington and the cities of Alexandria, Fairfax, and Falls Church which are under jurisdiction of the Washington, D.C. VA-RO)	210 Franklin Road, SW Roanoke, VA 24011

PAYMENTS FOR CHILDREN AND SPOUSES

M0830.400 AID TO FAMILIES WITH DEPENDENT CHILDREN (AFDC)

A. Definition

Aid to Families with Dependent Children (AFDC) is the program of payments made under Part A of Title IV of the Social Security Act except for section 406(e) of that part. (Payments under section 406(e) are emergency assistance payments and the applicable instructions appear at S0830.405.)

B. Introduction

AFDC makes a payment to a family unit rather than an individual. The payment is frequently referred to as the "grant". An individual who meets the eligibility requirements for both AFDC and SSI may choose the program under which he/she prefers to receive benefits. However, if the individual receives SSI, he/she may no longer be included in the AFDC grant.

S0830.405 EMERGENCY ASSISTANCE UNDER TITLE IV A OF THE SOCIAL SECURITY ACT

A. Background

Emergency Assistance under title IV A is provided for children, including families with children, by States and localities. Their expenditures are matched by the Federal government. Although Emergency Assistance is authorized by title IV A of the Social Security Act ("Aid to Families with Dependent Children"), it is a program separate from the income maintenance program commonly known as AFDC (S0830.400).

The Emergency Assistance Program is optional to the State. The assistance may be provided in cash or in kind and may be a loan. The assistance may include support and maintenance, social services or medical services. The program's purpose is to meet emergency or crisis needs, not ongoing basic needs, and assistance is limited to payments which are authorized during a period of 30 consecutive days in any 12-month period. Although there is an immediately available resource test for eligibility, an Emergency Assistance Program is not required to have an income test.

B. Policy Principle

Emergency Assistance is subject to the general rules pertaining to income and income exclusions. Emergency Assistance is neither IBON (S0830.170) nor ABON (S0830.175).

C. Operating Procedures

Determine the nature of the assistance and apply the appropriate operating instructions pertaining to income and income exclusions. Related sections include:

S0815.050 Medical and Social Services
S0815.350 and S1120.220. Loans
S0810.420 $20 General Income Exclusion
S1110.600.B.4. Replacement of a Resource

M0830.410 FOSTER CARE

A. Definitions

1. Foster Care

An individual is considered to be in foster care when:

- a public or private nonprofit agency places the individual under a specific placement program; and
- the placement is in a home or facility which is licensed or otherwise approved by the State to provide care; and
- the placing agency retains responsibility for continuing supervision of the need for such placement and the care provided.

NOTE: When determining the eligibility of a child in foster care refer to the Family & Children's Policy. This section (S0830.410) is to be used only when evaluating the eligibility of a provider of foster care when the provider is the applicant.

2. Foster Care Payment

For Medicaid purposes, a foster care payment is a payment made to the provider for the purpose of meeting the needs of the individual in foster care.

NOTE: An agency may make an additional payment to the foster care provider for his or her own use (e.g., an incentive or service payment not intended to support the child). While these two payments may be combined and termed the "foster care payment" by the issuing agency, only the part which is provided to meet the needs of the individual in care is the foster care payment for Medicaid purposes.

B. Policy

a. Foster Care Provider

- Foster care payments (as defined in A.2. above) are not income to the provider.
- Amounts paid to a provider of foster care in addition to the foster care payment are income to the provider.

C. Procedure

1. Foster Care Payments to Providers of Foster Care

a. **Assume that the payment made to the provider is a foster care payment** (i.e., is to meet the needs of the individual in care) and is not income to the provider, unless there is evidence to the contrary.

b. **If the provider is a Medicaid recipient or deemor and evidence indicates a payment includes additional monies above the foster care payment,** verify the purpose(s) of the payment and the amounts involved using documents in the individual's possession, or regional

precedents, or contact with the agency. Consider any payment in excess of the amount paid to meet the needs of the individual to be income to the care provider.

NOTE: This income is usually unearned income but may be earned income.

If the care provider is not self-employed and evidence indicates a payment was made for a specific service (e.g., $20 for shopping assistance), accept the care provider's signed allegation of any cost of providing the service (e.g., $5 automobile expense). Deduct the cost from the payment and consider the remainder to be unearned income.

E. References

- Forms and amounts of income, S0810.020.
- $20 general income exclusion, S0810.420.
- Medical and social services, S0815.050.
- Assistance based on need, S0830.175.
- Foster care payments made by the Bureau of Indian Affairs, S0830.810

S0830.415 ADOPTION ASSISTANCE

A. General

Adoption assistance programs provide payments and/or services for children for whom unassisted adoption is unlikely because of age, ethnic background, physical, mental or emotional disability, etc. The income of either the adopting parent, the adopted child, or both may have been considered in determining the payment. Usually, adoption assistance will be formalized in a written agreement between the adopting parents and the agency involved. Adoption assistance may be provided by public or private agencies and may be based on financial need.

Adoption assistance is provided by States under title IV-E of the Social Security Act involves Federal funds and is needs-based. Under IV-E, there is no income test for the adopting parents but the children must be those who are, or could be, eligible for AFDC or SSI prior to adoption. Therefore, there is an income test for the children who receive IV-E adoption assistance.

B. Policy Principles

1. Adoption Assistance Under Title IV-E

These individuals are eligible for Medicaid as Mandatory Categorically Needy. No further development is necessary. These individuals are automatically eligible. Refer to Family & Children's Policy.

M0830.420 SUPPORT PAYMENTS (CHILD SUPPORT, SPOUSAL SUPPORT, ALIMONY) --GENERAL

A. Policy

1. Definitions

Alimony and support payments are cash. In-kind contributions for food, clothing or shelter are not income. Support payments may be made voluntarily or because of a court order. Alimony (sometimes called "maintenance") is an allowance made by a court from the funds of one spouse to the other spouse in connection with a suit for separation or divorce.

2. Alimony, Spousal, and Other Adult Support

Alimony, spousal, and other adult support payments are unearned income.

3. Child Support Exclusion

Child support payments are unearned income *to the child. O*ne-third of the amount of a payment made to or for an eligible child by an absent parent *is excluded*. (See B. below for definition of an absent parent for purposes of this exclusion.)

4. Child Support on Behalf of an Adult Child

a. Current Child Support Received on Behalf of an Adult Child

Child support payments (excluding arrearages) received for an adult child by a parent after an adult child stops meeting the definition of a child are income to the adult child. The support payments are income to the adult child whether or not the adult child lives with the parent or receives any of the child support payment from the parent. Such support payments are not subject to the one-third exclusion.

b. Child Support Arrearages Received on Behalf of an Adult Child

When a parent receives a child support arrearage payment on behalf of an adult child:

- *Any amount of that payment that the parent receives and does not give to the adult child is income to the parent. The portion of the arrearage payment retained by the parent is not income to the adult child and does not affect the adult child's Medicaid eligibility.*
- *Any amount of that payment that the parent gives to the adult child is income to the adult child in the month given, not income to the parent.*
- *The one-third child support exclusion does not apply.*
- *When an adult child receives a child support arrearage payment directly from the absent parent, the arrearage payment is income to the adult child.*

B. Definition--Absent Parent

1. General

A parent is considered absent if the parent and the child do not reside in the same household. **NOTE:** There is no connection between the terms used in this subsection and the concept of "temporary absence" for deeming purposes.

a. If the periods of living together are brief and the child remains independent or under the care and control of another person, agency, institution, or is living in the home of another, the parent is usually considered absent unless he/she retains **parental responsibility and control.**

b. A parent is not considered absent if he is away due to **employment** (except for military service), intends to resume living with the child, and retains parental control and responsibility.

c. A child (or parent) who is a **boarding student** in an educational facility is not considered absent.

C. Procedure

1. Verification of Amount and Frequency

To verify the amount and frequency of support payments use:

court records;
records of an agency through which the payments are made;
documents in the individual's possession; or
contact with the source of the payment.

If this is not successful, accept the individual's notarized statement.

2. Relationship

Accept the individual's allegation of relationship of the payer to the payee unless you doubt the allegation.

3. One Payment for Two or More Individuals

In the case of one payment for two or more individuals:

a. To determine one individual's share of a support payment made for more than one person, **look first to the legal document** setting the payments.

b. **If the legal document** addresses each person's share, divide the payment according to the terms of the document. If the payment does not equal the established support amount, contact the source of the payment to establish intent and divide the payment according to that intent. If this is unsuccessful, divide the payment proportionately.

c. If **no legal document** exists or the document does not address shares, contact the source of the payment to establish intent and allocate the support according to that intent.

d. If this is not successful, accept the individual's **signed allegation** of who the support is for and how the support is divided. If the individual does not know how the support should be divided, divide the payment equally.

D. References Estimating income, S0810.600-.610

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EDUCATIONAL ASSISTANCE

S0830.450 GENERAL

A. Introduction

Educational assistance is provided in many forms. For Medicaid purposes, treatment will vary depending on the nature and sometimes the use of the assistance. Educational assistance may be earned or unearned income and may be counted or excluded, B. below provides a guide to specific educational assistance instructions and related sections.

B. References

1. Specific Instructions

The following sections address specific types of educational assistance:

- Department of Education or Bureau of Indian Affairs Involved S0830.460
- Tuition, Fees, and Other Expense Amount of Grants, Scholarships & Fellowships S0830.455
- VA Educational Benefits S0830.306

2. Related Instructions

The following sections contain related instructions:

- Student Child Earned Income Exclusion S0820.510
- Plan for Achieving Self-Support *S0810.430*
- Proceeds of a Loan S0815.350
- Earned Income S0820.001

S0830.455 TUITION, FEES AND OTHER EXPENSE AMOUNTS OF GRANTS, SCHOLARSHIPS, AND FELLOWSHIPS

A. Definition

1. Grant, Scholarship, or Fellowship

Grants, scholarships, and fellowships are amounts paid by private nonprofit agencies, the U.S. Government, instrumentalities or agencies of the U.S., State and local governments, foreign governments, and private concerns to enable qualified individuals to further their education and training by scholastic or research work, etc.

2. Not a Grant, Scholarship, or Fellowship

a. Any amount provided by an individual to aid a relative, friend, or other individual in pursuing his studies where the grantor is motivated by family or philanthropic considerations is a **gift** and is not a grant, scholarship, or fellowship for purposes of this section.

b. Any amount which is **earned income** is not a grant, scholarship, or fellowship.

B. Policy

1. Exclusion

Any portion of a grant, scholarship, or fellowship used for paying tuition, fees, or other necessary educational expenses is excluded from income. This exclusion does not apply to any portion set aside or actually used for food, clothing, or shelter. (See S0830.460 if the Department of Education or BIA is involved.)

2. Allowable Expenses

It is expected that **expenses will include** carfare, stationery supplies, and impairment-related expenses necessary to attend school or perform schoolwork (e.g., special transportation to and from classes, special prosthetic devices necessary to operate school machines or equipment etc.).

3. Allowable Fees

Allowable fees will include laboratory fees, student activity fees, etc.

C. Procedure

1. Verify Nature of Assistance

Use documents in the individual's possession, contact with the institution or provider, or a precedent to verify the nature of the assistance (e.g., scholarship, grant, etc.) and then, if not totally excluded under another provision, the amount, date(s) of payment, payee, etc. (See S0830.460 if the Department of Education or the Bureau of Indian Affairs is involved.)

2. Allowable Expenses

In determining allowable expenses:

a. Use your **judgment** to determine whether payment of an expense was a necessary part of obtaining an education.
b. Use any **reasonable method** for deducting educational expenses from income.

3. Verify Expense

Use receipts, bills with cancelled checks, contact with the provider, etc., to verify expenses paid. If an expense is verified as incurred but not paid, assume the individual will pay the expense unless you have reason to question the situation. No followup is required if the assumption is applied.

4. Tolerance - Miscellaneous Expenses

A signed allegation is acceptable evidence of expenses when it is unreasonable to obtain other evidence (e.g., daily busfare, small expendable items, etc.). Do not apply this tolerance to major expenses such as tuition, fees, and books.

D. References

Department of Education or the Bureau of Indian Affairs involved, S0830.460
Veteran Administration educational benefits, S0830.306

S0830.460 DEPARTMENT OF EDUCATION OR THE BUREAU OF INDIAN AFFAIRS INVOLVED

A. Background

Federal funds or insurance are provided for a number of educational programs at middle school, secondary school, undergraduate and graduate levels under title IV of the Higher Education Act of 1965 and student assistance programs of the Bureau of Indian Affairs (BIA). Included are work-study programs, upward bound and talent search programs, as well as grants-in-aid and loans for college study.

B. Policy

1. Undergraduate College Study--Grants/Loans

Any grant, scholarship, or loan to an undergraduate student for educational purposes made or insured under any program administered by the U.S. Commissioner of Education is excluded from income and resources.

2. Financial Assistance

Any portion of student financial assistance for attendance costs received from a program funded in whole or in part under title IV of the Higher Education Act of 1965 or under BIA Student Assistance Programs is excluded from income and resources. Attendance costs are:

- tuition and fees normally assessed a student carrying the same academic workload (as determined by the institution), including costs for rental or purchase of any equipment, materials, or supplies required of all students in the same course of study; or

- allowances for books, supplies, transportation, and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution.

NOTE: This exclusion applies to the common programs of Federal financial aid for college students; e.g., Supplemental Education Opportunity Grants (SEOG), National Defense Student Loans (NDSL), Pell Grants, and State Student Incentive Grants (SSIG)

C. Procedure

1. Determine Funding

Determine whether Federal funds under a Department of Education (DE) or BIA program are involved in any educational assistance (e.g., loan, scholarship, stipend, employment under a work-study program, etc.). Use documents in the individual's possession, printed material, precedents, contact with the school or provider, etc. If such Federal funds are not involved, follow the instructions in S0830.455.

2. Undergraduate Study With DE Involvement

If Federal funds under a DE program are involved and the individual has received a grant, scholarship, or loan for **undergraduate** college study, use documents in the individual's possession, contact with the school or provider and/or precedents to verify the DE involvement and the purpose of the assistance. Totally exclude all the assistance from both income and resources. No further development is necessary.

3. Other Study With DE Involvement

In all other situations involving Federal funds under a DE program, determine if any of the funds are provided under title IV of the Higher Education Act of 1965. If not provided under title IV, follow the instructions in S0830.455. Otherwise, see 4. below.

4. BIA or Title IV Involvement

If educational assistance is provided under title IV of the Higher Education Act of 1965 or a BIA Student Assistance program:

a. **Verify** the amount of the assistance and the portion which has been provided for tuition, fees, equipment, books, supplies, transportation, and/or miscellaneous personal expenses. Also, if a portion of the assistance is provided as an allowance for books, supplies, transportation and/or miscellaneous expenses, **verify** that the student is attending the institution on at least a half-time basis. Use **documents** in the individual's possession, or **contact** with the institution.

b. **Exclude** from income and resources any verified assistance made available for tuition, fees, equipment and supplies and, the case of a student attending school on at least a half-time basis, as an allowance for books, supplies, transportation and miscellaneous personal expenses.

c. Consider any student assistance in excess of the amount made available for the purposes in 4.b. above as income and resources. For example, $400 of $500 in work-study earnings may be excluded from income and resources if a college indicates that $400 from work-study was provided for tuition, books, supplies, transportation and miscellaneous personal expenses. The remaining $100 is considered as earned income.

However, excess income may be excludable under the instructions in S0830.455 or under a plan for achieving self-support.

MISCELLANEOUS UNEARNED INCOME

M0830.500 DIVIDENDS AND INTEREST

A. Definition

Dividends and interest are returns on capital investments such as stocks, bonds, or savings accounts.

B. Policy-- Month Dividends/Interest are Unearned Income

Dividends and interest are unearned income at the earlier of the following:

- the month they are credited to an individual's account and are available for use;
- the month they are set aside for the individual's use; or
- the month they are received by the individual.

NOTE: Account service fees or penalties for early withdrawal do not reduce the amount of interest or dividend income.

C. Policy - Income Treatment

The following describes when dividends or interest are considered unearned income.

When the source of dividends or interest is a	and it ...	then ...
financial institution	credits income to a customer account,	the interest is income.
	computes or com-pounds interest or up-dates its own records **but** does not report income to a customer account,	the interest is not income.
series E/EE U.S. savings bond	was purchased by the owner; or was a gift to the owner **prior** to the expiration of the minimum retention period,	the interest is not income upon receipt or upon expiration of the minimum retention period. **Rationale:** When series E/EE bonds are redeemed, the interest is an income in the value of a resource; it is **not** income.
	was a gift to the owner **after** expiration of the minimum retention period	the bond produces income equal to the purchase price plus accrued interest through the month the individual receives it.
series H/HH U.S. savings bonds	makes a semi-annual interest payment,	the interest is income when available to the individual.
	was a gift to the owner **after** expiration of the minimum retention period,	the bond produces income equal to the purchase price plus accrued interest through the month the individual receives it.

C. Policy - Income Treatment (Cont'd)

The following describes when dividends or interest are considered unearned income.

When the source of dividends or interest is a	and it ...	then ...
life insurance policy	pay dividends;	the dividends are not income.
life insurance policy	pays interest on dividend,	the interest is income (this is the case even when the policy is not a resource; i.e., face value is under $1,500).
promissory note or other loan agreement	pays interest; or pays principal and interest in the same payment,	the interest **only** is income. **Rationale**: the principal amount represents conversion of a resource.

D. Procedure - Verification and Documentation

1. Development for Dividends and Interest

If you must develop dividends or interest, use the chart below to verify and document frequency and amount.

If the payer is a ...	and the owner ...	then....
financial institution that pays interest	has countable resources within the applicable resource limit (S1110.003),	Verify: • type of account • whether it pays interest; and if so, • the frequency and amount.
financial institution that pays interest	has countable resources in excess of the resource limit,	accept the allegations as to the three points listed above and stop development. The individual is not eligible.
	alleges joint ownership of all interest-bearing account,	see S0810.130.
promissory note or other loan agreement	alleges interest income,	verify amount and frequency of interest income with a check or notice issued by the source or an amortiza-tion table. If one of these is not available, see S0830.005 on developing unearned income. **NOTE:** If interest income is excludable because it is received infrequently or irregularly, see S0810.410.

D. Procedure - Verification and Documentation (Cont'd)

1. Development for Dividends and Interest (Cont'd)

If you must develop dividends or interest, use the chart below to verify and document frequency and amount.

If the payer is a ...	and the owner ...	then....
promissory note or other loan agreement	does not know whether interest income is received or due, or does not know the amount of interest income,	• inspect the loan agreement for the needed information; or • if necessary, consult an amortization schedule.
	has countable resources in excess of resource limit,	verify resources.
source of interest different from above	has a check or award notice from the payer,	document the file with a copy of the check or award notice.
	does not have a check or award notice.	see S0830.005 on developing unearned income.
source of dividends	has a check or dividend notice from the payer,	use the check or dividend notice from the source as verification; or if necessary, see S0830.005 on developing unearned income.
	receives payment in a form other than cash (e.g., shares of stock),	determine the value as income under instructions specific to that item.

E. Procedure - Resolving Discrepancies

Use the following procedure to resolve discrepancies when an individual disagrees with the amount and/or frequency of interest or dividend payments as shown on account records.

is...	**and ...**	**then...**
totally excludable	_____	no resolution is necessary
not totally excludable	the individual has a reasonable explanation for the discrepancy	accept his/her allegation; and document the file
	the individual does not have a reasonable explanation for the discrepancy	use account records as as verification.

F. Procedure -- Projecting Future Interest/Dividend

Unless there is evidence to the contrary, **assume** that interest or dividend payments will continue at the current amount and frequency.

G. References

These are **some** (not all) of the exclusions that may apply to dividend or interest income:

- Infrequent or irregular income, S0810.410;
- Interest on and appreciation in value of excluded burial funds, S0830.501;
- Interest on disaster assistance funds, S0830.620 B.3.;
- Interest on funds to replace certain excluded resources, S1130.620-.630;
- *German Reparations Payments, S0830.710;*
- *Austrian Social Insurance Payments, S0830.715;*
- *Japanese-American and Aleutian Restitution Payments, S0830.720;*
- *Netherlands WUV Payments to Victims of Persecution, S0830.725;*
- *Agent Orange Settlement Payments, S0830.730;*
- *Radiation Exposure Compensation Trust Fund (RECTF) Payments, S0830.740; and*
- *Walker v. Bayer Settlement Payments, M0830.760.*

S0830.501 INTEREST AND APPRECIATION IN VALUE OF EXCLUDED BURIAL FUNDS AND BURIAL SPACE PURCHASE AGREEMENTS

A. Policy--Exclusion of Interest and Appreciation

1. The Exclusion

a. Interest earned on the value of excluded burial funds is excluded from income (and resources), if left to accumulate.

b. Interest earned on agreements representing the purchase of an **excluded burial space** is excluded from income (and resources), if left to accumulate.

2. When Exclusion Applies

This income exclusion applies only if the burial fund or space purchase agreement is excluded at the time the interest is paid.

3. Interest and Appreciation Must Be Left to Accumulate

Appreciation in value and interest must be left to accumulate to be excluded from income. If not left to accumulate (e.g., paid directly to the individual, spouse, or parent), the receipt may result in countable income.

B. Policy--Related Burial Issues

1. Nonexcluded Funds

If interest is paid on a burial fund or space purchase agreement and the fund or agreement is not excluded at the time the interest is paid, the interest is treated under interest income rules. See S0830.500.

2. Commingled Funds

When excluded funds or spaces are commingled with nonexcluded funds or spaces, only the interest on the excluded portion is excluded. See M1130.410C.

3. Irregular or Infrequent Exclusion

Effective April 1, 1990, it is not necessary to apply the irregular or infrequent income exclusion to interest earned on excluded burial funds or burial space purchase agreements.

- You must apply the irregular or infrequent exclusion to income other than that earned on excluded burial funds or burial space purchase agreements. See S0810.410.

- You should apply the specific burial funds or burial space interest exclusion as discussed in this section.

C. Procedure -- Development and Documentation of Interest Earned on Burial Funds

1. Consider Type of Contract

If funds and space items are held together in the same purchase agreement or contract, first determine which portions are funds and which are space items. See M1130.420.

2. Entire Burial Fund is Excluded

Do not document interest if entire burial fund is excluded.

3. Only a Portion of the Burial Fund is Excluded

a. Use the following procedure to determine countable interest to be counted:

STEP	ACTION
1	**Determine** total interest paid on the commingled account following development guidelines in S0830.500.
2	**Determine** the ratio of the nonexcluded portion of the fund to the excluded portion by dividing the value of the nonexcluded portion of the fund by the total value of the fund. Carry the quotient to 3 decimal places.
3	**Multiply** the decimal obtained in step 2 representing the nonexcluded portion by the total amount of interest earned on the fund. The result is the amount of interest paid on the nonexcluded portion of the fund for the period in question.

NOTE: The same action (in step 2) may be used every month as long as there are no deposits to or withdrawals from the total fund.

b. **EXAMPLE -** Computation When Only a Portion of the Burial Fund is Excluded.

Mr. Sam Rogers filed for Medicaid on January 8, 1990. His assets as of January 1, 1990 included the following:

• Savings account ($1,000 resources) ($50 interest income posted 1/1/90)	$1,050
• Irrevocable burial contract	$1,200
• Nonhome real property	$ 500
• Checking account	$ 474
	$1,974

Mr. Rogers designated $500 of his savings account for burial. His available burial fund exclusion is $1,300. ($2,500 - $1,200 irrevocable burial contract.)

Computation of countable interest using steps above:

- $500 = nonexcluded portion of funds
- Divided by $1,000 (total resources in savings account for January)
- Percentage of nonexcluded funds = 50 percent
- Total interest paid = $50
- Percentage of countable interest = 50 percent x $50 = $25 countable income for January.

4. Burial Fund Exclusion No Longer Applies

If you determine that application of the burial funds exclusion ceased during a past period, the interest paid on the burial funds in the months the burial funds are not excluded may result in countable income the month of receipt and countable resource following the month of receipt. Follow interest income development for each month that the burial funds exclusion does not apply.

D. Procedure -- Interest Earned On Burial Space Purchase Agreements

a. **Consider Type of Contract** - See C.1. above.

b. **Entire Burial Space Purchase Agreement is Excluded**
Do not document interest if entire burial fund is excluded.

c. **Only a Portion of Burial Space Purchase Agreement is Excluded**
Follow the interest computation procedures explained in C.3. above when excluded and nonexcluded burial space items are held in the same purchase agreement or contract.

M0830.505 RENTAL INCOME

A. Policy

1. Definitions

a. **Rent** is a payment which an individual receives for the use of real or personal property, such as land, housing or machinery.

b. **Net rental income** is gross rent less the ordinary and necessary expenses paid in the same taxable year.

c. **Ordinary and necessary expenses** are those necessary for the production or collection of rental income. In general, these expenses include:

- interest on debts;
- State and local taxes on real and personal property and on motor fuel;
- general sales taxes; and
- expenses of managing or maintaining property. See A.10. below a for more specific list.

2. Depreciation Not Deductible

Depreciation or depletion of property is not a deductible expense.

3. When to Deduct Expenses

We deduct expenses when paid, not when incurred.

4. Earned or Unearned Income

Net rental income is unearned income unless it is earned income from self-employment (e.g., someone who is in the business of renting properties).

5. Rental Deposits

Rental deposits are not income to the landlord while subject to return to the tenant. Rental deposits used to pay rental expenses become income to the landlord at the point of use.

6. Rent/Expenses Prior to Eligibility

In determining net rental income, we do not consider rents received or expenses paid in months prior to Medicaid eligibility.

7. Multiple Family Residence

In multiple family residence:

- If the units in the building are of approximately **equal size**, we prorate allowable expenses based on the number of units designated for rent compared to the total number of units.

- If the units are **not** of approximately **equal size**, we prorate allowable expenses based on the number of rooms in the rental units compared to the total number of rooms in the building. (The rooms do not have to be occupied.)

NOTE: Any expenses strictly related to a particular rental unit are deducted in total from the rent for that unit. Such expenses are not prorated

8. Rooms in Single Residence

For rooms in a single residence:

a. We prorate allowable expenses based on the **number of rooms** designated for rent compared to the number of rooms in the house.

b. We do not count **bathrooms** as rooms in the house.

c. We count **basements** and **attics** only if they have been converted to living spaces (e.g., recreation rooms).

NOTE: Any expenses strictly related to a particular rental room are deducted in total from the rent for that room. Such expenses are not prorated.

9. Land

We prorate expenses based on the percentage of total acres that is for rent.

10. Deductible Expenses

Example of deductible expenses:

- Interest and escrow portions of a mortgage payment (at the point the payment is made to the mortgage holder);

- real estate insurance;
- repairs (i.e., minor correction to an existing structure);
- property taxes;
- lawn care;
- snow removal; and
- advertising for tenants.

11. Nondeductible Expenses

Examples of nondeductible expenses:

- principle portion of a mortgage payment; and

- capital expenditures (i.e., an expense for an addition or increase in the value of property which is subject to depreciation for income tax purposes).

B. Procedures

1. Evidence

a. **Use documents** in the individual's possession (e.g., bills, receipts, etc.) to verify the gross rent and the dates received, and the expenses and the dates paid.

NOTE: The individual's most recent Federal tax return including Schedule E will be helpful in identifying past expenses and in estimating future rental income.

b. **If no documents are available**, obtain a signed statement explaining why no documents are available and providing an allegation of the gross rent and expenses paid for the period involved. **Do not** contact the tenants to verify the allegation.

c. If you are **uncertain** whether an expense is allowable (e.g., whether it is an incidental repair or a capital expenditure), contact the local Internal Revenue Service (IRS) or refer to IRS Publication 527. Document the file with the information obtained from IRS.

2. Computation

a. **Determine** gross rent received and deductible expenses month-by-month.

b. **Subtract** deductible expenses paid in a month from gross rent received in the same month.

c. If deductible expenses exceed gross rent in a month, subtract the **excess expenses** from the next month's gross rent and continue doing this as necessary until the end of the tax year in which the expense is paid.

d. If these are **still excess expenses** after applying b. above, subtract them from the gross rent received in the month prior to the month the expenses were paid and continue doing this as necessary to the beginning of the tax year involved.

NOTE: Do not carry excess expenses over to other tax years nor use them to offset other income.

3. Documenting Calculations

Document the proration of allowable expenses and the calculation of net rental income.

4. Joint Owners

Absent evidence to the contrary, apportion net rental income equally among owners. (A signed statement can be acceptable evidence if it reasonably explains why apportionment is not equal.)

If the gross rent is split between two joint owners before expenses are paid, deduct expenses paid by the Medicaid recipient from his/her portion of the gross rent.

5. Future Rental Income

a. Use evidence from the retroactive period to estimate net rental income for the next 12 months; however, deduct only **predictable expenses**, (e.g., utilities, interest payments, taxes, etc.).

b. If an **unpredictable expense** is reported at a later date (e.g., a repair), deduct it in the month paid. If the expense exceeds the rent for that month, recalculate the rest of the estimated period as necessary (see 2.b. above).

6. Interest

a. Use the individual's **amortization schedule** to determine interest expense.

b. If a **schedule is not available**, divide the yearly interest by twelve to determine monthly interest.

7. Refunds on Paid Expenses

If the Medicaid recipient receives a refund for an expense already paid (e.g., a property tax refund), recalculate his/her future net rental income for the remainder of the eligibility period.

C. Examples

1. Proration of Room Rental Expenses

Mr. Joshua Steele, a Medicaid recipient, rents out a room in his house to a cousin. The house has six rooms excluding the bathroom. Since Mr. Steele's expenses (interest on a mortgage, utilities, etc.) are for the whole house, only one-sixth of the expenses is deducted from the gross rent.

2. Rental Income Interrupted

Mrs. Anna Minnick, an Medicaid recipient, owns a multiple family residence and rents out half of it. In 9/89, her tenants leave and she receives no gross rent until 11/89 when new tenants move in. Mrs. Minnick continues to pay the mortgage and utilities on the residence during 9/89 and 10/89. The EW determines that Mrs. Minnick has excess expenses and no rental income for 9/89 and 10/89 because she received no gross rent for those months. The excess expenses are carried over into the calculation of net rental income for 11/89.

3. Gross Rent - Two Owners But Only One Owner Pays Expenses

Mrs. Kate Henning, an Medicaid recipient, owns her home jointly with her son, John. Mrs. Henning rents out a couple of rooms in her house for $350/month and gives her son half of it ($175/month). Mrs. Henning pays all the rental expenses herself. To calculate Mrs. Henning's net rental income, deduct the allowable expenses she pays (prorated, if necessary) from $175 (her portion of the gross rent).

D. References

Property essential to self-support, S1130.500.
Net earnings from self-employment, S0820.200.

E. Exhibit -Rental Income Worksheet

RENTAL INCOME WORKSHEET												
Expenses	Jan/July*		Feb/August *		March/Sept *		April/Oct *		May/Nov *		June/Dec *	
	Gross	Prorated	Gross	Prorated	Gross	Prorated	Gross	Prorated	Gross	Prorated	Gross	Prorated
Rent/Mtg Ins												
Property Ins												
Insurance												
Gas/Oil												
Electricity												
Water/Sewage												
Repairs												
Other												
Other												
Other												
Total Expenses (Prorated)												
Gross Rent												
Monthly Exp (from above)	(-)		(-)		(-)		(-)		(-)		(-)	
Prior Month Excess Exp	(-)		(-)		(-)		(-)		(-)		(-)	
Subtotal												
Excess Exp From End of Tax Year	(-)		(-)		(-)		(-)		(-)		(-)	
Net Rental Income												

*NOTE: Be sure to circle the applicable mont

S0830.510 ROYALTIES

A. Policy

1. Definition

Royalties include compensation paid to the owner for the use of property, usually copyrighted material (e.g., books, music, or art) or natural resources (e.g., minerals, oil, gravel or timber). Royalty compensation may be expressed as a percentage of receipts from using the property or as an amount per unit produced.

To be considered royalties, payments for the use of natural resources also must be received:

- under a formal or informal agreement whereby the owner authorizes another individual to manage and extract a product (e.g., timber or oil), and
- in an amount that is dependent on the amount of the product actually extracted.

2. Sale of Natural Resources

An outright sale of natural resources by the owner of the land or by the owner of rights to use of the land constitutes the conversion of a resource. Proceeds from the conversion of a resource are not income.

3. Earned vs. Unearned Income

Royalties are unearned income unless they are:

- received as part of a trade or business (see S0820.200. for NESE), **or**
- received by and individual in connection with any publication of his/her work. Royalties earned by an individual in connection with any publication of his/her work are earned income (e.g., publication of a manuscript, magazine article, or artwork) (S0820.450).

4. Income or Windfall Profits Tax

Some documents concerning royalty payments will provide both a gross and a net payment amount. When the difference between the gross and the net figures is due to income taxes withheld or windfall profit tax deductions, we use the gross figure when determining income for Medicaid purposes.

5. Production or Severance Tax

When the difference between the gross and net figures represents a production or severance tax (e.g., most oil royalties will be reduced by this tax), we use the net figure when determining income for Medicaid purposes. The production or severance tax is a cost of producing the income and, therefore, is deducted from the gross income.

B. Procedure

1. Verification

a. Verify that payments received meet the definition of royalty (A.1. above) by examining the agreement between the parties involved. If the agreement is unclear, unavailable, or informal, contact the company or source of the payment.

b. Verify the amounts of royalty payments by examining documents in the individual's possession. If documents are unclear or unavailable, contact the company or source of the royalty.

c. If verification cannot be obtained by the above means, see S0830.005 A.5. - A.6. for additional verification procedures.

2. Documentation

Document the file by including copies of documents or indicating in the file information provided by the payment source concerning the nature, amount(s), month(s) of receipt, and, if appropriate, frequency of payments.

C. References

- Mineral rights, S1140.110.
- Timber rights, S1140.110.
- Definition of nonbusiness income-producing property, S1130.502.
- Conversion of a resource, S0815.200 and S1110.600 B.4.

S0830.515 AWARDS

A. Policy

1. Definition

An award is usually something received as the result of a decision by a court, board of arbitration, or the like.

2. Award As Income

An award is unearned income subject to the general rules pertaining to income and income exclusions.

B. Procedure

1. Verification

Use documents in the individual's possession or contact with the court, board, source, etc; to verify:

- the amount of the award;
- the payment date; and
- if needed, the purpose(s) of the payment (e.g., part of the payment is reimbursement for medical expenses).

2. Apply Appropriate Rules

Determine the nature of the award and apply the appropriate rules pertaining to income and income exclusions.

C. References

Expenses of obtaining income, S0830.100

M0830.520 GIFTS

A. Policy

1. Definition

- A gift is something a person receives which is **not repayment** for goods or services the person provided and is **not** given because of a **legal obligation** on the givers' part.
- To be a gift, something must be given **irrevocably** (i.e., the donor relinquishes all control).
- **"Donations"** and **"contributions"** may meet the definition of a gift.

NOTE: A gift received as the result of a death is a death benefit. See S0830.545.

2. Gift as Income

A gift is unearned income subject to the general rules pertaining to income and income exclusions.

B. Procedure

1. Apply Appropriate Rules

Determine the nature of the gift and apply the appropriate operating instructions pertaining to income and income exclusions (see C. below).

C. References

- Cash income, S0810.020.
- Bills paid by a third party, S0815.400
- Home energy assistance and support and maintenance assistance, S0830.605
- Infrequent or irregular income exclusion, S0810.410
- $20 general income exclusion S0810.420
- Trusts, M1120.200
- Uniform gifts to minors, S1120.205
- Gifts of domestic travel tickets, S0830.521

S0830.521 GIFTS OF DOMESTIC TRAVEL TICKETS

A. Definition

Domestic travel is travel in or between the 50 States, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

B. Policy

1. Gift of Ticket Not Converted To Cash

The value of a ticket for domestic travel received by an individual, or his her spouse, or parent whose income is subject to deeming is excluded from income if:

- the ticket is received as a gift (S0830.520); and
- the ticket is not converted to cash (e.g., cashed in, sold, etc.).

2. Gift of Ticket Converted to Cash

A ticket received as a gift is treated as unearned income in the month the ticket was converted to cash.

C. Procedure

1. Obtain a Statement

Obtain the individual's signed statement as to whether the ticket has been retained, used, or converted to cash. If the ticket has been converted to cash, specify in the statement the amount of cash received. In the absence of evidence to the contrary, accept the statement as fact.

2. Ticket Used or Still Retained

Exclude from income.

3. Ticket Converted to Cash

Treat as unearned income in the month the ticket was converted to cash.

D. Reference

Gifts, S0830.520
Treatment of domestic travel tickets for resource purposes, S1120.150

S0830.525 PRIZES

A. Policy

1. Definition

A prize is generally something won in a contest, lottery or game of chance.

2. Prize As Income

A prize is unearned income subject to the general rules pertaining to income and income exclusions.

NOTE: We do not subtract gambling losses from gambling winnings in determining an individual's countable income.

3. Choice Between Cash and In-Kind Item

If an individual is offered a choice between an in-kind prize and cash, the cash offered is counted as unearned income. This is true even if the individual chooses the in-kind item and regardless of the value, if any, of the in-kind item.

B. Procedure

1. Signed Statement

When an individual reports receipt of a prize, obtain the individual's signed statement of the following:

- date the prize was received;
- type or prize received;
- individual's estimate of the value of the prize if not cash;
- amount of income tax withheld, if any; and
- source of the prize

2. Tolerance for Valuing

Accept an individual's signed estimate of the value of the prize (or actual value if cash or cash offer) unless you have reason to doubt the estimate. If you doubt the estimate, determine the item's current market value with an independent source.

3. Apply Appropriate Rules

Determine the nature of the prize and apply the appropriate operating instructions pertaining to income and income exclusions (see C. below).

C. References

- Cash income, S0810.020 A.2.a.
- Infrequent or irregular income exclusion, S0810.410
- $20 general income exclusion, S0810.420

S0830.530 WORK RELATED UNEARNED INCOME

A. Policy Principle

Unearned income is all income that is not earned income.

B. Related Policies

1. Earned Income

For policies on earned income, see S0820.000.

2. Title II Wage Exclusions

For title II wage exclusions as they related to the Medicaid program, see S0815.600.

3. Sick Pay

For treatment of sick pay, see S0830.543 and S0820.005.

C. Operating Policy

The following work related payments are unearned income:

Money paid to a resident of a public institution when no employer/employee relationship exists.

Tips under $20 per month.

Jury fees (i.e., fees paid for services, not expense money; see S0830.100 if expense money is provided).

Cash allowances for food, clothing and shelter provided to members of the Uniformed Services and their families, all types of special and incentive pay. (See S0830.540 for a description of and instructions on all aspects of compensation in the form of unearned income in the Uniformed Services.)

D. Development and Documentation

1. Individual Has Evidence

Verify the amounts of work-related payments, if possible, using papers in the individual's possession, and document the file with photocopies or document contact certifying the contents.

2. Individual Does Not have Evidence

If the individual cannot provide the required evidence:

Verify jury fees by contacting the court clerk or jury commissioner. Document the file.

Verify other work-related payments by contacting the source of payment. Document the file.

S0830.535 JOB TRAINING PARTNERSHIP ACT (JTPA)

A. Introduction

The purpose of the Job Training Partnership Act **(JTPA)** is to prepare individuals for entry into the labor force. JTPA funding is much like a block grant and programs will vary among areas within the State. JTPA payments may be called "needs-based" for JTPA purposes but are not "income based on need" or "assistance based on need" for Medicaid purposes. JTPA payments may be in cash or in kind, and participants in JTPA may receive supportive services in cash or in kind. Usually, adult participants receive **only** supportive services.

B. Policy

JTPA payments are **subject to the general rules** pertaining the income and income exclusions.

C. Procedure

1. Allegations

Accept an individual's allegation of participation in JTPA and receipt of supportive services unless there is reason to question the information.

2. Assumption

- **Assume** that supportive services such as child care, transportation, medical care, meals and other reasonable expenses, provided in cash or in kind, are **social services** and **not income**.

- Disregard the supportive services without further development or documentation.

NOTE: However, items such as salaries, stipends, incentive payments, etc., must be evaluated under the general rules of unearned and earned income.

D. References

Medical and Social Services S0815.050
Earned income, S0820.001
Blind Work Expenses, S0820.535
IRW E, S0820.540
PASS, S0810.430

M0830.540 UNIFORMED SERVICES -- PAY AND ALLOWANCES

A. Introduction

Compensation to most members of the Uniformed Services takes the form of b earned and unearned income, and often of both cash and in-kind income.

All branches of the Uniformed Services adhere to a single pay system, but that system is complex and varies significantly from branch to branch. Proper and efficient handling of cases require an understanding of:

- how the pay system works;
- what the key terms mean; and
- how Medicaid policies and procedures apply to different forms of compensation.

B. Definitions

1. Uniformed Services

The Uniformed Services are defined by law and include the:

- Army;
- Navy;
- Air Force;
- Marine Corps;
- Coast Guard;
- Reserve and National Guard components of the above;
- Public Health Service commissioned officer corps; and
- National Oceanic and Atmospheric Administration commissioned officer corps.

2. Entitlements

Entitlements are pay, allowances, and other **cash** benefits due a service member. Entitlements can include basic pay, special and incentive pay, allowances, advance pay, and reimbursements for certain work-related expenses.

3. Basic Pay

Basic (or base) pay is the service member's wage. It is based solely on the member's pay grade and length of service.

Basic pay is subject to FICA taxes as well as income tax.

4. Allowances

Allowances are **cash** benefits that compensate the service member, at least in part, for the expenses of housing, food, clothing, and special situations during periods of active duty service. Allowances are not paid for weekend drills of Reserve and National Guard components.

Allowances are not subject to FICA tax and usually are not subject to income taxes.

Often, for accounting purposes, a service branch changes a subcategory of allowance retroactively (e.g., from one type of subsistence allowance to another). The change is explained on the pay slip by showing, as an **entitlement**, the full amount due for the earlier month under the correct subcategory (e.g., leave rations). The full amount previously paid as the entitlement for the earlier month under the incorrect subcategory is shown as a **deduction** (e.g., separate rations). The amounts may be identical or different. (See D.6. for the policy governing these retroactive adjustments.)

5. Subsistence

Subsistence means food and is also referred to as rations. Service members usually receive either free rations from a service facility or an allowance for rations. (The value of free rations does not appear on pay records.)

Officers receive a subsistence allowance at a fixed monthly rate.

Enlisted persons receive an allowance based on a daily rate, so the monthly amount payable depends on the number of days in the month. The daily rate can vary depending on the availability of government dining facilities at the assigned location.

6. Quarters

Quarters are a service member's housing. Quarters sometimes are provided, free of charge or on a rental basis, by the service installation. (The value of free quarters does not appear on pay records.) Rent may be paid by payroll deduction.

Whether or not free housing is provided, the service member usually receives an allowance for quarters. The amount of this allowance can vary depending on factors such as:

- rank;
- whether the service member has a dependent (the number of dependents is irrelevant);
- whether the member lives in government housing and whether that housing is deemed substandard; and
- the location of the base.

In some cases, the service branch may pay a full quarters allowance to a service member living in free on-base housing, but then deduct the **allowance** (rather than rent) in the same month. This transaction is merely for accounting purposes and results in a zero payment transaction. What is actually received is rent-free shelter. See D.4. below for the policy governing quarters allowances paid and deducted in the same pay period.)

7. Clothing Issuances and Allowances

Clothing issuances consist of uniforms, boots, and other clothing items service members need when they enter on active duty. Whatever is received in cash is countable income. If uniform, insignia, boots, are provided, it is in-kind and not counted.

Clothing allowances are payments provided for the purchase and care of uniforms and, in some cases, civilian clothes.

a. **Officers**
Officers receive an allowance for uniforms and insignia after being commissioned and may receive periodic allowances thereafter.

b. **Enlisted Persons**
Enlisted persons receive in kind the uniforms, boots, and other clothing they need when they enter active duty. (The value of such clothing issued in kind does not appear on pay records.)

Generally, every 12 months thereafter, they receive an allowance for the care and replacement of those uniforms. The rates vary by branch of service, length of service, and sex, and they usually increase each year.

c. Special Clothing Allowances
Special clothing allowances are also paid when assignments require members to wear civilian clothes.

8. Special and Incentive Pay

Special and incentive pay is compensation to specific groups of uniformed people for inconveniences or hazards, or provides incentives for those with skills in high demand to joining or remain in the service. Special pay includes;

- enlistment and reenlistment bonuses;
- combat pay;
- flight pay;
- sea pay; and
- more than 30 additional types of pay.

Special and incentive pay is usually subject to income taxes but is not subject to FICA tax.

9. Hostile Fire Pay

Hostile fire pay is a type of special pay to a service member who is:

- subject to hostile fire or explosion of hostile mines; or
- on duty in an area in which he/she is in imminent danger of being exposed to hostile fire or explosion of hostile mines, **and** while on duty in that area, other service members in the same area are subject to hostile fire or explosion of hostile mines; or
- killed, injured, or wounded by hostile fire, explosion of a hostile mine, or any other hostile action.

10. Advance Pay

In the Uniformed Services, advance pay is a **cash loan** to be repaid in cash installments, usually by payroll deductions, rather than by future work. Advance pay is not taxed. (See S0815.350 for the treatment of loans in the Medicaid program.)

11. Allotments

Allotments are deductions, usually voluntary, from a service member's paycheck for special purposes. Allotments are often requested for purposes such as:

- payments to dependents;
- deposits to a savings account;
- charitable contributions; and
- purchasing savings bonds.

12. Pay Grade

The pay grade is an alphanumeric code designating the rank of a service member. It also indicates whether that service member is:

- an enlisted member (pay grades E-1 through E-9);
- a warrant officer (W-1 through W-4); or
- a commissioned officer (0-1 through 0-10).

Within a pay grade, pay levels vary according to the number of years of service.

13. Leave and Earnings Statement (LES)

The LES is the monthly pay slip issued to service members. Each service branch has its own version. G. below lists common abbreviations used on LES's.

C. Process--How the Pay System Works

1. Forms of Compensation

Compensation to members of the Uniformed Services take several forms, chiefly:

- basic (or base) pay;
- special and incentive pay; and
- cash allowances for, and in-kind provision of, subsistence (rations), clothing, and quarters.

2. Amount of Compensation

The amount of compensation, depending on the form it takes, can vary with rank, length of service, location of duty station, family size, and other factors.

3. Paydays

a. First-of-Month Payday

All branches of the Uniformed Services pay full-time service members on the first day of the month for work performed in the previous calendar month.

b. **Mid-Month Payday**

All service branches (other than the Public Health Service) offer full-time members a mid-month payment as partial payment of the net amount due for the full calendar month. The mid-month payment is optional or standard, depending on the service branch:

- Army and Air Force -- Optional
  Navy, Marine Corps, Coast Guard, and National Oceanic and Atmospheric Administration (NOAA) – Standard

c. **Casual Pay**
While away from base, a service member can receive payment of pay and allowances due for the current month. This casual pay is issued at odd times of the month. Casual pay is not an entitlement. It is a manner of paying compensation that is already due.

d. **Reserve and National Guard Paydays**
Part-time service members are paid at different times depending on their periods of service.

4. Apportionment Between Paydays

a. **First-of-Month Payday**

The first-of-month payment represents all net compensation due for the work month less the amount paid earlier in the pay period.

b. **Mid-Month Payday**
The amount paid mid-month (if any) varies according to the rules of the service branch and rank of the service member, as illustrated in the following chart:

SERVICE BRANCH	**AMOUNT PAID MID-MONTH**	
	BASIC PAY, SPECIAL PAY AND ALLOWANCES (EXCEPT SUBSISTENCE)	**SUBSISTENCE ALLOWANCE**
Air Force Navy Marine Corps Coast Guard NOAA	One-half of net amount due for work month.	**Enlisted Persons:** Total of daily rates for 1st through 15th days of work month. **Officers:** One-half of amount due for work month.
Army	Optional percentage (up to 50%) of net amount paid for the month **before** the work month	

5. Pay Slips

The service branches issue a **single** pay slip each month on or after the first-of-month payday. That pay slip shows the gross amount due for the full calendar month and the net amount issued on each payday of the month.

D. Policy

1. Basic Pay

Only basic pay constitutes wages.

2. Special Pay and Allowances

All special pay and allowances, except hostile fire pay, are countable unearned income to the service member.

3. Hostile Fire Pay

Hostile fire pay is excluded from income. Any unspent hostile fire pay becomes a resource if retained into the following month and not otherwise excluded. See B.9. above for the definition of hostile fire pay.

4. Quarters Allowances

A quarters allowance is not income if:

- the service member lives in free on-base housing, **and**
- the allowance is paid and deducted in the same pay period. (See B.6. above and D.5. below.)

5. Overpayments

a. Basic Pay

An overpayment of basic pay (wages) is income when received. Any amount deducted to recover a wage overpayment is not wages, regardless of when the overpayment occurred.

See B.10. for a discussion of advance pay.

b. Allowances and Special Pay

An overpayment of an allowance or special pay, other than hostile fire pay, is countable income when received. Any amount deducted to recover an overpayment of an allowance or special pay is also income, unless double counting would result (the allowance or special pay has been previously counted AND Medicaid eligibility established). Apply the policy in S0830.110 (regarding overpayments from other benefit programs) to amounts deducted to recover overpayments of allowances and special pay.

See 6. below for the policy on retroactive adjustments of allowances and

See B.10. for a discussion of advance pay.

6. Retroactive Adjustments

A retroactive adjustment in the **type** of pay or allowance, even if the change affects the amount due, is not an overpayment. Such retroactive adjustments are usually made in full in a single month. (B.4. above describes how these adjustments appear on the pay slips.) Only the **net** amount paid for a month in a category of allowance or special pay (e.g., all subsistence **entitlements** less all subsistence **deductions**) is income for the month.

See 5. above for the policy on overpayments.

E. Procedure

1. General

a. Request LES's from the applicant or service member. If LES's are unavailable, make oral or written contact with the employer, per 5. and 6. below. If all else fails, take the service member's signed allegation, and proceed as explained in 7. below.

Except as provided in 7. below, you need not document the reason for using one verification method rather than another.

b. Ask the service member to estimate the amount and expected payment date of future clothing allowances.

NOTE: Clothing allowances usually are paid annually.

c. Keep in mind the need to consider retroactive adjustments of pay and allowances per D.6. above when determining countable income.

2. Pay Slips—General

Whenever possible, use the individual's copy of an LES to verify the gross pay for a work month, including both earned and unearned income.

NOTE: In most cases, two checks are issued to pay the amounts due for the month, and these checks are issued in different months, as explained in C.3. above.

Determine how much earned and unearned income is countable for each payday. Use the charts in 3. and 4. below unless evidence indicates another method would be more appropriate. If you use another method, document the reason in file. Carry all calculations three digits to the right of the decimal point.

See 4. below for an example of the use of an LES in dividing gross pay between paydays. See 0830.541C. for an example of the use of a worksheet to perform these calculations.

3. Pay Slips—Army and Officers

Use this chart to determine how much earned and unearned income from Army or officer pay is countable for each payday.

STEP	ACTION
1	Divide the mid-month payment by the total net pay for the work month to calculate the fraction of pay and allowances paid mid-month.
2	Multiply the result of step 1 by the basic pay for the work month to calculate wages paid mid-month.
3	Subtract the result of step 2 from the basic pay for the work month to calculate wages paid the first of the next month.
4	Add up all other pay and allowances for the work month.
5	Multiply the result of step 1 by the result of step 4 to calculate the amount of unearned income paid mid-month.
6	Subtract the result of step 5 from the result of step 4 to calculate the amount of unearned income paid the first of the next month.

4. Pay Slips--Non-Army, Non-Officer—Example

Use this chart to determine how much earned and unearned income from non-Army and non-officer is countable for each payday.

To see the procedure illustrated, refer to the example in the right column of the chart below (and in the completed worksheet in S0830.541C.), which is based on the following case facts:

- Karen Dean is an Medicaid recipient married to Ken Dean, an enlisted person in the Air Force.
- The couple lives in off-base housing.
- Mr. Dean is paid twice a month. Mr. Dean's LES for October 1992 shows the following (gross) entitlements:

  base pay -- $808.80
  quarters -- $253.20
  rations -- $166.47
  variable housing allowance (VHA) --$34.14

- The LES shows a mid-month (October 15) net payment of $564.02 and a first-of-month (November 1) net payment of $569.39.

NOTE: In the example, the results of steps 8 and 13 below provide the gross wages and unearned income paid October 15. The results of steps 9 and 14 provide the gross wages and unearned income paid November 1.

E. Procedure—

4. Pay Slips-- Non-Army, Non-Officer -- Example (cont.)

STEP	ACTION	EXAMPLE
1	Divide the total subsistence (i.e., rations) allowance for the work month by the number of days in the calendar month of work to calculate the daily subsistence rate.	$ 166.470 ÷ 31 $ 5.370
2	Multiply the result of step 1 by 15 days (regardless of the number of days in the work month) to calculate the subsistence allowance paid mid-month.	$ 5.370 x 15 $ 80.550
3	Subtract the result of step 2 from the total subsistence allowance for the work month to calculate the subsistence allowance paid the first of the next month.	$ 166.470 - 80.550 $ 85.920
4	Subtract the result of step 2 from the net amount paid mid-month to calculate the total nonsubsistence pay (i.e., special pay and allowances for quarters and clothing) issued mid-month.	$ 564.020 - 80.550 $ 483.470
5	Subtract the result of step 3 from the net amount paid first-of-month to calculate the total nonsubsistence pay for the work month.	$ 569.390 - 85.920 $ 483.470
6	Add the result of steps 4 and 5 to calculate the total net nonsubsistence pay for the work month.	$ 483.470 + 483.470 $ 966.940
7	Divide the result of step 4 by the result of step 6. The result is the fraction of basic pay, special pay, and nonsubsistence allowances paid mid-month.	$ 483.470 ÷ 966.940 $ .500
8	Multiply the result of step 7 by the basic pay for the work month to calculate wages paid mid-month.	$ 808.800 x .500 $ 404.400
9	Subtract the result of step 8 from the basic pay for the work month to calculate wages paid the first of the next month.	$ 808.800 ÷ 404.400 $ 404.400
10	Add up all Quarters Allowance: other pay and VHA: allowances for work month, except for subsistence.	$ 253.200 + 34.140 $ 287.340
11	Multiply the result of step 7 by the result of step 10 to calculate the nonsubsistence unearned income paid mid-month.	$ 287.340 ÷ .500 $ 143.670

E. Procedure Pay Slips—Non-Army, Non-Officer -- Example (cont.)

12	Subtract the result of step 11 from the result of step 10 to calculate the nonsubsistence unearned income paid the first of the next month.	$ 287.340 - 143.670 $ 143.670
13	Add the results of steps 2 and 11 to calculate the total unearned income paid mid-month.	$ 80.550 + 143.670 $ 224.220
14	Add the result of steps 3 and 12 to calculate the total unearned income paid the first of the next month.	$ 85.920 + 143.670 $ 229.590

5. Oral Statement of Employer

If LES's are not available, verify, if possible, the amounts of pay and allowances by telephone contact with the service member's Pay and Finance Office. Document the information.

6. Written Information from Employer

If LES's are not available and telephone contact with the employer is not productive, request pay information in writing as follows:

a. Request Information From Military Installation
- Request information from the Pay and Finance Office of the service installation to which the service member is attached.
- Ask the installation for copies of LES's for needed months in the period under review.
- Provide the installation with the beginning and ending dates of service if the member is no longer on active duty.
- Determine monthly income per 2.-4. above.

b. Member's Installation Will Not Provide Information
- Request the information from the national Pay and Finance Center for the member's branch of service. (Reserve components, other than the National Guard, are part of their service branches.)

NOTE: Since responses from the national centers often take 30-45 days, make requests to them only when the service member's base will not cooperate.

7. Signed Allegation

If other methods (2., 5., and 6. above) of verifying basic pay, special pay, and allowances are unproductive, document the file accordingly. Take the service member's signed allegation of the amounts along with any available supporting evidence.

F. References

- Advance dated paychecks, S0810.030.
- Allotments sent to dependents, S0810.120.
- Estimating future pay and allowances, S0810.600.-620.
- Evidence not readily available, S0830.005A.6.
- Uniformed services monthly Income Worksheet, S0830.541.

G. List of Common Abbreviations On LES's

CATEGORY	ABBREVIATIONS	MEANING
Clothing	BCRA CLOTHING ALW CMA CRA FCRA SCRA UNIF	clothing allowances
Quarters	ASHA AVHA BAQ FSBAQ INADQTR OHA RENT COL SHA TLA VHA	advance housing allowances basic allowance for quarters family separation BAQ inadequate quarters allowance overseas housing allowance payroll deduction for rent station housing allowance temporary lodging allowance variable housing allowance
Special Pay	DIVE EB FDP HDIP HFP HSTL PROPAY SRB VRB	special pay for diving enlistment bonus foreign duty pay hazardous duty pay hostile fire pay superior performance pay reenlistment bonuses

G. List of Common Abbreviations On LES's (cont.)

CATEGORY	ABBREVIATIONS	MEANING
Subsistence	BAS	basic allowance for subsistence
	EMR	rations allowances
	FLD RAT	
	FLDRE	
	LR	
	LV RATS	
	RATS-LV	
	RATS-SEP	
	SEP RATS	
	SR	
Miscellaneous	ACLVN	accrued leave (unearned income)
	ACLVT	accrued leave (basic pay)
	AP (APA)	advance pay (and allowances)
	BP	basic pay
	DLA	dislocation allowance
	EOM	end-of-month payment (actually paid on the first day of the next month)
	FSA	family separation allowance
	MALT	monetary allowance in lieu of transport
	MM MID-MO PMT	mid-month payment
	SGLI	Servicemen's Group Life Insurance
	USSH	U.S. Soldiers' Home (charitable deduction)

H. List of National Pay and Finance Centers

SERVICE BRANCH	FACILITY ADDRESS
Air Force	Documentation Branch Directorate of Resource Management Building 444 HQ Air Force Accounting Finance Denver, CO 80279
Air National Guard	The Adjutant General, VA Attn: Executive Support Staff Officer for Air 401 E. Main Street Richmond, VA 23219
Army	USAFAC, CMDR Social Security Sections Centralized Pay Operations Fort Benjamin Harrison Indianapolis, IN 46249-0865
Army National Guard	The Adjutant General, VA 401 E. Main Street Richmond, VA 23219
Coast Guard	Commandant U.S. Coast Guard Washington, DC 20593
Marine Corps	Centralized Pay Division Marine Corps Finance Center 1500 East Bannister Road Kansas City, MO 64197
National Oceanic and Atmospheric Administration	Commissioned Personnel Division NCI Rockwall Building, Room 115 Department of Commerce, NOAA Rockville, MD 20852
Navy	Navy Finance Center Anthony J. Celebrezze Building Cleveland, OH 44199
Public Health Service	U.S. Public Health Service Employment Operations Branch Commissioned Personnel Division Park Lawn Building, Room 4-35 5600 Fishers Lane Rockville, MD 20852

S0830.541 UNIFORMED SERVICES -- WORKSHEETS

A. Introduction

Form SSA-3991 and form SSA-3992 guide the user through the calculation of monthly earned and unearned income using a leave and earnings statement (LES), as explained in S0830.540 E. Use of these worksheets is optional.

B. Procedure

1. Heading

Enter the names, Social Security number, and page number at the top of the form.

Then **enter the consecutive LES work months** (i.e., the calendar months and years of work).

2. Section I

Enter the verified amounts of pay from the LES for each work month requested. If using the SSA-3992, also enter the number of days in each calendar month of work.

NOTE: The "Net Pay First-of-Month" entry refers to the **second** regular payment for the work month, usually issued on the first day of the following month.

3. Section II

Perform the calculations (described in the first column) within each of the columns headed by a work month. Carry each result to 3 decimal places, dropping the fourth digit, if any.

4. Section III

a. **Enter the same months** at the top of the "Received in" columns as were entered in the "LES Work Month" columns.

b. **Enter the amounts from the requested cells in Section II (and from the previous worksheet used, if any).**

NOTE: In Section III, all cell names in column 1 that begin with "4" are carry-over amounts from the last column of a previous worksheet.

c. **Total the entries** to obtain countable earned and unearned income for each month.

C. Exhibits

If you choose to use either the SSA-3991 or the SSA-3992, you must reproduce the appropriate exhibit below; the forms will not be available by order.

The completed example below illustrates use of the SSA-3992 in the situation described in S0830.540. E.4.

C. Exhibits (Cont.)

UNIFORMED SERVICES MONTHLY INCOME WORKSHEET (All Army and Officers)				
Applicant/Recipient A/N				
Service Member Page _____ Of _____				
	LES Work Month 1 _____/_____	LES Work Month 2 _____/_____	LES Work Month 3 _____/_____	LES Work Month 4 _____/_____
Section I: Pay Amounts from the LES				
Basic Pay	1A	2A	3A	4A
Total Allowances and Special Pay	1B	2B	3B	4B
Net Pay Midmonth	1C	2C	3C	4C
Net Pay First-of-Month	1D	2D	3D	4D
Section II: Calculations (Carry to 3 decimal places.)				
C + d	1E	2E	3E	4E
C ÷ E	1F	2F	3F	4F
A x F	1G	2G	3G	4G
A - G	1H	2H	3H	4H
B x F	1J	2J	3J	4J
B - J	1K	2K	3K	4K

Section III: Countable Income by Month of Receipt

Received in Month 1 _____/_____	Received in Month 2 _____/_____	Received in Month 3 _____/_____	Received in Month 4 _____/_____
EARNED INCOME 4H*: + 1G : Total:	EARNED INCOME 1H: + 2G: Total:	EARNED INCOME 2H: + 3G: Total:	EARNED INCOME 3H: + 4G: Total:
UNEARNED INCOME 4K*: + 1J : Total:	UNEARNED INCOME 1K: + 2J: Total:	UNEARNED INCOME 2K: + 3J: Total:	UNEARNED INCOME 3K: + 4J: Total:
*Carried over from column 4 of prior worksheet.			

Form SSA-3991

C. Exhibits (Cont.)

UNIFORMED SERVICES MONTHLY INCOME WORKSHEET (Non-Army, Non-officers)

Applicant/Recipient **A/N**

Service Member **Page _____ Of _____**

	LES Work Mth 1 _____/_____	LES Work Mth 2 _____/_____	LES Work Mth 3 _____/__	LES Work Mth 4 _____/__
Section I: Pay Amounts from the LES				
Basic Pay	1A	2A	3A	4A
Total Subsistance	1B	2B	3B	4B
Total Nonsubsistance Allowance & Special Pay	1C	2C	3C	4C
Net Pay Midmonth	1D	2D	3D	4D
Net Pay First-of-Month	1E	2E	3E	4E
Number of Days in Month	1F	2F	3F	4F
Section II: Calculations (Carry to 3 decimal places.)				
B ÷ F	1G	2G	3G	4G
G x 15	1H	2H	3H	4H
B - H	1J	2J	3J	4J
D - H	1K	2K	3K	4K
E - J	1L	2L	3L	4L
K + L	1M	2M	3M	4M
K ÷ M	1N	2N	3N	4N
A x N	1P	2P	3P	4P
A - P	1Q	2Q	3Q	4Q
C x N	1R	2R	3R	4R
C - R	1S	2S	3S	4S

Section III: Countable Income by Month of Receipt

Received in Month 1 /	Received in Month 2 /	Received in Month 3 /	Received in Month 4 /
EARNED INCOME	EARNED INCOME	EARNED INCOME	EARNED INCOME
4Q*:	1Q:	2Q*:	3Q:
+ 1P :	+ 2P:	+ 3P:	+ 4P:
Total:	Total:	Total:	Total:
UNEARNED INCOME	UNEARNED INCOME	UNEARNED INCOME	UNEARNED INCOME
4J*:	1J:	2J:	3J:
+ 4S*:	+ 1S:	+ 2S:	+ 3S:
+ 1H :	+ 2H:	+ 3H:	+ 4H:
+ 1R :	+ 2R:	+ 3R:	+ 4R:
Total:	Total:	Total:	Total:

*Carried over from column 4 of prior worksheet.

Form SSA-3992

C. Exhibits (Cont.)

UNIFORMED SERVICES MONTHLY INCOME WORKSHEET (Non-Army, Non-officers)				
Applicant/Recipient Karen Dean A/N				
Service Member Ken Dean Page _____ Of _____				
	LES Work Mth 1 10 /93	**LES Work Mth 2** _____/_____	**LES Work Mth 3** _____/_____	**LES Work Mth 4** _____/_____
Section I: Pay Amounts from the LES				
Basic Pay	**1A 808.80**	**2A**	**3A**	**4A**
Total Subsistance	**1B 166.47**	**2B**	**3B**	**4B**
Total Nonsubsistance Allowance & Special Pay	**1C 287.34**	**2C**	**3C**	**4C**
Net Pay Midmonth	**1D 564.02**	**2D**	**3D**	**4D**
Net Pay First-of-Month	**1E 569.39**	**2E**	**3E**	**4E**
Number of Days in Month	**1F 31**	**2F**	**3F**	**4F**
Section II: Calculations (Carry to 3 decimal places.)				
B ÷ F (166.47 ÷ 31)	**1G 5.370**	**2G**	**3G**	**4G**
G x 15 (5.370 x 15)	**1H 80.550**	**2H**	**3H**	**4H**
B - H (166.47 - 80.550)	**1J 85.920**	**2J**	**3J**	**4J**
D - H (564.02 - 80.550)	**1K 483.470**	**2K**	**3K**	**4K**
E - J (569.39 - 85.920)	**1L 483.470**	**2L**	**3L**	**4L**
K + L (483.470 ÷ 483.70)	**1M 966.940**	**2M**	**3M**	**4M**
K ÷ M (483.470 ÷ 966.940)	**1N 0.500**	**2N**	**3N**	**4N**
A x N (808.80 x 0.500)	**1P 404.400**	**2P**	**3P**	**4P**
A - P (808.80 - 404.400)	**1Q 404.400**	**2Q**	**3Q**	**4Q**
C x N (287.34 x (0.500)	**1R 143.670**	**2R**	**3R**	**4R**
C - R (287.34 - 143.670)	**1S 143.670**	**2S**	**3S**	**4S**
Section III: Countable Income by Month of Receipt				
Received in Month 1 10/93 **EARNED INCOME** 4Q*: -- + 1P: 404.400 **Total: 404.400** **UNEARNED INCOME** 4J*: -- + 4S*: -- + 1H: 80.550 + 1R: 143.670 **Total: 224.220**	**Received in Month 2** 11/93 **EARNED INCOME** 1Q : 404.400 + 2P: -- **Total: 404.400** **UNEARNED INCOME** 1J: 85.920 + 1S: 143.670 + 2H: -- + 2R: -- **Total: 229.590**	**Received in Month 3** / **EARNED INCOME** 2Q*: + 3P: **Total:** **UNEARNED INCOME** 2J: + 2S: + 3H: + 1R: **Total:**	**Received in Month 4** / **EARNED INCOME** 3Q: + 4P: **Total:** **UNEARNED INCOME** 3J: + 3S: + 4H: + 4R: **Total:**	

***Carried over from column 4 of prior worksheet.**

S0830.543 SICK PAY AS UNEARNED INCOME

A. Policy

Any payments on account of sickness and accident disability paid more than 6 months after work stopped because of that sickness or disability are unearned income.

B. References

1. Earned or Unearned?

For detailed guidelines for determining whether sick pay is earned or unearned income, see S0820.005.

2. Amount of Income

For instructions on the amount of unearned income sick pay that is countable to the individual, see S0830.100.

M0830.545 DEATH BENEFITS

A. Definitions

A death benefit is something received as the result of another's death. Examples of death benefits include:

- proceeds of life insurance policies received due to the death of the ... insured;
- lump sum death benefits from SSA;
- RR burial benefits;
- VA burial benefits;
- inheritances in cash or non cash;
- cash given by relatives, friends, or a community group to "help out" with expenses related to the death.

NOTE: Recurring survivor benefits such as those under title II, private pension programs, etc. are not death benefits.

B. Policy Principle--

Death benefits provided to an individual are income to such individual to the extent that the total amount exceeds the expenses of the deceased person's last illness and burial paid by the individual.

Last illness and burial expenses include: related hospital and medical expenses; funeral, burial plot, and interment expenses; and other related expenses.

C. Operating Policy—Life Insurance Proceeds

A life insurance policy may have been a resource in the past (i.e., the cash surrender value was a resource), at the time of the insured's death that particular resource ceases to exist. The insurance proceeds received as a result of the death are not a converted resource (i.e., the proceeds represent the death benefit payable not a return of the cash surrender value).

D. Operating Procedure

1. Identifying Death Benefits

The Medicaid application and redetermination forms do not ask specifically about death benefits. Be alert for situations where further questioning about death benefits is advisable.

2. Verifying Expenses

Verify all last illness and burial expenses. If verification (e.g., bills, receipts, contact with provider, etc.) cannot be obtained, accept the individual's signed allegation. If an expense has been incurred but not paid, assume the individual will pay the expense unless you have reason to question the situation. No followup is required if the assumption is applied.

Use your judgment to determine whether an expense is reasonably related to the last illness and burial. It is expected that related expenses may include such items as: new clothing to wear to the funeral; food for visiting relatives; taxi fare to and from the hospital and funeral home; etc.

3. Amount of Death Benefits

Accept the individual's signed allegation of the amount of death benefits and when received unless you have reason to doubt the allegation.

4. Income From Death Benefits

To determine the income derived from death benefits, subtract the total expenses from the total death benefits. Count the income in the month the death benefit(s) is received. If death benefits are received in more than one month, assume that the funds first received are the first spent. For example, if the death benefits are $1,000 received in January and $1,000 in February and the allowable expenses are $1,500, count the remaining $500 as income in February.

M0830.550 INHERITANCES

A. Policy

1. Definitions

An **inheritance** is cash, a right, or a noncash item(s) received as the result of someone's death.

2. Inheritance as Income

An inheritance is a **death benefit**. See M830.545.

NOTE: Until an item or right has a value (i.e., can be used to meet the heir's need for food, clothing, or shelter), it is neither income nor a resource. The inheritance is income in the first month it has a value and can be used, if it meets the definition of income. (See S0810.005 A.)

3. Inheritance Already a Resource

An inheritance is not income to an individual if the inheritance is something which was considered that individual's resource (either as a member of an eligible couple or through deeming of resources) immediately before the death.

NOTE: The proceeds of a life insurance policy were **not** a resource before the death. (See M830.545 D.)

B. Procedure

1. General

Follow the instructions at M0830.545 pertaining to death benefits.

2. Establishing Date of Receipt

Individual State laws establish when an inheritance is received.

If it is not specified in state law when an inheritance is "received", assume the individual derives no income until the earliest of:

- the date the individual alleges receiving the inheritances (using a signed statement from the individual or documents in the individual's possession); or
- the date the estate is closed (which may be determined by contacting the court or an attorney involved in the closing of the estate).

3. Amount Received

a. Verify the amount or value of the inheritance using:

- **documents** in the individual's possession;
- a **court order** closing the estate;
- a copy of the **will**; or
- an **estimate** from a knowledgeable source, if real property involved.

b. Based on what the inheritance is, apply the appropriate instructions for valuing what was received. Depending upon what has been received, some instructions will be found in S0810 (Income) and some in S1120.001. (Resources). See C. below.

C. References

Trusts, M1120.200

Types of liquid resources, S1110.305

Inheritance and unprobated estates, M1120.215

Real property, M1130.100.

Personal property--household goods and personal effects, M1130.430

Personal property--automobile, M1130.200

EXCLUSIONS INVOLVING ASSISTANCE PROGRAMS

S0830.600 LOW INCOME ENERGY ASSISTANCE

A. Introduction

Through a block grant, the Federal Government provides funds to States for energy assistance (including weatherization) to low income households. This assistance may be provided by a variety of agencies (e.g., state or local welfare offices, community action agencies, special energy agencies, etc.) and known by a variety of names (e.g., HEAP, Project Safe, etc.) It is most often provided in a medium other than cash (e.g., voucher, two-party check, direct payment to vendor, etc.) but may be in cash.

B. Policy

Home energy assistance payments or allowances provided under subchapter II of chapter 94, title 42 of the U.S. Code (Low-Income Energy Assistance) are excluded from income and resources.

C. Procedure

Use documents in the individual's possession, contact with the provider or agency involved, or a precedent to verify that assistance from a particular program is provided under the Federal Low-Income Home Energy Assistance Program or "LIHEAP". Once this is verified, no further development or documentation is necessary.

D. References

Home energy assistance and support and maintenance assistance, S0830.605.

S0830.605 HOME ENERGY ASSISTANCE AND SUPPORT AND MAINTENANCE ASSISTANCE (HEA/SMA)

A. Background

The legislative intent of this exclusion was to address charitable efforts by the community to help Medicaid recipients.

NOTE: See S0830.600 for instructions pertaining to energy assistance provided under Federal programs.

B. Policy — Definitions

1. Appropriate State Agency

The **appropriate State agency** is the agency designated by the chief executive officer of the State to handle the State responsibilities with regard to the home energy assistance and support and maintenance (HEA/SMA) exclusion. In Virginia it is the Department of Social Services.

2. Based on Need

For purposes of this exclusion, **based on need** means that the provider of the assistance:

- does not have an express obligation to provide the assistance ;
- states the aid is given for the purpose of support and maintenance assistance or for home energy assistance (e.g., vouchers for heating/cooling bills, storm door); and
- provides the aid for an Medicaid applicant/recipient, a member of the household in which a Medicaid applicant/recipient lives, or a Medicaid applicant/recipient ineligible spouse, or parent.

3. Private Nonprofit

A private nonprofit agency is a religious, charitable, educational, or other organization **such as** described in section 501(c) of the Internal Revenue Code of 1954. (Actual tax exempt certification by IRS is not necessary.)

4. Rate-of-Return Entity

A rate-of-return entity is an entity (generally a utility company) whose revenues are primarily received from the entity's charges to the public for goods or services and such charges are based on rates regulated by a State or Federal governmental body.

5. Support and Maintenance Assistance (SMA)

Support and maintenance assistance (SMA) is in-kind support and maintenance, or cash provided for the purpose of meeting food, clothing, or shelter needs. It includes home energy assistance.

NOTE: Remuneration for work is not assistance.

6. Home Energy Assistance (HEA)

Home energy assistance is any assistance related to meeting the costs of heating or cooling a home. It includes such items as payments for utility service or bulk fuels, assistance in kind such as portable heaters, fans, blankets, storm doors, or other items which help reduce the costs of heating and cooling such as conservation or weatherization materials and services.

C. Policy Exclusion

1. Certification

a. General

Home energy or support and maintenance assistance is excluded from income if it is certified in writing by the appropriate State agency to be both based on need and:

- provided **in kind** by a private nonprofit agency; or
- provided **in cash or in kind** by a supplier of home heating oil or gas, a rate-of-return entity providing home energy, or a municipal utility providing home energy.

b. State Certification: Individual or Blanket

State certification may be in the form of an individual certification of a particular case, or a **"blanket"** certification of a program or organization. A blanket certification serves as a precedent for assistance from the certified agency or program.

2. Recipient of Assistance

The exclusion applies to such assistance provided for:

- Medicaid applicant/recipient;
- a member of the household in which Medicaid applicant/recipient lives; or
- Medicaid applicant's/recipient's spouse, or parent(s).

D. Procedure

1. General

At times, the interaction of the private and public sectors and various funding sources may make it difficult to determine whether income received may be excluded under these instructions. Exclude assistance on the basis of the individual's allegation and a State certification precedent without further development unless you have reason to question the situation.

2. Statement Required-Income

Obtain a signed statement which identifies:

- the HEA or SMA received;
- when the HEA or SMA was received;
- who received the HEA or SMA; and
- the source of the HEA or SMA.

3. Certification Before Assistance

- Certification may be made before any assistance is actually provided.
- Exclude assistance which might meet the requirements for State certification pending certification.
-

4. Certification Precedent Established

If a precedent has been established, document the file to state that a precedent exists unless the certification is listed in regional instructions. Exclude the income on the basis of the claimant's/recipient's allegation. (See D.2. above for documentation of the allegation.)

5. Certification Precedent not Established

a. **Exclude** any HEA/SMA assistance which might meet the requirements for State certification.

b. **Contact** the RO unless instructed to do otherwise by regional instructions.

c. **Provide** the name of the individual who allegedly received the assistance, and the alleged amount and/or form, date and/or frequency and source of the assistance.

d. **Do not** contact the State agency directly unless you have been instructed to do so by the RO

E. References

S0830.625, Federal Emergency Management Agency (FEMA) emergency food distribution and shelter programs.

S0830.610 ACTION PROGRAMS/DOMESTIC VOLUNTEER SERVICES

A. Introduction

The Federal government through the ACTION, the Federal domestic volunteer agency, is involved in a number of volunteer service programs including:

- Volunteers in Service to America (VISTA);
- University Year for ACTION (UYA);
- Special and Demonstration Volunteer Programs;
- Retired Senior Volunteer Program (RSVP);
- Foster Grandparent Program;
- Senior Companion Program.

B. Policy

1. General Exclusion

Payments to volunteers under chapter 66 of title 42 of the U.S. Code Domestic Volunteer Services (ACTION programs) are excluded from income and resources.

2. Exception

Payments are not excluded if the Director of the ACTION agency determines that their value, adjusted to reflect the hours served, is equivalent to or greater than the minimum wage in effect under the Fair Labor Standards Act of 1938 or the minimum wage under the applicable State law, whichever is greater.

NOTE: See assumption in C.3. below. To date, the Director of Action has not made the above determination and the ACTION agency does not foresee that such a determination will ever be made.

C. Procedure

1. Assume Excluded

Assume that all payments made by ACTION programs are excludable.

2. Verify Program

Use documents in the individual's possession, contact with the program or agency involved or a precedent to verify that a program is one of those listed in A. above or is otherwise funded by or according to agreement with the Federal government under an ACTION program.

3. Accept Allegation

Accept an individual's allegation of participation in an ACTION program and exclude any payments from income and resources without further development or documentation.

S0830.615 COMMUNITY SERVICE BLOCK GRANTS

A. Background

The Department of Health and Human Services makes community service block grants to States to provide a broad range of services and activities to assist low-income individuals and alleviate the causes of poverty in a community. States may subsequently make grants or enter into contracts with private nonprofit organizations or political subdivisions.

B. Policy--Principle

Assistance involving community service block grants is subject to the general rules pertaining to income. It is neither IBON (S0830.170) nor ABON (S0830.175).

C. Operating Procedures

Determine the nature of the assistance and apply the appropriate operating instructions pertaining to income and income exclusions. Related sections include:

S0815.050, Medical and Social Services
S0830.605, Home energy Assistance and Support and Maintenance Assistance
S0810.420, $20 General Income Exclusion

M0830.620 DISASTER ASSISTANCE--PRESIDENTIALLY-DECLARED DISASTER

A. Background

1. General

This section addresses presidentially-declared disasters. There are no specific instructions or exclusions addressing other disasters.

2. Declaration

At the request of a State governor, the President may declare a major disaster when the disaster is of such severity and magnitude that effective response is beyond the capabilities of the State and local governments, and Federal assistance is needed. Disasters include such things as hurricanes, tornadoes, floods, earthquakes, volcano eruptions, landslides, snowstorms, drought, etc.

3. Source

Assistance provided to victims of a presidentially-declared disaster includes assistance from:

- Federal programs and agencies;
- joint Federal and State programs;
- State or local government programs;
- private organizations (e.g., the Red Cross).

B. Policy

1. Support and Maintenance Other Than Repair or Replacement of Property

The value of support and maintenance in cash or in kind is excluded from countable income if:

a. the individual lived in a household which he or she (or he/she and another person) maintained as his/her or their home at the time a catastrophe occurred in the area; and

b. the President declared the catastrophe a major disaster for purposes of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (formerly the Disaster Relief Act of 1974); and

c. the individual stopped living in his/her home because of the catastrophe and began to receive support and maintenance within 30 days after the catastrophe; and

d. the individual receives support and maintenance while living in a residential facility maintained by another person. A residential facility is to be interpreted broadly, including a private household, a shelter, or any other temporary housing arrangement resorted to because of the disaster.

2. Other Disaster Assistance

Assistance (other than support and maintenance described in B.1. above) received under the Robert T. Stafford Disaster Relief and Emergency Assistance Act or any other Federal statute because of a catastrophe which the President declares to be a major disaster, is excluded from countable income. This includes assistance to repair or replace the individual's own home or other property, and disaster unemployment assistance.

3. Interest Earned

Any interest earned on assistance described in B.2. above is excluded from countable income.

C. Process--Verification of Presidential Declaration

A declaration by the President of a major disaster will be public information, i.e., newspaper, television, radio, and printing in the Federal Register. The Office of the ARC, Programs for the area is responsible for confirming a presidential declaration of a major disaster and the geographic area involved and communicating this information.

D. Procedure

1. Presidential Declaration - Documentation

When a residentially-declared disaster has been verified, document the following:

a. that it is declared to be a major disaster by the President in accordance with the Robert T. Stafford Disaster Relief and Emergency Assistance Act;

b. the geographic areas included in the declared disaster area;

c. the fact that the Medicaid applicant/recipient lived in the declared disaster area and was affected by the disaster; and

d. the exact date(s) on which the disaster occurred.

NOTE: If a precedent has been established, only document the fact that the Medicaid applicant/recipient lived in the disaster area and was affected by the disaster.

2. Support and Maintenance

a. Absent evidence to the contrary:

- **Accept** an individual's allegation that he was affected by the disaster and that he is receiving support and maintenance on a temporary basis as a result.

- **Assume** that a living arrangement change due to a disaster is temporary.

b. **Be alert** to situations where an individual reports a change in circumstances (living arrangements, receipt of household items, cash receipts, etc.) which has been brought about by a disaster, but the individual has not reported involvement in the disaster.

3. Verification of Assistance Other Than Support and Maintenance

Use documents in the individual's possession, or contact with the source to verify that assistance, other than support and maintenance subject to the exclusion in B.1. above, is provided under a Federal statute and because of the disaster.

E. Reference

Disaster assistance (exclusion from resources), S1130.620.

S0830.625 FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA) EMERGENCY FOOD DISTRIBUTION AND SHELTER PROGRAMS

A. Background

Through a national board chaired by the Federal Emergency Management Agency (FEMA) and local boards, funds are provided to private nonprofit organizations and State and local governmental entities for the purpose of providing emergency food and shelter to needy individuals. The entity receiving these funds decides how they will be best used (e.g., to buy beds and blankets, to stock a soup kitchen or to pay an individual's rent). The Federal funds are not provided to meet ongoing basic needs.

B. Policy Principle

Assistance involving FEMA funds is subject to the general rules pertaining to income and income exclusions. It is neither IBON (S0830.170) nor ABON (S0830.175).

C. Operating Procedures

Determine the nature of the assistance and apply the appropriate operating instructions pertaining to income and income exclusions. Related sections include:

S0815.050 (Medical and Social Services)
S0830.605 (Home Energy Assistance and Support and Maintenance Assistance)
S0810.420 ($20 General Income Exclusion)

NOTE: Assistance involving FEMA funds is most often provided in kind by private nonprofit organizations and with State certification will qualify for exclusion as HEA/SMA (see S0830.605).

S0830.630 FEDERAL HOUSING ASSISTANCE

A. Introduction

The Federal Government through the Office of Housing and Urban Development (HUD) and the Farmers Home Administration (FMHA) provides many forms of housing assistance including:

- Subsidized housing (e.g., public housing, reduced rent, cash towards utilities, etc.);
- loans for renovations;
- loans for construction, improvement, or replacement of farm homes and other buildings;
- mortgage or investment insurances;
- guaranteed loans and mortgages.

This assistance may be provided directly by the Federal Government or through other entities such as local housing authorities, nonprofit organizations, etc.

B. Policy

1. Exclusion

The value of any assistance paid with respect to a dwelling unit is excluded from income and resources if paid under:

- the United States Housing Act of 1937 (section 1437 et seq. of 42 U.S.C.)
- the National Housing Act (section 1701 et seq. of 12 U.S.C.)
- section 101 of the Housing and Urban Development Act of 1965 (section 1701s of 12 U.S.C., section 1451 of 42 U.S.C.);
- title V of the Housing Act of 1949 (section 1471 et seq. of 42 U.S.C.); or
- section 202(h) of the Housing Act of 1959.

C. Procedure

1. Assumption

Assume that any housing assistance in which HUD or FMHA is involved is subject to the exclusion in B. above.

NOTE: "Section 8" housing is HUD housing assistance.

2. Allegation Acceptable

Accept an individual's allegation about receipt of housing assistance with HUD or FMHA involvement.

3. HUD or FMHA Involvement Unknown

If an individual alleges receipt of housing assistance and it is not known whether HUD or FMHA is involved, use documents in the individual's possession, contact with the appropriate housing authority, or a precedent (see Note below) to verify whether HUD or FMHA is involved.

NOTE: A precedent may be used to establish HUD or FMHA involvement when it has been verified that a project provides only HUD or FMHA assistance.

4. State, Local or Indian Assistance

In some cases, States, Indian tribes, or local housing authorities may control public housing and provide assistance without Federal involvement. See the instructions listed below for pertinent instructions for this and other non-Federal housing assistance.

D. References

Assistance programs with governmental involvement--general S0830.165
Home energy assistance and support and maintenance assistance, S0830.605

S0830.635 FOOD PROGRAMS WITH FEDERAL INVOLVEMENT

A. Policy

1. Food Stamp Program

The value of the food under the food stamp program to any household is excluded from income and resources.

2. School Lunch Programs

The value of any assistance to children under chapter 13 of title 42 of the U.S. Code, School Lunch Programs, is excluded from income and resources.

3. Child Nutrition Programs

The value of any assistance to children (e.g., school breakfasts, WIC Program, Milk Programs) under chapter 13A of title 42 of the U.S. Code, Child Nutrition, is excluded from income and resources.

4. Nutrition Programs for Older Americans

The value of any assistance (other than a wage or salary) provided by any project under chapter 35 of title 42 of the U.S. Code, Programs for Older Americans, is excluded from income.

S0830.640 PROGRAMS FOR OLDER AMERICANS

A. Introduction

The Federal Government through the Administration on Aging is involved in a variety of programs for older Americans. The programs may be operated by State or local governments or community organizations. Some types of programs are:

- health services;
- nutrition services (see S0830.635);
- legal assistance; and
- community service employment.

B. Policy

1. Wage or Salary

A wage or salary paid under chapter 35 or title 42 of the U.S. Code, Programs for Older Americans, is earned income subject to the general Medicaid policies on earned income.

2. Not a Wage or Salary

Anything provided under chapter 35 of title 42 of the U.S. Code, Programs for Older Americans, other than a wage or salary is excluded from income.

C. Procedure

1. Verify Program

Use documents in the individual's possession, contact with the provider or a local council on aging, or a precedent to verify that the program is funded by the Federal Government under chapter 35 of "The Older Americans Act" and whether a wage or salary is paid.

2. Wage or Salary

See S0820.100.

3. Not a Wage or Salary-Accept Allegation

Accept the individual's allegation of receipt of anything other than a wage or salary and exclude it without further development unless you have reason to question the allegation.

D. References

ACTION programs (e.g., foster grandparents, retired senior volunteer program, senior companion program), S0830.610

Food programs with Federal involvement, S0830.635

S0830.645 REFUGEE CASH ASSISTANCE, CUBAN AND HAITIAN ENTRANT CASH ASSISTANCE, AND FEDERALLY REIMBURSED GENERAL ASSISTANCE PAYMENTS TO REFUGEES

A. Background

Refugee Cash Assistance and Cuban Haitian Entrant Cash Assistance and federally funded programs which make ongoing needs-based payments to refugees during their first 18 months in the United States.

B. Policy Principles

1. Refugee Cash Assistance, Cuban and Haitian Entrant Cash Assistance and federally reimbursed general assistance payments to refugees are federally funded income based on need and, unless excluded under a PASS (S0810.430), are counted as income. The $20 general income exclusion (S0810.420) does not apply to this income.

2. A payment under one of these programs is always considered to be a cash payment.

C. Operating Procedures

If a payment is made under one of these programs to a family unit or a group of people, the amount of the grant attributable to one individual in the family is determined by the incremental method (i.e., the income is the difference between the amount paid and the amount which would have been paid had the individual not been included).

S0830.650 REFUGEE RECEPTION AND PLACEMENT GRANTS AND REFUGEE MATCHING GRANTS

A. Background

Federal funds are provided to national voluntary refugee resettlement agencies such as Catholic Charities or the Hebrew Immigrant Aid Society, which provides services (including food, clothing and shelter) related to initial resettlement of new refugees. Assistance involving these funds will usually be received during the first 30 days after the refugee arrives in this country.

Refugee reception and placement grants are provided by the Department of State. Refugee matching grants are provided by the Department of Health and Human Services.

B. Policy Principle

Assistance involving a refugee reception and placement grant or a refugee matching grant is subject to the general rules pertaining to income and income exclusions.

NOTE: Assistance involving a refugee reception and placement grant or a refugee matching grant is not federally funded income based on need (S0830.170). However, do not confuse this assistance with Refugee Cash Assistance, Cuban and Haitian Entrant Cash Assistance, and federally reimbursed general assistance. The latter three types of assistance are provided by governmental entities rather than the voluntary agencies and pertinent instructions are found in S0830.645.

C. Operating Procedures

Consider the assistance to be provided and funded by the voluntary agency. Determine the nature of the assistance and apply the appropriate operating instructions pertaining to income and income exclusions. Related instructions include:

S0815.050 (Medical and Social Services)
S0830.605 (Home Energy Assistance and Support Maintenance Assistance)
S0810.420 ($20 General Income Exclusion)

S0830.655 RELOCATION ASSISTANCE

A. Kinds of Relocation Assistance

Relocation assistance is provided to persons displaced by projects which acquire real property. The following types of reimbursement, allowances, and help are provided:

- moving expenses;
- reimbursement for losses of tangible property;
- expenses of looking for a business or farm;
- displacement allowances;
- amounts required to replace a dwelling which exceed the agency's acquisition cost for the prior dwelling;
- compensation for increased interest costs and other debt service costs of replacement dwelling (if it is encumbered by a mortgage);
- expenses for closing costs (but not prepaid expenses) on replacement dwelling (if it encumbered by a mortgage);
- rental expenses for displaced tenants;
- amounts for downpaymets on replacement housing for tenants who decide to buy;
- mortgage insurance through Federal programs with waiver of requirements of age, physical condition, personal characteristics, etc., which borrowers must usually meet; and
- direct provision of replacement housing (as a last resort).

B. Policy - Federal or Federally Assisted Project

1. Exclusion

Relocation assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 (subchapter II, chapter 61, title 42 of the U.S. Code) is excluded from income.

2. Applicability

This exclusion applies to relocation assistance provided to persons displaced by any Federal or federally-assisted project. Any Federal assistance is sufficient to bring into play the Federal statutes controlling acquisition of real property, requiring that relocation assistance be available and excluded from income.

3. Exception: Revenue Sharing

If the only Federal assistance is revenue sharing, this exclusion does not apply, since such funds are considered to belong to the governmental unit which received them from the Federal Government. However, the exclusion in C. below may apply.

C. Policy - State, Local, or State - Assisted/Locally Assisted Project

1. Exclusion

Relocation assistance provided by a State or local government or through a State-assisted or locally-assisted project, which is the same type of assistance described in A. above (i.e., comparable to relocation assistance provided under the statute shown in B.1. above) is excluded from income.

2. Applicability

This exclusion applies to relocation assistance provided by persons displaced by any State, local, or State-assisted/locally-assisted project.

D. Procedure

Verify that the project which displaces the individual has governmental involvement. This can be done by using documents in the individual's possession, contacting the provider or entity involved in the project, or using a precedent. Once verified, accept the individual's signed statement of the assistance without further development or documentation.
NOTE: If the individual retains relocation assistance beyond the month of receipt, see S1130.670B.

E. References

- Treatment of resources excluded by other Federal statutes, S1130.640.
- Treatment of resources excluded as relocation assistance, S1130.670.

S0830.660 VICTIMS COMPENSATION PAYMENTS

A. Policy

Any payment received from a fund established by a State to aid victims of crime is excluded from income.

B. Procedure

1. Verification

Verify that the compensation came from a State-established fund to aid victims of crime. This can be done by using documents in the individual's possession, contacting the provider or using a precedent. Once verified, accept the individual's allegation of amounts and date of receipt and exclude the payment without further development.

NOTE: If the individual retains compensation payments beyond the month of receipt, see S1130.665 for additional verification requirements.

C. References

- Exclusion from resources of crime victim's compensation payments, S1130.665.

OTHER UNEARNED INCOME EXCLUSIONS

S0830.700 HOME PRODUCE FOR PERSONAL CONSUMPTION

A. Definition Home produce is food which a person catches in the wild or raises.

B. Policy

1. Home Produce Which is Consumed Home produce is excluded from income if it is consumed by the individual or his or her household.

2. Home Produce Which is Sold The proceeds from the sale of home produce are earned or unearned income according to the chart below:

If the activity is	and the individual is	and the income was derived from land the income from which is...	then the value received is.....
not a trade or business	N/A	N/A	unearned income
A trade or business	not an Indian	N/A	net earnings from self-employment (NESE)
	an Indian	exempt from income tax by reason of a Federal statute or treaty	unearned income
		not exempt from income tax by reason of a Federal statute or treaty	NESE

C. Procedure

1. Assumption About Use Assume that any home produce which an individual alleges will be used for personal or household consumption will be so used.

2. Amount of Home Produce Traded or Sold is Small If the produce is basically raised for home consumption rather than as a business and the amount of produce traded or sold is small (e.g., extra eggs, home-canned beans, etc.), assume that the production costs equaled the value of what was received. No income is derived from such a trade or sale.

3. Accept Allegation Accept an individual's allegations concerning the raising, catching, and consuming of home produce unless you have reason to question the allegation.

4. Documentation If you apply an assumption from 1. or 2. above, document the allegation only. No further development or documentation is needed.

S0830.705 REFUNDS OF TAXES PAID ON REAL PROPERTY OR FOOD

A. Policy Any amount received from any public agency as a return or refund of taxes paid on real property or on food purchased is excluded from income.

B. Procedure Accept an allegation that a refund of this nature has been received and exclude the income without further development unless you have reason to question the allegation (e.g., the program making the refunds is unknown, the amount of the refund appears inordinate, etc.).

C. Reference Income tax refunds, S0815.270.

S0830.710 GERMAN REPARATIONS PAYMENTS

A. Introduction German reparations payments are made under the Republic of Germany's Federal Law for Compensation of Nationalist Socialist Persecution ("German Restitution Act") to certain survivors of the Holocaust. The payments may be made periodically or as a lump sum.

B. Policy

1. Income Reparations payments received from the Federal Republic of Germany are excluded from income. These payments are excluded prior to application of the $20 general income exclusion.

2. Interest Income *Interest earned on German Reparations payments received on or after July 1, 2004 is excluded from income.*

C. Procedure If an individual reports receiving German reparations payments, accept a signed allegation of the amount(s) involved and the date(s) these payments were received. No further development or documentation is needed.

D. Reference Exclusion of German reparations payments from resources, S1130.610.

S0830.715 AUSTRIAN SOCIAL INSURANCE PAYMENTS

A. Background

The nationwide class action lawsuit, Bondy v. Sullivan, involved Austrian social insurance payments which were based, in whole or in part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act (GSIA). These paragraphs grant credits to individuals who suffered a loss (i.e., were imprisoned, unemployed, or forced to flee Austria) during the period from March 1933 to May 1945 for political, religious, or ethnic reasons. (The GSIA does not specify what entity, e.g., the government or an employer, must be responsible for the loss in order for the credits to be granted.) Not all Austrian social insurance payments are based on Paragraphs 500-506.

B. Policy

1. Income Rule

Austrian social insurance payments based, in whole or in part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act are not counted as income. Austrian social insurance payments not based, in whole or in part, on wage credits granted under Paragraphs 500-506 are counted as income for Medicaid purposes.

2. Interest Income

Interest earned on Austrian social insurance payments received on or after July 1, 2004 is excluded from income.

C. Description of Award Notices

Austrian pension insurance agencies issue many types of award notices. Some notices contain information about wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act. The notices are written in German, and anywhere in the notice, the following language may appear:

DIE BEGUENSTIGUNGSVORSCHRIFTEN FUER GESCHAEDIGTE AUS POLITISCHEN ODER RELIGIOESEN GRUENDEN ODER AUS GRUENDEN DER ABSTAMMUNG WURDEN ANGEWENDET (§500FF ASVG);

TRANSLATION: "The regulations which give preferential treatment for persons who suffered because of political or religious reasons or reasons of origin were applied (§500ff ASVG)."

D. Procedure

Use this chart to determine whether or not to count Austrian social insurance payments as income.

STEP	ACTION
1	Does the individual have an award notice from an Austrian pension insurance agency? If yes, go to step 2. If no, go to step 4.
2	Does the notice include the German phrase from C. above? If yes, retain a copy of the notice for the file. Go to step 3. If no, retain a copy of the notice for the file. Go to step 4.
3	• Do **not** count the payment as income. • STOP.
4	Does the individual allege that the payment is based, in whole or in part, on wage credits under Paragraph 500-506 of the Austrian General Social Insurance Act? If **yes,** document the allegation. Go back to step 3. If **no**, document the allegation. Go to step 6. If **unknown**, go to step 5.
5	Does the individual allege being imprisoned, unemployed or forced to flee Austria during the period 1933 - 1945 because of political or religious reasons? **NOTE:** The individual need not specify which entity caused the loss. If **yes**, document the allegation. Go back to step 3. If **no**, document the allegation. Go to step 6.
6	• Count the payment as unearned income. • Follow verification requirements in S0830.005 and S0830.105. If verification is not readily available, accept the individual's signed statement as to the amount, source, and frequency of the payment. • STOP.

E. References

- General rules for developing unearned income, S0830.005
- Payments in foreign currency, S0830.105
- Dividends and interest, S0830.500
- German reparations payments, S0830.710
- Treatment of Austrian social insurance payments as resources, S1130.615
- Excluded funds commingled with nonexcluded funds, S1130.700

S0830.720 JAPANESE-AMERICAN AND ALEUTIAN RESTITUTION PAYMENTS

A. Policy

Restitution payments made by the U.S. Government to individual Japanese-Americans or the spouse or parent of an individual of Japanese ancestry (or, if deceased, to their survivors) and Aleuts who were interned or relocated during World War II are excluded from income and resources. Also, restitution payments from the Canadian Government to individual Japanese-Canadians who were interned or relocated during World War II are excluded from income and resources.

Interest earned on Japanese-American and Aleutian Restitution payments received on or after July 1, 2004 is excluded from income.

B. Procedure

Use documents in the individual's possession to verify the nature of these payments. Accept the individual's signed allegation of the amount and date of receipt if this is not evident from the documents.

If the individual alleges receiving restitution payments from the U.S. Government but has no documents which verify this, obtain verification from the:

Office of Redress Administration
U.S. Department of Justice
P. O. Box 66260
Washington, DC 20035-6260

Provide the individual's name, address, date of birth and Social Security number in the request accompanied by signed authorization from the individual for release of information.

If the individual alleges receiving restitution payments from the Canadian Government but has not documents which verify this, ask if the individual was imprisoned, relocated, deported, or deprived of other rights in Canada during the period December 1941 to March 1949 because of their Japanese ancestry.

If the answer is "yes," exclude the payment. If the answer is "no," count the payment as income.

C. Reference

Funds commingled, S1130.700

S0830.725 NETHERLANDS WUV PAYMENTS TO VICTIMS OF PERSECUTION

A. Background

The Dutch government, under the Netherlands' Act on Benefits for Victims of Persecution 1940-1945 (Dutch acronym, WUV), makes payments to both Dutch and non-Dutch individuals who, during the German and Japanese occupation of the Netherlands and Netherlands East Indies (now the Republic of Indonesia) in World War II, were victims of persecution because of their race, religion, beliefs, or homosexuality and, as a result of that persecution are presently suffering from illnesses or disabilities.

Payments under this Act began January 1, 1973 and include four categories of benefits: periodic income payments, compensation for non-definable disability expenses (Dutch acronym, NMIK), reimbursement of persecution related disability expenses, and partial compensation for persecution related disability expenses.

B. Policy

1. Income Rule WUV payments are excluded from income.

2. Interest Income *Interest earned on WUV payments received on or after July 1, 2004 is excluded from income.*

C. Procedure Use documents in the individual's possession to verify that the payment is a Netherlands WUV payment. If the individual has no documentation or there is reason to question the source of the payments, obtain verification from:

Consulate General of the Netherlands
Attn: WUV Department
Suite 509
3460 Wilshire Blvd.
Los Angeles, CA 90010-2270
(213) 480-1471 (9:00 - 12:30 Pacific Time)

If you will also be developing a resource exclusion for retained WUV payments, see S1130.605 for instructions on verifying dates and amounts of payments.

D. References Exclusion of Netherlands WUV Payments From Resources, S1130.605.

S0830.730 AGENT ORANGE SETTLEMENT PAYMENTS

A. Background Agent Orange settlement payments made in connection with the case of **In re Agent Orange Product Liability Litigation** come from a fund created by manufacturers of Agent Orange who agreed to pay into a settlement fund. Payments began in March 1989. Qualifying veterans will receive at least one payment a year for the life of the program. Qualifying survivors of deceased veterans will receive a single lump sum payment.

Interest earned on Agent Orange settlement payments received on or after July 1, 2004 is excluded from income.

B. Policy Effective January 1, 1989, payments made from the Agent Orange settlement fund or any other fund established pursuant to the settlement in the Agent Orange product liability litigation are excluded from income and resources.

S0830.740 RADIATION EXPOSURE COMPENSATION TRUST FUND (RECTF) PAYMENTS

A. Background

Fallout emitted during the U.S. Government's atmosphere nuclear testing in Nevada during the 1950's and during a brief period in 1962 exposed some individuals to doses of radiation that put their health at risk. In addition, some individuals employed in uranium mines during the period January 1, 1947 to December 31, 1971 were exposed to large doses of radiation Public Law Fund 101-426 created the Radiation Exposure Trust Fund (RECTF) and authorizes the Department of Justice (DOJ) to make compensation payments to individuals (or their survivors) who were found to have contracted certain diseases after the exposure. The payments will be made as one-time lump sum. Generally, the exposure occurred in parts of Arizona, Colorado, Nevada, New Mexico, Utah, and Wyoming.

B. Policy

1. RECTF Payments

Payments from RECTF are excluded from income.

2. Interest on Unspent RECTF Funds

Interest earned on unspent RECTF payments received on or after July 1, 2004 is excluded from income.

C. Procedure

Use documents in the individual's possession to verify that the payment is from the RECTF. Accept the individual's signed allegation of the amount and date of receipt if it is not evident from the documents.

If the individual has no documents or there is reason to question the source of the payments, obtain verification from:

The Radiation Exposure Compensation Program
U.S. Department of Justice
P. O. Box 146
Benjamin Franklin Station
Washington, DC 20044-0146

Use the individual's name and Social Security number (SSN) as identifying information when writing to the DOJ. When writing on behalf of a survivor, also include the survivor's name and SSN. Include an authorization from the individual for release of the information.

D. Reference

Exclusion of Radiation Exposure Compensation Trust Fund payments from resources, S1130.680.

M0830.760 WALKER V. BAYER SETTLEMENT PAYMENTS

A. Policy

Section 4735 of the Balanced Budget Act of 1997 (P.L. 105-33) states that payments described in this subsection from the settlement of the Susan Walker v. Bayer Corp., et.al., class action lawsuit are NOT counted as income in determining eligibility for Medicaid. Payments described in this subsection are:

a. payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corp., et. al., 96-C-5024 (N.D.III.); and

b. payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement of Susan Walker v. Bayer Corp., et. al., and that is signed by all affected parties on or before the later of

- December 31, 1997, or
- the date that is 270 days after the date on which such release is first sent to the persons to whom the payment is to be made.

Interest earned on retained funds from payments made pursuant to a class settlement in the case of Susan Walker v. Bayer Corp, et. al. on or after July 1, 2004 is excluded from income.

B. Procedure

Information received by claimants in this lawsuit shows that claimants can choose to receive the payment in one of three ways - in a lump sum, a structured settlement, or a special needs trust. Regardless of which form the individual chooses, the payment(s) are excluded if the above requirements are met.

Verify the source of the funds from a letter from the individual's attorney or a copy of the check which identifies the payer as a Walker v. Bayer settlement account.

SPECIAL CONSIDERATIONS FOR NATIVE AMERICANS

S0830.800 BUREAU OF INDIAN AFFAIRS GENERAL ASSISTANCE

A. Definition

Bureau of Indian Affairs General Assistance (BIA GA) is a federally funded program administered by the Bureau of Indian Affairs (BIA) through its local agency or a tribe. The program makes periodic payments to needy Indians.

B. Policy

BIA GA payments are federally funded income based on need and, therefore, count as income. The $20 per month general income exclusion does not apply.

C. Procedure

Develop BIA GA payments using the instructions and development guidelines for AFDC payments in S0830.400 D. except contact the local agency administering the BIA GA program.

S0830.810 BUREAU OF INDIAN AFFAIRS ADULT CUSTODIAL CARE AND CHILD WELFARE ASSISTANCE PAYMENTS

A. Introduction

Bureau of Indian Affairs (BIA) Adult Custodial Care (ACC) and Child Welfare Assistance (CWA) payments are made on behalf of both institutionalized and noninstitutionalized recipients. BIA foster care payments are made under the ACC and CWA programs.

B. Policy

1. Noninstitutionalized Recipients

BIA ACC and CWA payments (other than foster care assistance) made to noninstitutionalized individuals are federally funded income based on need and, therefore, count as income.

2. Foster Care

BIA foster care assistance is considered a social service and, therefore, is not income for Medicaid purposes.

C. References

- Definition of foster care, S0830.410
- Income Based on need, S0830.170
- Social Services, S0815.050

S0830.820 INDIVIDUAL INDIAN MONEY ACCOUNTS

A. Introduction

No special policy applies to Individual Indian Money (IIM) accounts. Regular income and resources rules concerning restricted and unrestricted accounts apply. The following material is provided for informational purposes only.

IIM accounts are similar to regular bank accounts. Funds retained in an IIM account may earn interest. The BIA area office or agency on the reservation administers these accounts which are either restricted or unrestricted. A restricted account may be converted to an unrestricted account or vice versa, but only with BIA approval.

B. Definitions

1. Restricted IIM Account

A restricted IIM account requires BIA authorization for the individual to make a withdrawal.

2. Unrestricted IIM Account

An unrestricted account does not require BIA authorization for the individual to make a withdrawal.

C. List of IIM Deposit Sources

The following are typical sources of deposits to IIM accounts. The following list is not all-inclusive:

- Money distributed from tribal funds;
- Proceeds from trust sources;
- Proceeds from the sale or conversion of trust capital assets;
- Proceeds from an inheritance interest in trust lands;
- Per capita payments from judgments of the Indian Claim

Commission;
- Proceeds from the sale of crops, livestock, or other personal property held in trust;
- Restricted funds pursuant to a specific plan approved by the Federal Government;
- Benefits from Federal agencies due minors and incompetents who have neither guardians nor payees;
- Lease income.

D. Procedures

Use the following guidelines, when necessary, to develop IIM accounts.

REMINDER: Regular income and resources rules apply to the development of IIM accounts.

As necessary, use information in the recipient's possession, or determine through contact with BIA.

If an account has been converted from restricted to unrestricted or vice versa, note the beginning and ending dates for each period.

E. Examples

These examples show how regular income and resources rules apply to IIM accounts.

Example 1 - Restricted Account

In March, Mr. Strong's $2,200 annual individual Indian trust income payment is deposited, as required by BIA, into the restricted IIM account. The same month, his title II check of $250 is also directly deposited into that account. Because Mr. Strong's title II check was available to him in March (though he opted to have it deposited into his restricted account), regular income rules require treating the $250 as unearned income for that month. If retained in the restricted account, the title II benefits are not a resource.

Under P.L. 103-66, $2,000 of lease income would be excluded per S0830.850. However, per S1140.200, none of the lease income is income when deposited or a resource when retained in the IIM account since Mr. Strong does not have direct control of the funds.

In April, the BIA releases $200 to Mr. Strong. Per S0810.030 A., $200 is counted as unearned income for the month of April since the nonexcludable $200 of the $2,200 lease income was then available to him. Per S1130.700 B.2., the EW assumes that the nonexcludable lease income funds are withdrawn first, leaving as much of the excludable funds in the account as possible.

Example 2 - Unrestricted Account

In May, a $150 per capita payment from locally managed tribal funds is deposited into Mr. Thornton's unrestricted IIM account. Development reveals that these funds were not held in trust by the Secretary of the Interior and, therefore, are not excluded from income and resources. The $150 counts as income to Mr. Thornton in May, per S0810.030 A., and counts as a resource, to the extent retained, in June per S1120.005 B.2. In June, Mr. Thornton withdraws the money from his account. The $150 is a conversion of a resource in June per S0815.200, and is therefore not counted as income for that month.

F. References

- When income is counted, S0810.030
- What is income, S0810.005
- What is not income, S0815.001
- Conversion of a resource, S0815.200
- Definition of resources, S1110.100
- Checking and savings accounts, S1140.200
- Comingled funds, S1130.700

S0830.830 INDIAN-RELATED EXCLUSIONS ACCOUNTS

A. Introduction

For Medicaid purposes, many Federal statutes provide for the exclusion from income and resources of certain payments made to members of Indian tribes and groups. Some statutes pertain to specific tribes or Indian groups while others apply to certain types of payments. Some statutes that predate the SSI program provide that some payments made under those acts shall not be considered as income or resources when determining eligibility for assistance under the Social Security Act.

B. Definition Per Capita Payments

Per capita payments are payments that are made according to the number of individual in a specific group and in which each individual shares equally.

C. Policy - Type of Payment

The following statutes provide that certain **types of payments** made to members of Indian tribes are excluded from income **and** resources (1.-4., below), or **only** from income (5., below).

1. Indian Judgment Funds Distribution Act—Public Law (P.L.) 93-134

Effective October 19, 1973, per capita distribution payments to members of Indian tribes who are due judgment funds, according to a plan of the Secretary of the Interior (or legislation, when a plan cannot be prepared or is not approved by the Congress) are excluded from income and resources. This does not include payments of funds distributed or held in trust (i.e., in the possession or care of a trustee) according to public laws enacted before October 19, 1973.

2. Distribution of Indian Judgment Funds—P.L. 97-458

Effective January 12, 1983, Indian judgment funds held in trust (i.e., in the possession or care of a trustee) or distributed per capita, pursuant to an approved plan, or their availability, are excluded from income and resources Indian judgment funds include interest and investment income accrued while the funds are held in trust. Initial purchases made with distributed judgment funds are excluded from resources.

3. Per Capita Act — P.L. 98-64

Effective August 2, 1983, per capita distributions of all funds held in trust by the Secretary of the Interior to members of Indian tribe are excluded from income and resources.

NOTE: Any local tribal funds that a tribe distributes to individuals on a per capita basis, but which have not been held in trust by the Secretary of the Interior (e.g., tribally managed gaming revenues) are **not** excluded from income and resources under this provision.

4. Alaska Native Claims Settlement Act (ANCSA) — P.L. 100-241

Effective February 3, 1988, the following items received from a native corporation are excluded from income and resources:

- cash received from a native corporation (including cash dividends on stock received from a native corporation) to the extent it does not exceed $2,000 per individual per year;
- stock (including stock issued or distributed by a native corporation as a dividend or distribution on stock);
- a partnership interest;
- land or an interest in land (including land or an interest in land received from a native corporation as a dividend or distribution on stock);
- an interest in a settlement trust.

The ANCSA also provides that up to $2,000 in retained distribution from a native corporation may be excluded from resources for each year beginning with 1988.

5. Payments From Individual Interests in Trust or Restricted Lands — P.L. 103-66

Effective January 1, 1994, up to $2,000 per year received by Indians that is derived from individual interests in trust or restricted lands is excluded from income. (See S0830.850.)

NOTE: Interests of individual Indians in trust or restricted lands are excluded from resources (S1130.150.)

D. Policy — Payments to Specific Indian Tribes and Groups

The following statutes provide that certain payments made to members of **specific Indian tribes and groups** and excluded from income and resources.

1. Distribution of Per Capita Funds — P.L. 85-794

Effective August 28, 1958, per capita payments to members of the **Red Lake Band of Chippewa Indians** from the proceeds of the sale of timber and lumber on the Red Lake Reservation are excluded from income and resources.

2. Distribution of Judgment Funds — P.L. 92-254

Effective March 18, 1972, per capita distribution payments by the **Blackfeet and Gros Ventre** tribal governments to members, which resulted from judgment funds to the tribes, are excluded from income and resources.

3. Distribution of Claims Settlement Funds — P.L. 96-531 and 96-305

Effective December 22, 1974, settlement fund payments to members of the **Hopi and Navajo Tribes,** and the availability of such funds, are excluded from income and resources.

4. Receipts from Lands Held in Trust for Indian Tribes — P.L. 94-114

Effective October 17, 1975, receipts derived from the following trust lands and distributed to members of designed Indian tribes are excluded from income and resources.

The first four Indian groups had lands conveyed with mineral rights prior to P.L. 94-114; that law conveyed the rest of the lands to the remaining Indian groups.

Indian Group	Conveyance Statue	State
Seminole Indians	P.L. 84-736 (70 Stat 581) (July 20, 1956)	Florida
Pueblos of Zia and Jemez	P.L. 84-926 (70 Stat 941) (August 2, 1956)	New Mexico
Stockbridge Munsee Indian Community	P.L. 92- 480 (86 Stat 795) (October 9, 1972)	Wisconsin
Burns Indian Colony	P.L. 92-488 (86 Stat 806) (October 13, 1972)	Oregon

Indian Group	Lands Conveyed Reservation	Lands Conveyed By P.L. 94-114	State
Assiniboine and Sioux Tribe	Fort Peck	LI-MT 6 Fort Peck	Montana
Bad Rive Band of the Lake Superior Tribe of Chippewa Indians	Bad River	LI-WI 8 Bad River	Wisconsin
Blackfeet Tribe of Montana	Blackfeet	LI-MT 9 Blackfeet	Montana
Cherokee Nation of Oklahoma	None	LI-OK 4 Delaware LI-OK 5 Adair	Oklahoma
Cheyenne River Sioux Tribe	Cheyenne River	LI-SD 13 Cheyenne Indian	South Dakota
Crow Creek Sioux Tribe	Crow Creek	LI-SD 10 Crow Creek	South Dakota
Devil's Lake Sioux Tribe	Fort Totten	LI-ND 11 Fort Totten	North Dakota
Fort Belknap Indian Community	Fort Belknap	LI-MT 8 Fort Belknap	Montana
Keweenaw Bay Indian Community	L' Anse	LI-MI 8 L' Anse	Michigan
Lac Courte Oreilles Band of Lake Superior Chippewa Indians	Lac Courte Oreilles	LI-WI 9 Lac Courte	Wisconsin
Lower Brule Sioux Tribe	Lower Brule	LI-SD 10 Lowers Brule	South Dakota
Minnesota Chippewa Tribe	White Earth	LI-MN 6 Twin Lakes LI-MN 15 Flat Lake	Minnesota
Navajo Tribe	Navajo	LI-NM 18 Gallup Two Wells	New Mexico
Oglala Sioux Tribe	Pine Ridge	LI-SD 7 Pine Ridge	South Dakota
Rosebud Sioux Tribe	Rosebud	LI-SD 8 Cutmeat LI-SD 9 Antelope	South Dakota
Shoshone-Bannock Tribe	Fort Hall	LI-ID 2 Fort Hall	Idaho
Standing Rock Sioux Tribe	Standing Rock	LI-ND 10 Standing Rock	North Dakota
		LI-SD 10 Standing Rock	South Dakota

5. Distribution of Judgment Funds — P.L. 94-189	Effective December 31, 1975, judgment fund distributed per capita to, or held in trust for, members of the **Sac and Fox Indian Nation,** and the availability of such funds, are excluded from income and resources.
6. Distribution of Judgement Funds — P.L. 94-540	Effective October 18, 1976, judgment funds distributed per capita to, or held in trust for, members of the **Grand River Band of Ottawa Indians,** and the availability of such funds, are excluded from income and resources.
7. Distribution of Judgment Funds — P.L. 95-433	Effective October 10, 1978, any judgment funds distributed per capita to members of the **Confederated Tribes and Bands of the Yakima Indian Nation** or the **Apache Tribe of the Mescalero Reservation** are excluded from income and resources.
8. Receipts from Lands Held in Trust — P.L. 95-498	Effective October 21, 1978, receipts derived from trust lands awarded to the **Pueblo of Santa Ana** and distributed to members of that tribe are excluded from income and resources.
9. Receipts from Lands Held in Trust — P.L. 95-499	Effective October 21, 1978, receipts derived from trust lands awarded to the **Pueblo of Zia** and distributed to members of that tribe are excluded from income and resources.
10. Distribution of Judgment Funds — P.L. 96-318	Effective August 1, 1980, any judgment funds distributed per capita or made available for programs for members of the **Delaware Tribe of Indians** and the absentee **Delaware Tribe of Western Oklahoma** are excluded from income and resources.
11. Maine Indian Claims Settlement Act — P.L. 96-420	Effective October 10, 1980, all funds and distributions to members of the **Passasmaquoddy Tribe, the Penobscot Nation, and the Houlton Band of Maliseet Indians** under the Maine Indian Claims Settlement Act, and the availability of such funds, are excluded from income and resources.
12. Distribution of Judgment Funds — P.L. 97-95	Effective December 17, 1981, any distributions of judgment funds to members of the **San Carlos Tribe of Arizona** are excluded from income and resources.
13. Distribution of Judgment Funds — P.L. 97-371	Effective December 20, 1982, any distributions of judgment funds to members of the **Wyandot Tribe of Indians of Oklahoma** are excluded from income and resources.
14. Distribution of Judgment Funds — P.L. 97-372	Effective December 20, 1982, distributions of judgment funds to members of the **Shawnee Tribe of Indians (Absentee Shawnee Tribe of Oklahoma, the Eastern Shawnee Tribe of Oklahoma, and the Cherokee Band of Shawnee descendants)** are excluded from income and resources.
15. Distribution of Judgment Funds — P.L. 97-376	Effective December 21, 1982, judgment funds distributed per capita or made available for programs for members of the **Miami Tribe of Oklahoma** and **the Miami Indians of Indiana** are excluded from income and resources.

16. Distribution of Judgment Funds — P.L. 97-402

Effective December 31, 1982, distributions of judgment funds to members of the **Clallam Tribe of Indians of the State of Washington (Port Gamble Indian Community, Lower Elwha Tribal Community, and the Jamestown Band of Clallam Indians)** are excluded from income and resources.

17. Distribution of Judgment Funds — P.L. 97-403

Effective December 31, 1982, judgment funds distributed per capita or made available for programs for mmbers of the **Pembina Chippewa Indians (Turtle Mountain Band, Chippewa Cree Tribe, Minnesota Chippewa Tribe, and Little Shell Band of Chippewa Indians of Montana)** are excluded from income and resources.

18. Distribution of Judgment Funds — P.L. 97-408

Effective January 8, 1983, per capita disributions of judgment funds to members of the **Gros Ventre and Assiniboine Tribes of Fort Belknap Indian Community, and the Papago Tribe of Arizona,** are excluded from income and resources.

19. Distribution of Judgment Funds — P.L. 97-436

Effective January 8, 1983, up to $2,000 of per capita distributions of judgment funds to members of th **Conferated Tribes of the Warm Springs Reservation** are excluded from income and resources.

20. Distribution of Judgment Funds — P.L. 98-123

Effective October 13, 1983, judgment funds distributed to the **Red Lake Band of Chippewa Indians** are excluded from income and resources.

21. Distribution of Claims Settlement Funds — P.L. 98-124

Effective October 13, 1983, funds distributed per capita or family interest payments for members of the **Assiniboine Tribe of the Fort Belknap Indian Community of Montana and the Assiniboine Tribe of the Fort Peck Indian Reservation of Montana** are excluded from income and resources.

22. Distribution of Claims Settlement Funds — P.L. 98-432

Effective September 28, 1984, judgment funds and income therefrom distributed to members of th **Shoalwate Bay Indian Tribe** are excluded from income and resources.

23. Distribution of Claims Settlement Funds — P.L. 98-500

Effective October 19, 1984, all distributions to heirs of certain deceased Indians under the Old Age Assistance Claims Settlement Act are excluded from income and resources.

24. Distribution of Judgment Funds — P.L. 98-602

Effective October 30, 1984, judgment funds distributed per capita or made available for any tribal program, for members of the **Wyandotte Tribe of Oklahoma** and the **Absentee Wyandottes,** are excluded from income and resources.

25. Distribution of Judgment Funds — P.L. 99-130

Effective October 28, 1985, per capita and dividend payment distributions of judgment funds to members of the **Santee Sioux Tribe of Nebraska**, the **Flandreau Santee Sioux Tribe,** and the **Prairie Island Sioux, Lower Sioux,** and **Shakopee Mdewakanton Sioux Communities of Minnesota** are excluded from income and resources.

26. Distribution of Judgment Funds — P.L. 99-146	Effective November 11, 1985, funds distributed per capita or held in trust for members of the **Chippewas of Lake Superior** and the **Chippewas of the Mississippi** are excluded from income and resources.
27. Distribution of Claims Settlement Funds — P.L. 99-264	Effective March 24, 1986, distributed of claims settlement funds to members of the **White Earth Band of Chippewa Indians** as allottees, or their heirs, are excluded from income and resources.
28. Distribution of Judgment Funds — P.L. 99-346	Effective June 30, 1986, payments or distributions of judgment funds, and the availability of any amount for such payments or distributions, to members of the **Saginaw Chippewa Indian Tribe of Michigan** are excluded from income and resources.
29. Distribution of Judgment Funds — P.L. 99-377	Effective August 8, 1986, judgment funds distributed per capita or held in trust for members of the **Chippewas of Lake Superior and the Chippewas of the Mississippi** are excluded from income and resources.
30. Distribution of Judgment Funds — P.L. 100-139	Effective October 26, 1987, judgment funds distributed to members of the **Cow Creek Band of Umpqua Tribe of Indians** are excluded from income and resources
31. Aleutian and Pribilof Islands Restitution Act — P.L. 100-383	Effective August 10, 1988, per capita restitution payments made to eligible **Aleuts** who were relocated or interned during World War II are excluded from income and resources. See S0830.720.
32. Distribution of Claims Settlement Funds — P.L. 199-411	Effective August 22, 1988, per capita payments of claims settlement funds to members of the **Coushatta Tribe of Louisiana** are excluded from income and resources.
33. Hoopa-Yurok Settlement Act —P.L. 100-580	Effective October 31, 1988, funds distributed per capita for members of the **Hoopa Valley Indian Tribe and the Yurok Indian Tribe** are excluded from income and resources.
34. Distribution of Judgment Funds — P.L. 100-581	Effective November 1, 1988, judgment funds held in trust by the United States, including interest and investment income accruing on such funds, and judgment funds made available for programs or distributed to members of the **Wisconsin Band of Potawatomi (Hannahaville Indian Community and Forest County Potawatomi)** are excluded fro income and resources.
35. Distribution of Money and Land — P.L. 101-41	Effective June 21, 1989, all funds assets, and income from the trust fund transferred to the member of the **Puyallup Tribe** under the Puyallup Tribe of Indians Settlement Act of 1989 are excluded from income and resources.

36. Distribution of judgment Funds — P.L. 101-277

Effective April 30, 1990, judgment funds distributed per capita, or held in trust, or made available for programs, for members of the **Seminole Nation of Oklahoma, the SeminoleTribe of Florida,** and **Miccosukee Tribe of Indians of Florida,** (plus any interest and investment income accruing on the funds held in trust), and the availability of those funds, are excluded from income and resources.

37. Distribution of Settlement Funds — P.L. 101-503

Effective November 3, 1990, payments, funds, distributions, or income derived from them under the **Seneca Nation** Settlement Act of 1990 ar excluded from income and resources.

38. Distribution of Settlement Funds — P.L. 101-618

Effective November 16, 1990, per capita distributions of settlement funds under the **Fallon Paiute Shoshone Indian Tribes** Water Rights Settlement Act of 1990 are excluded from income and resources.

E. Procedure

If there is an allegation or other indication that an individual received excluded judgment funds or settlement fund distributions, per capita payments, land, or receipts from land, follow these procedures.

1. Verification of Tribe Member-ship

As necessary, verify that the individual is a member of the relevant tribe by contact with BIA or tribal authorities.

2. Payment/ Distribution Development

Develop the identity and amount of excludable payment or distribution by contact with BIA or tribal authorities or use of a precedent file. Trust Property Income (TPI) reports may also be available form BIA, which list to whom restricted individual Indian property is assigned, and show if lease or grazing rights payments are not paid through BIA or the tribe. If land is distributed, identify the location of the land as recorded by deed or other legal conveyance. (Additional contacts with the Bureau of Land Management may be necessary to develop land information.)

3. Documentation

Document the file using the method(s) below as needed:

- Document case record for verifications made over the phone with the tribal authorities or the BIA area office.
- Income report or comparable document from the BIA, the tribe's governing body, or its official financial representatives.
- Signed statement from the tribal authorities, the BIA area offices, or Bureau of Land Management.

F. References

- Aleutian restitution payment, S0830.720
- BIA student assistance program, S0830.460
- Certain stock in Alaska regional or village corporations, S1120.105
- Commingled funds S1130.700
- Indian trust or restricted funds, S1130.150

S0830.840 ALASKA NATIVE CLAIMS SETTLEMENT ACT EXCLUSIONS

A. Policy

1. Current Exclusions-- Effective February 3, 1988

P.L. 100-241 provided Medicaid income and resource exclusions to Alaska Natives and their descendants. The following items received from a Native Corporation, are excluded from income and resources for Medicaid purposes:

- cash received from a native corporation (including cash dividends on stock received from a native corporation) to the extent it does not exceed $2,000 per individual per year;
- stock (including stock issued or distributed by a native corporation as a dividend or distribution on stock);
- a partnership interest;
- land or an interest in land (including land or an interest in land received from a native corporation as a dividend or distribution on stock);
- an interest in a settlement trust.

S0830.850 EXCLUSION OF INCOME FROM INDIVIDUAL INTERESTS IN INDIAN TRUST OR RESTRICTED LANDS

A. Introduction

Native American income derived from tribal trust lands is excluded by federal statutes (see S0830.830 B). Individual interests of Native Americans in trust or restricted lands are excluded from resources (see S1130.150). The Omnibus Budget Reconciliation Act of 1993 (P.L. 103-66), enacted August 10, 1993, further provides for an exclusion of income derived from those individual interests in Indian trust or restricted lands for purposes of determining Medicaid eligibility.

This income (often called individual Indian trust or lease income) generally comes from interests in lands that were allotted to individual Indians many years ago. The income generated by those interests may be quite small since many of the original interests in allotted lands have fractionated over time, e.g., due to inheritance by multiple heirs over several generations.

B. Policy

Up to $2,000 per year in payments derived from individual interests in Indian trust or restricted lands is excluded from income. Such payments include any interest which accrues on funds while held by B/A and before being distributed or credited to an individual's account.

This exclusion applies to the income of an ineligible spouse or ineligible parent(s) in the deeming process.

For purposes of applying the $2,000 annual exclusion, for both eligibles and deemors, only payments received in months of the Medicaid individual's eligibility count toward the $2,000 annual exclusion.

C. Procedure--Development and Documentation

Verify and document income derived from individual interests in trust or restricted lands per S0830.820 E.

If that income exceeds $2,000 per calendar year, determine the month that the $2,000 annual exclusion was exceeded, and count the excess as unearned income in the months received.

EXAMPLE: During a redetermination interview, Mr. Elwell, a member of the Yakima Indian Tribe, reports receiving accumulated lease payments of $2,800 in 1994 from his individual interests in allotted Indian grazing lands. He alleges receiving $1,000 in March, $700 in June and $ 1,100 in October. Review of case records shows that the payments for March and June were reported timely, but Mr. Elwell was ineligible for Medicaid in June due to receipt of earned income. The eligibility worker (EW) excludes the payment received in March and $1,000 of the payment received in October, and does not consider the $700 received in June. The EW determines unearned income of $100 for October, the month the $2,000 annual exclusion was exceeded.

D. References

- Other Indian related exclusion, S0830.830
- Resource exclusion of individual Indian interests in trust or restricted lands, S1130.150
- Rental Income, S0830.505

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CHAPTER S11

RESOURCES FOR AGED, BLIND, AND DISABLED INDIVIDUALS (ABD) *

SUBCHAPTER 10

RESOURCES, GENERAL

S1110 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	page 2
TN #95	3/1/11	page 2
Update (UP) #3	3/2/10	Table of Contents page 2
TN #93	1/1/10	page 2
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OVERVIEW

M1110.001 ROLE OF RESOURCES

A. Introduction

As a program based on need, Medicaid uses the value of a person's countable resources as one of two financial criteria in determining eligibility. The other criterion is income.

B. Policy Principles

1. Monthly Determinations

Eligibility with respect to resources is a determination made for each calendar month, beginning with the third month prior to the month in which the application is received. Resource eligibility exists for the full month if countable resources were at or below the applicable resource limit for any part of the month.

2. Countable Resources

Not everything a person owns (i.e., not every asset) is a resource and not all resources count against the resource limit. The Social Security Act and other Federal statutes require the exclusion of certain types and amounts of resources. Any assets that are resources but not specifically excluded are "countable." See:

- M1110.003 B.2. for the resource limits;
- S1110.100 for the distinction between assets and resources; and
- S1110.210 for a listing of exclusions.

3. Whose Resources Can Count

Medicaid law specifies that resources are only considered available between spouses and from parents to their children under age *21*, and for certain blind and disabled children ages 18 to 21.

See M1110.530 for blind and disabled children age 18 to 21.

4. Whose Resources Can Not Count

Medicaid law will not allow certain resources to be considered in determining eligibility. Do not count resources:

- From a step-parent.
- From siblings.
- From spouse or parent living apart unless it is a voluntary financial contribution. (Exception for Long-term care)
- From an alien sponsor.

M1110.003 RESOURCE LIMITS

A. Introduction

The resource limit is the maximum dollar amount of countable assets an individual, couple, or family may own and still meet the established criteria for Medical Assistance in an ABD category. These amounts are established by law.

B. Policy Principles

1. Resource Ineligibility

An individual (or couple) with countable resources in excess of the applicable limit is not eligible for Medicaid.

2. Resource Limits

ABD Eligible Group	One Person	Two People
Categorically Needy Cat-Needy Non-money Payment Medically Needy	$2,000	$3,000
ABD With Income ≤ 80% FPL	$2,000	$3,000
QDWI	$4,000	$6,000
QMB SLMB QI	***Calendar Year 2011*** $6,680 ***2010*** *$6,600*	***Calendar Year 2011*** $10,020 ***2010*** *$9,910*

3. Change in Marital Status

A change in marital status can result in a change to the applicable resource limit. The resource limit change is effective with the month that we begin treating both members of a couple as individuals. For example, separation from an ineligible spouse can change the limit from $3,000 to $2,000. See M1110.530 B.

4. Reduction of Excess Resources

Month of Application

Excess resources throughout the month of application causes ineligibility for the application month. Reduction of excess resources within the application month can cause resource eligibility for that month.

ASSETS vs. RESOURCES

S1110.100 DISTINCTION BETWEEN ASSETS AND RESOURCES

A. Introduction

Not everything an individual owns (assets) are resources for Medicaid purposes. Moreover, in certain situations, an asset that is not a resource may become one at a later date or vice versa. The distinction is important since:

- an asset that is not a resource does not count against the resource limit; and
- proceeds from the sale or trade of a resource (i.e., the amount representing conversion of principal from one form to another) are also resources but what a person receives from a nonresource is subject to evaluation as income at the time of receipt.

EXAMPLE: An individual is the beneficiary of a trust which is not his resource. Therefore, when the trust pays him his monthly allowance, he receives income.

B. Policy Principles

1. Resources Defined

Resources are cash and any other personal or real property that an individual (or spouse, if any):

- owns;
- has the right, authority, or power to convert to cash (if not already cash); and
- is not legally restricted from using for his/her support and maintenance.

2. Resources with Zero Value

Property does not cease to be a resource simply because it has no current market value. Even though there is no value to count, the property remains a resource for so long as it meets the criteria in 1. above. If the property develops a market value at a later time, there has been an increase in the value of a resource rather than a receipt of income.

3. Property That Is Not a Resource

Any property (an asset) that does not meet the criteria in 1. above is not a resource even though it may be an asset (e.g., an individual who has an ownership interest in property but is not legally able to transfer that interest to anyone else does not have a resource).

C. Definitions

1. Real Property

Real property is land, including buildings or immovable objects attached permanently to the land.

2. Personal Property

Personal property is any property that is not real property. The term encompasses such things as cash, tools, life insurance policies, and automobiles.

D. Related Policies

1. Conserved Fund in Change-Of-Payee Situations

Conserved funds (or other property) remain resources even during a period when they are being held in a bank account or by the paying agency because it is necessary to obtain a new payee or guardian. See S1120.022.

2. Liquid vs. Nonliquid Resources

Except for cash, any kind of real or personal property may be either liquid or nonliquid. For the distinction between liquid and nonliquid resources, and its significance, see S1110.300.

3. Evaluation of Receipt of Property As Income

When an individual first receives property (as a gift or inheritance, for instance, but not as a purchase or trade of one resource for another), the new property is subject to evaluation under the income rules for the month of receipt and under the resources rules thereafter.

4. Discovery of Unknown Assets

For the resources treatment of previously unknown assets, see S1110.117.

S1110.115 ASSETS THAT ARE NOT RESOURCES

A. Policy Principle--General Rule

Assets of any kind are not resources if the individual does not have:

- any ownership interest; and
- the legal right, authority, or power to liquidate them (provided they are not already in cash); or
- the legal right to use the assets for his/her support and maintenance.

EXAMPLE: An individual owns a block of stock jointly with his brother. Although the form of ownership is one which would permit either to sell the property without the other's consent, the brothers have a legally binding agreement that one will not sell without consent of the other. The individual's brother refuses his consent, thereby making the stock not a resource for the individual. However, if the brother should give his consent, the stock would be subject to evaluation under the resources-counting rule beginning with the month following the month of consent.

The value of the stock would **not** be counted as income to the individual in the month consent is given.

B. Policy Principles--Certain Specific Assets That Are Not Resources

Though not an exhaustive listing, the term "resources" does not apply to the assets described below.

1. Cash to Purchase Medical or Social Services

For 1 calendar month following its receipt, cash paid by a recognized medical or social services program is not a resource provided the cash is:

- not income under S0815.050; and
- not repayment for a bill already paid.

See S1120.110.

2. Home Energy Assistance/ Support and Maintenance Assistance

(HEA/SMA) HEA/SMA which is excluded from income and is not a resource regardless of how long a person retains it (S1120.100).

S1110.117 UNKNOWN ASSETS

A. Policy

An individual may be unaware of his or her ownership of an asset. If this is the case, the asset is not a resource during the period in which the individual was unaware of his/her ownership.

The value of the previously unknown asset, including any monies (such as interest) that have accumulated on it **through the month of discovery by the individual,** is **income** (not a resource) in the **month of discovery.**

For months after the month of discovery, the previously unknown asset is a **resource** subject to the usual resource-counting rules.

B. Procedure-Documentation

When an individual alleges having been unaware of his/her ownership of an asset, obtain a signed statement from the individual. Also obtain any available supporting documentation, including (but not limited to) signed statements from other individuals who are familiar with the individual's situation.

Document the file with your determination regarding the alleged "unknown" resource.

C. Examples

1. As a result of contacting a tax assessor's office, the eligibility worker (EW) learns that the recipient has an ownership interest in previously unreported property (undeveloped land). The property is co-owned with another individual who has always paid the property taxes. Contacts with the recipient and the other individual confirm the recipient's allegations that he was unaware the original owner of the property has died and, therefore, the recipient never knew that he had inherited an ownership interest. The value of the recipient's ownership interest is counted as **income** in the month he learned of the ownership interest and as a **resource** in the following month.

C. Example (cont.)

2. While in the hospital, the recipient received a check for $25 as a "get-well" gift from her neighbors. She was unaware of the gift. At the time, her affairs were being managed by her daughter, who put the check in a desk drawer and failed to tell the recipient anything about it.

   In the month the recipient learns of the existence of the check, the check is counted as her **income**. In the following month, the $25 is counted as her **resource.**

COUNTABLE VS. EXCLUDED RESOURCES

S1110.200 COUNTABLE RESOURCES

Policy

The value of any asset that meets the definition of a resource counts against the applicable resource limit to the extent that the instructions in S1130 do not provide for its exclusion.

M1110.210 EXCLUDED RESOURCES

A. Introduction

Once you have determined that an asset meets the definition of a resource, it is necessary to determine that resource's effect on eligibility. Certain resources do not count against the resource limit; i.e., they are excluded.

B. Description -- List of Resource Exclusions

Exclusion	Reference	No Limit on Value and/or Length of Time	Limit on Value and/or Length of Time
Home serving as the principal place of residence, including the land on which the home stands (*contiguous property exempt for QDWI, QMB, SLMB, *QI and ABD 80% FPL)*.	M1130.100	* X	X
Funds from sale of a home if reinvested timely in a replacement home	S1130.110		X
Jointly-owned real property which cannot be sold without undue hardship (due to loss of housing) to the other owner(s)-For QMB, QDWI, SLMB, *QI and ABD 80% FPL* only	*S1130.130* Appendix 1 *Appendix 2*	X	
Real property for as long as the owner's reasonable efforts to sell it are unsuccessful	M1130.140	X	
Restricted, allotted Indian land if the Indian/owner cannot dispose of the land without the permission of other individuals, his/her tribe, or an agency of the Federal Government	S1130.150	X	
One automobile (Exception – QDWI – *See Appendix 1 to chapter S11)*	M1130.200 A.3.	X	

B. Description--List of Resource Exclusions

Exclusion	Reference	No Limit on Value and/or Length of Time	Limit on Value and/or Length of Time
Life insurance, depending on its face value	S1130.300		X
Burial space or plot held for an eligible individual, his/her spouse, or member of his/her immediate family	M1130.400	X	
Burial funds for an individual and/or his/her spouse	M1130.410		X
Certain prepaid burial contracts	M1130.420		X
Household Goods and Personal Effects	M1130.430	X	
Property essential to self-support	S1130.500-.504		X
Resources of a blind or disabled person which are necessary to fulfill an approved plan for achieving self-support	S0870.001 S1130.510		X
Retained retroactive SSI or RSDI benefits	S1130.600		X
Radiation Exposure Compensation Trust Fund payments	S1130.680	X	
German reparations payments made to World War II Holocaust survivors	S0830.710 S1130.610	X	
Austrian social insurance payments	S0830.715 S1130.615	X	
Japanese-American and Aleutian restitution payments	S0830.720	X	
Federal disaster assistance received because of a Presidentially declared major disaster, including accumulated interest	S0830.620 S1130.620	X	
Cash (including accrued interest) and in-kind replacement received from any source at any time to replace or repair lost, damaged, or stolen excluded resources	S0815.200 S1130.630		X
Certain items excluded from both income and resources by other Federal statutes	S0830.055 S1130.640	Varies	
Agent Orange settlement payments to qualifying veterans and survivors	S0830.730 S1130.660	X	
Victim's compensation payments	S0830.660 S1130.665		X
Tax refunds related to Earned Income Tax Credits	S0820.570 S1130.675		X

C. References

- Identifying excluded funds that have been commingled with non-excluded funds, S1130.700

LIQUID VS. NONLIQUID RESOURCES

S1110.300 DETERMINING THE LIQUIDITY/NONLIQUIDITY OF RESOURCES

A. Policy

1. Definitions

- **Liquid resources** are any resources in the form of cash or in any other form which **can** be converted to cash within 20 workdays.
- **Nonliquid resources** are any resources which are not in the form of cash which **cannot** be converted to cash within 20 workdays.
- Workdays are any days other than Saturdays, Sundays, and Federal holidays.

Liquidity/nonliquidity has no effect on a resource's countability.

B. Reference

Liquid resources do not qualify for exclusion as property essential to self-support unless they represent necessary assets of a trade or business. See S1130.500 B.3.

S1110.305 RESOURCES ASSUMED TO BE LIQUID

A. Introduction

Cash is **always** liquid. In addition, certain noncash items are nearly always liquid.

B. Policy

1. Assumption of Liquidity

Absent evidence to the contrary, we assume that the following types of resources are liquid:

- stocks, bonds, and mutual fund shares;
- checking and savings account and time deposits;
- United States Savings Bonds, Treasury bills, notes and bonds; and
- mortgage and promissory notes.

2. Evidence to the Contrary

If there is no apparent evidence to the contrary of the assumptions in 1. above, we do not seek out any evidence to the contrary. There is no need to document a lack of evidence to the contrary.

We resolve any issue and document the file if:

- liquidity is material to a particular resource; and
- an individual's statement or information in file suggests that one of the above-listed types of resources is not liquid.

C. Examples- Evidence to the Contrary

1. Recently Issued U.S. Savings Bond: Not a Resource

a. Situation - On January 6, 1994 Ms. Minnie Marbel applied for Medicaid benefits. Among her alleged resources was a $500 series EE U.S. Savings Bond which she had won a month earlier in a Christmas raffle at church. Since series EE bonds are never redeemable for 6 months following issue, the EW questioned whether the minimum retention period had expired.

b. Analysis - The bond's issue date was December 1, 1993. Therefore, Ms. Marbel by law could not redeem it before June 1, 1994. Consequently, the bond not only was not a liquid resource, it was not a resource at all. The value of the bond, including any interest accrued, does not become a liquid resource until July 1, 1994.

2. Guardianship Account -- Guardian Dies: Non-Liquid Resource

a. Situation - Ms. Harriet Dalton had a court-appointed guardian who had sole access to Ms. Dalton's savings account. On September 8, 1988 the guardian filed for Medicaid on Ms. Dalton's behalf. On November 2, while the claim was still pending, the guardian died. Because of the delay in having a new guardian appointed and establishing a new account signatory, there was no one authorized to withdraw funds from the account for at least 60 days (and possibly longer).

b. Analysis - For September through November the account was Ms. Dalton's liquid resource because her guardian had access to it as of the first moment of each month. Beginning in December and until the first of the month in which a new guardian had access to the account, it was a nonliquid resource.

3. Comparison of Analyses in 1. And 2. Above

The guardianship account continues to be a resource because, at all times, Ms. Dalton owned it and had the legal right to use it for her own support and maintenance. The delay in appointing a new guardian who could access it within 20 days does not remove Ms. Dalton's right to the funds.

In the case of the savings bond, neither Ms. Marbel nor anyone acting on her behalf had the right, authority or power to redeem the bond for cash until 6 months from the date of issue.

S1110.310 RESOURCES ASSUMED TO BE NONLIQUID

A. Introduction

Certain non-cash resources, though they may occasionally be liquid, are nearly always non-liquid.

B. Operating Policy

1. Assumption of Nonliquidity

Absent evidence to the contrary, we assume that the following type of resources are non-liquid.

- automobile, trucks, tractors, and other vehicles;
- machinery and livestock;
- buildings, land and other real property rights; and
- non-cash business property.

2. Evidence to The Contrary

a. If there is no apparent evidence to the contrary of the assumptions in 1. above, we do not seek out any evidence to the contrary. There is no need to document a lack of evidence to the contrary.

b. In very rare situations an individual may volunteer firm evidence that one of the above types of resources is liquid (i.e., its sale has been accomplished or arranged within 20 workdays). Document the file and proceed accordingly only if the distinction is material.

C. Operating Policy-- Life Insurance

This subchapter provides no categorical assumption regarding the liquidity or non-liquidity of life insurance policies.

VALUATION OF RESOURCES

M1110.400 WHAT VALUES APPLY TO RESOURCES

A. Policy Principles

1. Definitions

a. *The current market value (CMV) or fair market value (FMV) of a resource is:*

- *Real property – 100% of the local tax assessed value.*

- Countable vehicles
  – the **average trade-in value** listed in the National Automobile Dealers Official Used Car Guide (NADA) Guide, or
  – the value assessed by the locality for tax purposes may be used, if vehicle is not listed in N.A.D.A. Guide.

b. Equity value (EV) is the CMV of a resource minus any encumbrance on it.

c. An encumbrance is a legally binding debt against a specific property. Such a debt reduces the value of the encumbered property but does not have to prevent the property owner from transferring ownership (selling) to a third party. However, if the owner of encumbered property does sell it, the creditor will nearly always require a debt satisfaction from the proceeds of sale.

2. Valuation

General Rule
The value of a resource is the amount of an individual's/couple's equity in it.

3. Determining the Countable Value of Real Property

The procedures for determining the countable value of real property are found in Appendix 1 to subchapter S1130. An "ABD Home Property Evaluation Worksheet" is found in Appendix 2 to subchapter S1130.

B. Related Policy

See M1110.600 concerning the points in time for establishing resource values.

OWNERSHIP INTERESTS

S1110.500 SIGNIFICANCE OF OWNERSHIP

A. Introduction

Ownership interests in property, whether real or personal, can occur in various types and forms. Since the type and form of ownership may affect the value of property and even its status as a resource, they are significant in determining resource eligibility.

B. Description-Types of Ownership

1. Sole vs. Shared Ownership

An individual may have sole ownership of a property or may share its ownership with others. See S1110.510.

2. Fee Simple Ownership

Fee simple ownership, which relates only to real property, is completely free of conditions imposed by others. See S1110.515 A.1.

3. Less than Fee Simple Ownership

a. A life estate interest conveys ownership of limited duration. See S1110.515 A.2. and B.

b. Equitable ownership can occur when an individual does not have legal title to property. See S1110.515 A.2b. and C.

4. Property Rights Without Ownership

a. A leasehold conveys a time-limited control of property but not ownership of it. See S1110.520 B.1.

b. An incorporeal interest in property is a right to use the property but without any right to possess it or sell it. See S1110.520. B.2.

C. Operating Policy--Variance in State Laws with Respect to Ownership

The explanations of ownership in the following sections represent general legal principles. However, specific points may vary with State law and issues may have to be reviewed by the Regional Office and/or Assistant Attorney General's Office.

S1110.510 SOLE VS. SHARED OWNERSHIP

A. Introduction

An individual may be the sole owner of real or personal property or may share ownership with one or more others.

B. Definitions

1. Sole Ownership

Sole ownership of (real or personal) property means that only one person may sell, transfer or otherwise dispose of the property. However, sole ownership may be subject to conditions imposed by others as, for example, sole ownership of a remainder interest in property. See S1110.515.

2. Shared Ownership

Shared ownership of (real or personal) property means that two or more people own it concurrently. See C. below concerning different types of shared ownership.

C. Descriptions-Shared Ownership

1. Tenancy-In-Common

a. Owners Do Not Have Same Interests

In tenancy-in-common, two or more persons each has an undivided fractional interest in the whole property for the duration of the tenancy. These interests are not necessarily equal; e.g., two joint tenants do not necessarily each own half of the property. One owner may sell, transfer or otherwise dispose of his or her share of the property without permission of the other owner(s) but cannot take these actions with respect to the entire property.

b. No Survivorship Rights

When a tenant-in-common dies, the surviving tenant(s) has no automatic survivorship rights to the deceased's ownership interest in the property. Upon a tenant's death, the deceased's interest passes to his or her estate or heirs.

c. Example

Don, Charles, and Fred Evans own property as tenants-in-common. Charles and Fred each owns an undivided one-fourth interest in the property while Don owns the remaining one-half interest. If Don Evans were to sell his half interest to Stanley Long, Mr. Long would become a tenant-in-common with Charles and Fred Evans. If Mr. Long were then to die so that his property passed to his four children, each of them would own one-eighth interest as tenants-in-common with Charles and Fred who would each continue to own one-fourth interest.

2. Joint Tenancy

a. Each Owner Has Same Interest

In joint tenancy, each of two or more persons has one and the same undivided ownership interest and possession of the whole property for the duration of the tenancy. In effect, each owner owns all of the property.

b. Survivorship Rights

Upon the death of one of only two joint tenants, the survivor becomes sole owner. On the death of one of three or more joint tenants, the survivors become joint tenants of the entire interest.

c. Conversion to Tenancy-in-Common

In most States, it is possible for joint tenants to take action during their lifetime to convert the joint tenancy to a tenancy-in-common (see 1. above).

3. Tenancy by The Entirety

a. Married Couples Only

A tenancy by the entirety can exist only between the members of a married couple. The wife and husband as a unit own the entire property which can be sold only with the consent of both parties. However, if a marriage has been legally dissolved, the former spouses become tenants-in-common and one can sell his or her share without the consent of the other.

b. Survivorship Rights

Upon the death of one tenant by the entirety, the survivor takes the whole.

D. Operating Policy--Shared Ownership

1. General Rule

With the exception noted below, we assume, absent evidence to the contrary, that each owner of shared property owns only his or her fractional interest in the property. We divide the total value of the property among all of the owners in direct proportion to the ownership share held by each.

2. Exception: Checking/ Savings Accounts and Time Deposits

For a joint checking or savings account or a jointly-owned time deposit, we assume that all of the funds in the account belong to the applicant(s) recipient(s), in equal shares if there is more than one applicant or recipient (S1140.205 B and .210 B).

3. Determining the Countable Value of Jointly Owned Real Property

The procedures for determining the countable value of jointly owned real property are found in Appendix 1 to subchapter S1130.

M1110.515 OWNERSHIP IN FEE SIMPLE OR LESS THAN FEE SIMPLE

A. Definitions

1. Fee Simple

Fee simple ownership means absolute and unqualified legal title to real property. The owner(s) has unconditional power of disposition of the property during his or her lifetime. Upon his or her death, property held in fee simple can always pass to the owner's heirs. Fee simple ownership may exist with respect to property owned jointly or solely.

2. Less than Fee Simple Ownership

a. Life Estate

A life estate confers upon one or more persons (grantees) certain rights in a property for his/her/their lifetimes or the life of some other person. A life estate is a form of legal ownership and usually created through a deed or will or by operation of law. See B. below.

b. Equitable Ownership

An equitable ownership interest is a form of ownership that exists without legal title to property. It can exist despite another party's having legal title (or no one's having it). See C. below.

B. Description--Life Estate

1. Rights of Life Estate Owner

a. What Owner Can Do

Unless the instrument (will or deed) establishing the life estate places restrictions on the rights of the life estate owner, the owner has the right to possess, use, and obtain profits from the property and to sell his or her life estate interest.

Whether the value of a life estate is counted as a resource depends on when the life estate was created.

- The value of a life estate created prior to August 28, 2008 is **not** counted as a resource.
- *The value of a life estate created on or after August 28, 2008 but before February 24, 2009 is a countable resource to the owner of the life estate unless the life estate is excluded under one of the real property exclusions contained in Chapter S1l.*
- The value of a life estate created on or after February 24, 2009 is **not** counted as a resource.

Exception: The value of a life estate owned by a QDWI enrollee is countable, regardless of the date on which it was created. See M1140.110 for additional information.

b. What Owner Cannot Do

A life estate owner owns the physical property only for the duration of the life estate. The owner generally can sell only his or her interest; i.e., the life estate. The owner cannot take any action concerning the interest of the remainderman.

2. Remainder Interest

a. Future Interest in Physical Property

A life estate instrument often conveys property to one person for life (life estate owner) and to one or more others (remaindermen) upon the expiration of the life estate. A remainderman has an ownership interest in the physical property but without the right to possess and use the property until termination of the life estate.

b. Sale of Remainder Interest

Unless restricted by the instrument establishing the remainder interest, the remainderman is generally free to sell his/her interest in the physical property even before the life estate interest expires. In such cases, the market value of the remainder interest is likely to be reduced since such a sale is subject to the life estate interest.

3. Example

Mr. Heath, now deceased, had willed to his daughter a life estate in property which he had owned in fee simple. The will also designated Mr. Heath's two sons as remaindermen. Ms. Heath has the right to live on the property until her death at which time, under the terms of her father's will, the property will pass to her brothers as joint tenants.

C. Policy--Equitable Ownership Interest

Basically, existence of an equitable ownership interest is determined by a court of equity.

1. Unprobated Estate

For Medicaid purposes, an individual may have an equitable ownership interest in an unprobated estate if he or she:

- is an heir or relative of the deceased;
- receives income from the property; or
- has acquired rights in the property due to the death of the deceased in accordance with State intestacy laws.

M1120.215 contains instructions on how to determine whether an interest in an unprobated estate is a resource.

2. Trust

A trust is a right of property established by a trustor or grantor. One party (trustee) holds legal title to trust property which he or she manages for the benefit of another (beneficiary). The beneficiary does not have legal title but does have an equitable ownership interest.

M1120.200 contains instructions concerning resources treatment of trusts in the Medicaid program.

M1120.201 contains instructions for the resources treatment of trust established on or after August 11, 1993.

3. Equitable Home Ownership

If an individual alleges equitable ownership (e.g., an unwritten ownership interest or right of use for life) obtain any pertinent documents and a signed statement from each of the parties involved regarding any arrangement that has been agreed to. Forward the document to a medical assistance program consultant for an opinion from legal counsel.

D. References

The following references pertain to trust situations:

- Financial institution/conservatorship accounts, S1140.200 - S1140.215
- Property held under a State's Uniform Gift to Minors Act, S1120.205
- Situations involving an agent acting in a fiduciary capacity on behalf of another party, S1120.020
- Trust established on or after August 11, 1993, M1120.201

S1110.520 PROPERTY RIGHTS WITHOUT OWNERSHIP OF THE PROPERTY

A. Introduction

An individual may have certain rights with respect to property without also having the right to dispose of the property. However, the individual may have the right to sell his/her right or interest (i.e. the right to use or possess the property).

B. Definitions

1. Leasehold

A leasehold does not designate rights of ownership. Rather, it conveys to an individual use and possession of property for a definite term and usually for an agreed rent.

2. Incorporeal Interests

There are several types of real property rights called "incorporeal interests." They do not covey ownership of the physical property itself. They convey the right to use the property but not to possess it. These rights encompass mineral and timber rights and easements (explained in more detail at S1140.110).

M1110.530 WHOSE RESOURCES TO CONSIDER

A. Introduction

In addition to resources that actually belong to an eligible (or would-be eligible) individual, Medicaid Law provides that the resources of certain other persons are considered to be available to the individual. Therefore, all appropriate resources determinations include those other persons' resources.

B. Policy

1. Spouse of Adult Individual

The resources of an individual include those of a spouse, and the applicable resource limit is that for a couple, provided that the spouse:

- if **eligible,** lives in the same household as the individual as of the first of the month for which resources are being determined.
- if **ineligible,** lives in the same household as the individual as of the first of the month for which resources are being determined.

For institutionalized individuals with a community spouse, *see subchapter M1480.*

2. Parent(s) of Child under 18

If a blind or disabled child is under age 18 and is living in the same household with a parent, the agency must consider the parent's resources available to the child, whether or not they are actually contributed.

The applicable resource limit for a blind and/or disabled child is always that for an individual.

3. Parent(s) of Child Age 18 to 21

If a blind or disabled child age 18 to 21 is living in the same household with his parent, the agency must consider the parent(s') resources available to the child, whether or not they are actually contributed:

The applicable resource limit for a disabled or blind child is always that for an individual.

DETERMINING ELIGIBILITY BASED ON RESOURCES

M1110.600 RULE FOR MAKING DETERMINATIONS

A. Policy Principle--Rule

Make all resource determinations per calendar month. Resource eligibility exists for the full month if countable resources were at or below the resource standard for any part of the month.

B. Policy Principle--Significance of the Rule

1. Increase in Value of Resources

Consider any increase in the value of an individual's resources in the resources determination the month following the month in which:

- the value of an existing resource increase (e.g., the value of a share of stock goes up or installment payments increase a property's equity value);
- an individual acquires an additional resource (e.g., inherits property); or
- an individual replaces an excluded resource with one that is not excluded (e.g., sells an excluded automobile for nonexcludable cash).

2. Decrease in Value of Resources

Consider any decrease in the value of an individual's resources in the resource determination the month in which:

- the value of an existing resource decreases (e.g., the value of a share of stock goes down);
- an individual spends a resource (e.g., withdraws $150 from a savings account to pay bills); or
- an individual replaces a countable resource with one that is not countable (e.g., trades a countable piece of real property for an excluded automobile).

3. Treatment of Assets Under Income and Resource Counting Rules

When an individual receives an asset (real or personal property) during a month, *it is* evaluate*d* under the appropriate income-counting rules in that month. If the individual retains the item into the month following the month of receipt, *it is* evaluate*d* under the resource-counting rules. Do not evaluate the same asset under two sets of counting rules for the same month.

Funds cannot be both income and a resource in the same month. Income that has been added to a bank account during the month must be subtracted from the ending balance to ensure that the income is not also counted as a resource. See M1140.200.

EXCEPTION: Trusts established on or after August 11, 1993, have different counting rules. See M1120.201.

4. Receipts from the Sale, Exchange, or Replacement of a Resource

If an individual sells, exchanges, or replaces a resource, what he/she receives in return is not income. It is a different form of resource. This includes assets which have never been subject to resources counting because the owner sold, exchanged, or replaced them in the same month in which he/she received them.

Capital gains, which are profits made from the sale of capital assets (long-term assets such as land or buildings), are also not income. Any proceeds that remain the month after this type of sale must be evaluated as a resource.

The concept of such transactions not producing income does not apply to receipts from the sale of timber, minerals, or other like items which are part of the land.

C. Example--Receipt of a Resource Considered as Income and Exchanged in Same Month

Miss Laramie, a disabled individual, received a $350 unemployment insurance benefit on January 10 at which time it was unearned income. On January 18, she used the $350 to purchase several shares of stock; i.e., she exchanged one resource (cash) for another resource (stock). We never counted the $350 cash payment as a resource because Miss Laramie exchanged it for stock in the month of receipt. The stock is not income; it is a different form of resource. Since a resource is not countable until the first moment of the month following its receipt, we first count the stock in the resources determination made as of February 1.

S1120 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	Table of Contents pages 24-26
TN #93	1/1/2010	page 22

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IDENTIFYING RESOURCES

OVERVIEW

S1120.001 PURPOSE OF SUBCHAPTER

A. Introduction

This subchapter deals with the process of applying the basic principles in subchapter S1110 in determining whether property (an asset) is a resource. If it is a resource, subchapter S1130 provides guidance on possible exclusions. If a resource is not excludable, see subchapter S1140. These guidelines apply to both initial applications and to posteligibility situations.

B. Related Policies

1. Significance of Asset/ Resources Distinction	S1110.100 A.
2. Resources Defined	S1110.100 B.
3. Assets That Are Not Resources	S1110.115; S1120.100
4. Treatment of Assets as Income/ Resources	S1120.005.
5. Resource Conversion	S1110.600 B.4.

S1120.005 DISTINGUISHING RESOURCES FROM INCOME

A. Introduction

It is important to distinguish between resources and income to know which counting rules to use for any given month. An item is not subject to both income and resources counting rules in the same month.
Exception - Trusts established on of after August 11, 1993, See M1120.201

B. Policy Principles

1. Income-Counting Rules	Items received during a month are evaluated under the income-counting rules.
2. Resource-Counting Rules	Items retained as of the first moment of the month following receipt are subject to evaluation under resource-counting rules.

C. Example

1. Situation

Beverly Thompson, a single, disabled recipient, received $275 as a birthday gift in January. She used $50 to repay a loan; spent $100 for a Series EE U.S. Savings Bond; and put the remainder ($125) in her savings account. As of February 1, the account balance was $1,400.

2. Analysis

The $275 gift was income to Ms. Thompson in January when she received it. In February, only $125 of the cash gift counts as a resource; the remaining $150 she spent or converted into another form in the same month she received it. The U.S. Savings Bond is not a resource in February since Ms. Thompson cannot legally redeem it for 6 months. However, it will become a resource on August 1, when it is first legally redeemable. The $125 that she put in her savings account is a resource (along with the $1,275 deposited previously) as of February 1.

M1120.010 FACTORS THAT MAKE PROPERTY A RESOURCE

A. Introduction

Property of any kind, including cash, cannot be a resource in a month unless, it meets all three criteria in B. below. However, it is not unusual for a nonresource to become a resource or vice versa.

B. Policy-Resources Criteria

1. Ownership Interest

An individual must have some form of ownership interest in property in order for the property to be considered a resource. The fact that an individual has access to property, or has a legal right to use it, does not make it a resource if there is no ownership interest (S1110.100).

2. Legal Right to Access (Spend or Convert Property)

An individual must have a legal right to access property. Despite having an ownership interest, property cannot be a resource if the owner lacks the legal ability to access funds for spending or to convert noncash property into cash (S1110.100).

The fact that an owner does not have physical possession of property does not mean it is not his/her resource, provided the owner still has the legal ability to spend it or convert it to cash. However, see S1140.240 if a U.S. Savings Bond is involved.

3. Legal Ability to Use for Personal Support and Maintenance

Even with ownership interest and legal ability to access property, a legal restriction against the property's use for the owner's own support and maintenance means the property is not his/her resource (S1110.100).

C. Policy – Access to Resources

1. Access via an Agent

We consider that an individual has free access to, and unrestricted use of, property even when he/she can take those actions only through an agent; e.g., a representative payee, guardian, etc. (S1120.020). **For real property where reasonable but unsuccessful efforts to sell must be established, see M1130.140.**

2. Access Only via Litigation

When there is a legal bar to sale of property (e.g., if a co-owner legally blocks sale of jointly-owned property), we do not require an individual to undertake litigation in order to accomplish sale or access. The property is not a resource under such circumstances in a month if a legal bar exists anytime during that month.

An individual's interest in an unprobated estate is a countable resource. An heir can initiate a court action to partition. If a partition suit is necessary (because at least one other owner of or heir to the property will not agree to sell the property) in order for the individual to liquidate the interest, estimated partition costs may be deducted from the property's value.

An applicant or recipient's proportional share of the value of property owned jointly with another person to whom the applicant or recipient is not married as tenants in common or joint tenants with the right of survivorship at common law is counted as a resource unless it is exempt property or is unsalable.

3. Access via Petition - Conservatorship Accounts

If State law requires that funds in a conservatorship account be made available for the care and maintenance of an individual, we assume, absent evidence to the contrary, that funds in such an account are available for the individual's support and maintenance and are, therefore, that individual's resource. This is true despite the fact that the individual or his/her agent is required to petition the court to withdraw funds for the individual's support and maintenance. See S1140.215 for instructions concerning conservatorship accounts.

D. Examples

1. Lack of Ownership

a. **Situation** - In response to unstated income development, Mr. John Hart, explains that his brother, Ted, who lives in an adjacent State, allows him (John) access to his bank account in emergencies. John Hart says he withdraws funds to pay an overdue utility bill to avoid shutoff.

The EW confirms that the account is titled "Ted Hart by Ted Hart or John Hart." John Hart states that he uses the funds solely for his own benefit and not as an agent for his brother.

b. **Analysis** - Even though John Hart has unrestricted access to the account and can use the funds at his own discretion, the funds are not his resources because he has no ownership interest in them. The title of the account clearly designates Ted Hart as sole owner. However, whatever funds John withdraws from Ted's account are John's income in the month of the withdrawal.

c. **Situation** - A member of an Indian tribe states that he has several items, valued at several thousand dollars, that he would not sell because they are ceremonial in nature (clothing and beadwork). The EW questions him about the items and determines they were "entrusted" to him by the tribe for safekeeping.

d. **Analysis** - In order for an asset to be a resource, the individual must have an ownership interest in the asset. Since the individual in the above situation does not own the ceremonial items, they are not his resources.

2. Court Order Restricts Access

a. **Situation** - At the time of his divorce, Mark Thomas, an SSI recipient, was sole owner of the house in which his ex-wife and their two young sons are living. Under the terms of the divorce decree, Mr. Thomas must pay the taxes on the property and maintain it as a home for his ex-wife and the children until the younger boy reaches age 18. The decree also specifies that he is free to sell the property only after the younger boy's eighteenth birthday.

b. **Analysis** - Although Mr. Thomas clearly owns the property, he is legally barred from converting it to cash to be used for his own support and maintenance until 1997. Therefore, it is not his resource until the month following the month of his younger son's eighteenth birthday.

3. Binding Agreement Restricts Access

a. **Situation** - As a gift from their parents, Tom Brown, a Medicaid recipient, and his brother who is not eligible for Medicaid, received some shares of stock valued at $3,000. The stock certificates show that the brothers are joint tenants (S1110.510 C.2.), but the brothers have a legally binding agreement that one will not sell without consent of the other. The EW confirms that Tom's brother will not consent to sell.

b. **Analysis** - Normally, the gift would be valued under the income rules in the month of receipt and the resources rules thereafter. However, since Tom's brother will not consent to sale of the stock, Tom's share of the stock is not income in the month of receipt nor resources thereafter since it cannot be used for Tom's support and maintenance. If Tom's brother consents to sell, Tom's share would be a countable resource beginning with the month following the month that consent was given.

4. Lack of Possession Restricts Ability to Use-Savings Bonds

a. **Situation** - During a posteligibility review, the EW learns that George Jones, a Medicaid recipient, is co-owner along with his father of U.S. Savings Bonds with a face value of $3,500. The EW learns that George's father bought the bonds over a period of years with his own money and designated George as co-owner. The bonds are in the father's safe deposit b to which he will not give George access under any circumstances.

b. **Analysis** - The EW questions George's father and confirms that he will not give George the bonds under any circumstances. George's father states that, George can take possession of the bonds only after he (the father) dies. Generally, lack of physical possession of an otherwise liquid resource does not affect its status as a resource. However, physical possession of savings bonds is a legal requirement for cashing them. Although George is a legal owner, he cannot legally redeem the bonds for his own use. Therefore, they are not his resources.

5. Insurance Settlement Restricts Use

a. **Situation** - Bob Warfield, a Medicaid recipient, was injured in an automobile accident. A court awarded him damages of $10,000 to be used solely for medical expenses related to the accident.

b. **Analysis** - Although Mr. Warfield owns the funds and has direct access to them, he is not legally free to use them for his own support and maintenance. Therefore, the award funds are neither income nor resources.

Third party liability should be entered during enrollment.

6. No Access Without Litigation

a. **Situation** - Andrea Matthews, a disabled Medicaid recipient, has been separated from her spouse, who is not eligible for Medicaid, for 5 years. She and her spouse own a summer cottage in another State as tenants-by-the-entirety. Her spouse lives in the cottage and refuses to sell.

b. **Analysis** - If Ms. Matthews were to divorce her husband, she would, as a tenant-in-common, have the right to market her interest in the property without her ex-spouse's consent. However, since we do not require litigation to obtain access, the property is not a resource unless her husband changes his mind about the sale. Therefore, the cottage is not Ms. Matthew's resource. Even if Ms. Matthews could market her ownership interest in the cottage, for a QDWI, QMB, and SLMB coverage only, the cottage would be excluded from countable resources if its sale would cause undue hardship for Mr. Matthews due to loss of housing (S1130.130 in Appendix 2).

S1120.020 TRANSACTIONS INVOLVING AGENTS

A. Introduction

An eligible individual (EI) or deemor may have an agent to act on his/her behalf or may serve as an agent for someone else. When an agency relationship exists, it is important to distinguish an agent's actions on his/her own behalf from those on behalf of the person for whom he/she serves as agent.

B. Definitions

1. Agent

An agent is a person or organization acting on behalf of and/or with the authorization of another person. For Medicaid purposes, the term applies to anyone acting in a fiduciary capacity, whether formal or informal, and regardless of the applicable title (representative payee, conservator, guardian, etc.).

2. Ward

A ward, as used in this section, is the categorical designation of a party for whom an agent has authority to act. This is not necessarily a "ward" in the legal sense.

C. Operating Policies-Agent Holds Assets

1. Actions by Agent

For purposes of this section, an action by someone in his/her capacity as an agent is equivalent to an action by the ward for whom he/she acts. For example, RSDI funds held by a representative payee for a title II beneficiary are the same as funds held by the beneficiary himself.

2. Status of Assets Held for Ward

Unless there is a legal restriction on the agent's access to assets held for a ward or against their use for the ward's support and maintenance, the assets are the ward's resources. They are not the agent's resources since the agent has no ownership interest in them and often is not legally free to use them for his/her own support and maintenance.

3. Property Title Must Show Ownership

An agent holding property of any kind for a ward must keep it in a form that clearly shows ownership by the ward.

D. Operating Policies- Improperly Titled Financial Account

The most common type of improperly titled account is the savings account designated as held "in trust for" a ward. This form of holding is not a formal trust (M1120.200) and is misleading as to ownership of the funds. If State law does not recognize the funds as the ward's property, see E.3. below. If evaluating an improperly titled account, consult your Regional Coordinator.

1. Singly Owned Account; EI/Deemor Is Ward

a. Agent Agrees Funds Belong to Ward -
If there is an agency relationship so that deposits to the account are income to the ward, not the agent (S0810.120): we

- assume the funds are the ward's property; and
- request that the agent change the account designation.

b. Agent Does Not Agree Funds Belong to Ward - If the agent does not agree that the funds belong to the ward and refuses to correct the account title, we do not treat the funds as the ward's resources. See E.4. if the agent is a representative payee. See E.3. b. if the agent is not a representative payee.

2. Singly Owned Account; EI/Deemor Is Agent

Although deposits to the account are not the agent's income per S0810.120.D 2, we treat the account as the agent's resource. The account is the resource of the person shown as owner on the account title.

3. Jointly Owned Account

Regardless of whether the EI/deemor is ward or agent, an agent can rebut ownership of the funds and establish that they are the ward's property (S1140.205).

E. Development and Documentation

1. Verify Agency Relationship

Verify any allegation of an agency relationship per S0810.120 F.

2. Determine Resources

Document your decisions concerning the form and value of resources belonging to the EI/deemor. Follow the guidelines in C. and D. above, as well as in sections dealing with the specific type of property involved.

3. Improperly Titled Financial Account; EI/Deemor Has Agent

a. Agent Acknowledges Funds as Ward's
- Document the file with the agent's signed statement as to the ward's ownership.
- Ask the agent to have the account retitled.
- Treat the funds as the ward's property.

b. Agent Is Not Representative Payee and Does Not Acknowledge Funds as Ward's
If an agent (other than a representative payee) has set up an account incorrectly, will not change the account designation, and will not acknowledge the funds as the ward's:
- document the file with the agent's refusal;
- do not treat the funds as the ward's property; and
- see S0820.120 E. for the income rules that apply when the EI/deemor has an agent.

4. Representative Payee is Agent Who Does Not Acknowledge Funds As Ward's

a. If the conserved funds are SSI or RSDI funds and the representative payee will not change the account designation and acknowledge the ward's ownership of the funds:
- do not treat the funds as the EI's or deemor's property

b. Situation Changes - Consider the funds the ward's property the month following the month in which:
- the representative payee designates the funds properly; or
- a new representative payee establishes the account correctly.

NOTE: Do not consider any conserved SSI or RSDI funds as the EI's or deemor's income in the month the account is redesignated (S1120.022.B.2.)

F. Related Policies

1. Misuse of Funds by Representative Payee Who Is an EI or Deemor

See S0810.120 D.4. concerning misused funds as income to the agent. If the agent retains the misused funds, consider them his/her resources effective with the month following the month the funds are counted as income.

2. Representative Payee

SSA selects representative payees for recipients who are unable to manage their own funds. Representative payees have financial jurisdiction only over financial transactions involving SSI/RSDI benefits.

3. Agents and Income Determinations

For the effect on the income determinations of fees paid to an agent, misuse of funds, and correctly titled accounts, see S0810.120.

S1120.022 CONSERVED FUNDS WHEN FORMALLY DESIGNATED AGENT CHANGES

A. Introduction

1. General

An agent designated formally by an agency or court may conserve funds not used for a ward's (beneficiary's) current needs. If there is a change of agent, the former agent may return these savings to SSA or other paying agency (e.g., Veterans Administration).

2. Funds Reissued

SSA or other paying agency may reissue accumulated funds to a new payee or directly to the ward. The reissued funds may be paid in a lump sum or in installments and may be combined in a check with a current month's benefits.

B. Policy Principles

1. Conserved Funds as Resources

Conserved funds are a ward's resources while SSA or another agency is holding them for the ward. This is the case because the ward:

- owns the funds; and
- is legally entitled to use them (or have them used on his/her behalf) for his/her own support and maintenance.

2. Reissued Funds Not Income

Conserved funds are not income to the owner when reissued because they have been his/her resources while held for him/her. They may have changed from nonliquid to liquid in form but they are not new funds.

3. New Funds Issued Subject to Income Counting Rules

If a single check contains both reissued funds and new funds that do not represent income previously charged for a prior month, the new funds are subject to income-counting rules.

ASSETS THAT ARE NOT RESOURCES

S1120.100 HOME ENERGY ASSISTANCE/SUPPORT AND MAINTENANCE ASSISTANCE

A. Policy Principle

The term "resources" does not include home energy assistance/support and maintenance assistance (HEA/SMA) which qualifies for exclusion from income.

B. Operating Policy

We do not develop for HEA/SMA unless:

- retained funds, plus other countable resources, exceed the applicable resource standard, and
- resources exclusive of the alleged HEA/SMA funds would be within the limit.

C. Development and Documentation

When it is necessary to develop resources which include HEA/SMA, obtain the individual's signed statement identifying (if not already documented in file):

- amount of HEA/SMA funds received;
- when received and from what source, and
- amount of remaining funds.

S1120.110 CERTAIN CASH TO PURCHASE MEDICAL OR SOCIAL SERVICES

A. Introduction

An individual cannot always disburse in the month of receipt cash given him/her to purchase approved medical or social services. To permit use of such funds in the manner intended, it is reasonable to assume, for a limited time, that the individual will use them to pay for the approved services and, therefore, that they are not available for his/her support and maintenance.

B. Policy

1. What Is Not a Resource

Effective July 1, 1988, a cash payment for medical or social services that is not income under S0815.050, also is not a resource for one calendar month following the month of receipt.

2. Exception The rule in 1. above does not apply to cash received as repayment for medical or social services bills an individual has already paid. Even though not income, such cash is a resource and, if retained, is subject to resource-counting rules as of the first moment of the month following receipt.

3. Determination If the cash was neither income nor payment, it is not a resource for one calendar month following the month of receipt.

D. References

- Commingled funds, S1130.700.

S1120.112 RETROACTIVE IN-HOME SUPPORTIVE SERVICES PAYMENTS TO INELIGIBLE SPOUSES AND PARENTS

A. Introduction

In limited circumstances, governmental programs will pay a spouse or parent to provide a disabled spouse or child with certain in-home supportive (chore, attendant, and homemaker) services (IHSS). IHSS payments are income when received by the ineligible spouse or parent but are not included as income for deeming purposes.

So that the intended benefit of having services provided by a caregiver in the home can be realized, and to avoid Medicaid ineligibility due to excess deemed resources, the regulations provide for a reasonable period of time during which retroactive IHSS payments are not considered resources and, therefore, are not subject to resources deeming.

B. Policy

1. When an IHSS Payment Is Not a Resource A **retroactive** IHSS payment paid to an ineligible spouse or parent to provide chore, attendant, or homemaker services to an eligible individual is not a resource for one calendar month following the month of receipt. If retained into the second calendar month following receipt, the payment is a resource subject to deeming.

This provision applies only to **retroactive** IHSS payments.

2. "Retroactive" IHSS Payment For the purposes of this provision, a "retroactive" IHSS payment is one that is paid after the month in which it was due. If payment is made in the month due, but following the month in which services were rendered, such payment is not considered “retroactive” for purposes of this provision.

3. Interest Included in IHSS Payment If the retroactive IHSS payment includes an interest amount, the entire payment, and any interest included in the retroactive payment, is subject to the rule 1. above.

S1120.115 DEATH BENEFITS FOR LAST ILLNESS AND BURIAL EXPENSES

A. Introduction

Death benefits, including gifts and inheritances an individual will use to pay the deceased's last illness and burial expenses, may still be on hand the first moment of the month following the month of receipt. It is reasonable to assume, for a limited time, that death benefits will be used for last illness and burial expenses and are not available for support and maintenance.

B. Policy

1. When a Death Benefit Is Not a Resource

Effective August 1991, death benefits, including gifts and inheritances, that are not income under S0830.545, also are not a resource for **one calendar month** following the month of receipt. If retained until the first moment of the second calendar month following receipt, death benefits are resources.

2. Exception--Bills Already Paid

Death benefits that are repayment of bills for last illness and burial expenses the individual has already paid are subject to resources rules beginning with the first moment of the month following the month of receipt.

C. Procedure

1. Development Not Required

Do not develop unless the amount retained plus other countable resources exceeds the applicable resources limit.

2. Development Required

If an individual would have excess resources, determine and document whether death benefits:

- were income under S0830.545; and
- if not income, whether the amounts were for repayment of bills already paid.

If you determine that death benefits should not be counted for one calendar month, document the amounts and that month.

D. References

- Death benefits as income, S0830.545.

E. Example--Death Benefits Not a Resource

1. Situation

As a result of her uncle's death, Barbara Smith, a disabled recipient, receives $4,000 in July as beneficiary of his life insurance policy. She intends to spend the entire amount on his last illness and burial expenses. She has already received bills totaling $900 which she pays. On August 1, she receives a funeral bill for $2,900 and a few days later receives a cash gift of $500 to be used for last illness and burial expenses. She pays the $2,900 funeral bill in August and intends to use the remainder to pay some hospital expenses.

2. Analysis

Neither the $4,000 Ms. Smith receives in July nor the $500 she receives in August is unearned income. Since she uses $900 of the $4,000 life insurance check in July, as of August 1, she has a $3,100 balance which is not a resource for August. During August she pays the $2,900 bill and then has $200 left. However, the $500 she receives in August gives her $700 to use for funeral expenses. She must spend $200 in August for burial or last illness expenses, otherwise, the $200 will count as a resource September 1. She has until the end of September to spend the remaining $500, otherwise it will count as a resource October 1.

F. Example--Death Benefits Resource

1. Situation

Ruth Taylor, a 68 year old recipient, has total countable resources of $1,980 consisting of a $1,000 savings account and $980 checking account. Her brother died in late October. In November she receives $3,000 as beneficiary of her brother's life insurance policy. She has last illness and burial expenses of $2,750 to pay. There will be no more bills after these.

2. Analysis

Of the $3,000 Ms. Taylor received, $250 is unearned income in November because last illness and burial expenses are only $2,750. The $2,750 is not unearned income and will not be a resource until January 1 if she still has it then. The $250 amount will be a resource on December 1. This money will be added to the money she has in her checking and savings accounts. If the total is more than $2,000, she will be ineligible for Medicaid.

S1120.150 GIFTS OF DOMESTIC TRAVEL TICKETS

A. Policy

This policy is effective for tickets received on or after March 1, 1990.

The value of a ticket for domestic travel received by an individual (or spouse) is not a resource if the ticket is:

- received as a gift;
- not **converted** to cash; and
- excluded from income per S0830.521.

B. Procedure

1. When to Develop

Develop under this section when an individual alleges having retained an uncashed ticket for domestic travel **and** the value of the ticket, plus the value of other countable resources, exceeds the applicable resource limit.

PROPERTY THAT MAY OR MAY NOT BE A RESOURCE

M1120.200 TRUST PROPERTY

A. Introduction

A trust is a legal arrangement involving property and ownership interests. Property held in a trust may or may not be considered a resource. The general rules concerning resources apply to evaluating the resource status of property held in a trust.

Trusts are often complex legal arrangements involving State law and legal principals that an eligibility worker (EW) is not expected to know or be able to apply without legal counsel.

Therefore, the following instructions may only be sufficient for you to recognize that an issue is present and should be referred to the Regional Coordinator or Assistant Attorney General through your regional office. When in doubt, refer the issue for a legal opinion.

The enactment of OBRA 93 changed the evaluation of trusts established (other than by a will) on or after August 11, 1993. Assets of trusts established other than by a will may be countable as income, resources, or as asset transfers. Trusts established for disabled individuals are treated differently; see M1120.202.

Policy relating to trusts is located in the following sections.

- M1120.200, Trust Property
- M1120.201, Trust Established on or after August 11, 1993
- M1120.202, Trusts Established for Disabled Individuals On or After August 11, 1993
- M1130.520, Trusts Established Between July 1, 1993 and August 11, 1993
- M1140.400 Trust Established By A Will
- M1140.401, Trusts Which Were Not Created by a Will
- M1140.402, Medicaid Qualifying Trust (Created Prior to August 11, 1993)
- M1140.403, Trusts Created After July 1, 1993 and Before August 11, 1993 With Corpus In Excess of $25,000
- M1140.404, Trust Established on or After August 11, 1993

B. Definitions

1. Trust

A trust is a property interest whereby property is held by an individual (trustee) subject to a fiduciary duty to use the property for the benefit of another (the beneficiary).

2. Grantor

A grantor (also called a settlor or trustor) is a person who creates a trust. An individual may be a grantor if an agent, or other individual legally empowered to act on his/her behalf (e.g., a legal guardian, representative payee for title II/XVI benefits, a person acting under a power of attorney or conservator), establishes the trust with funds or property that belong to the individual. The terms grantor, trustor, and settlor may be used interchangeably.

3. Trustee

A trustee is a person or entity who holds legal title to property for the use or benefit of another. In most instances, the trustee has no legal right to revoke the trust or use the property for his/her own benefit.

4. Trust Beneficiary

A trust beneficiary is a person for whose benefit a trust exists. A beneficiary does not hold legal title to trust property but does have an equitable ownership interest in it.

5. Trust Principal

The trust principal is the property placed in trust by the grantor which the trustee holds, subject to the rights of the beneficiary plus any trust earnings paid into the trust and left to accumulate.

6. Trust Earnings (Income)

Trust earnings or income are amounts earned by trust principal. They may take such forms as interest, dividends, royalties, rents, etc. These amounts are unearned income to the person legally able to use them for personal support and maintenance.

7. Totten Trust

A Totten trust is a tentative trust in which a grantor makes himself/ herself trustee of his/her own funds for the benefit of another. The trustee can revoke a Totten trust at any time. Should the trustee die without revoking the trust, ownership of the money passes to the beneficiary.

8. Grantor Trust

A grantor trust is a trust in which the grantor of the trust is also the sole beneficiary of the trust.

9. Mandatory Trust

A mandatory trust is a trust which requires the trustee to pay trust earnings or principal to or for the benefit of the **beneficiary** at certain times. The trust may require disbursement of a specified percentage or dollar amount of the trust earnings or may obligate the trustee to spend income and principal, as necessary, to provide a specified standard of care. The trustee has no discretion as to the amount of the payment or to whom it will be distributed.

10. Discretionary Trust

A discretionary trust is a trust in which the trustee has full discretion as to the time, purpose and amount of all distributions. The trustee may pay to or for the benefit of the beneficiary, all or none of the trust as he or she considers appropriate. The beneficiary has no control over the trust. The kind and degree of the "discretion" given to the trustee is determined by the terms of the trust.

11. Medicaid Qualifying Trust

A "Medicaid qualifying trust" is a trust, or similar legal device, established (other than by a will) by an individual or an individual's spouse prior to August 11, 1993 under which the individual may be beneficiary of all or part of the payments from the trust. The distribution of such payments is determined by one or more trustees who are permitted to exercise discretion with respect to the distribution to the individual.

EXCEPTION: A trust or initial trust decree established **prior to** April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded is not a "Medicaid Qualifying Trust".

12. Residual Beneficiary

A residual beneficiary is not a current beneficiary of a trust, but will receive the residual benefit of the trust contingent upon the occurrence of a specific event, e.g., the death of the primary beneficiary.

13. Fiduciary

A person or other entity that holds something in trust for another and has a legal obligation to act in the best interests of that person in all matters regarding the property held, as the executor of a will who is responsible for preserving assets and investing wisely, when required to do so.

C. Policy-Accounts That May or May Not Be Trusts

1. Accounts That Are Not Trusts

The following accounts and instruments are similar to trusts and may be titled as trusts, but should generally not be developed under these instructions for Medicaid purposes.

a. Conservatorship Accounts

These accounts, established by a court, are usually administered by a court-appointed conservator for the benefit of an individual. They differ from a trust in that the "beneficiary" retains ownership of all of the assets, although in some cases they may not be available for support and maintenance. (See S1140.215 for instructions pertaining to conservatorship accounts.)

b. Patient Trust Accounts

Many nursing homes and institutions maintain so called "patient trust accounts" for individuals to provide them with toiletries, cigarettes, candy and sundries. Although titled trust accounts, these are agency accounts. The individual owns the money in the account which the institution is merely holding for him or her and making disbursements on his or her behalf as necessary. (See S1120.020, S0810.120 for information on transactions involving agents.)

2. "In Trust For" Financial Accounts

These accounts may or may not be trusts depending on the circumstances in the individual case. Examples of the most common situations follow:

a. Representative Payee Accounts

One of the most common types of "in trust for" accounts are representative payee accounts. These accounts are not trusts, but improperly titled accounts and are misleading as to the actual owner of the funds. If a representative payee deposits current or conserved benefits in an account, the account must be titled to reflect the beneficiary's ownership interest. (See S1120.020 and S0810.120 for instructions pertaining to agency accounts.)

b. Totten Trusts

An "in trust for" financial institution account may be a Totten trust if an individual deposits his or her own funds in an account and holds the account as owner for the benefit of another individual(s).

D. Policy - Trust as Resources

1. Trusts Which Are Resources

a. General

If an individual (applicant or recipient) has legal authority to revoke the trust and then use the funds to meet his food, clothing or shelter needs, or if the individual can direct the use of the trust principal for his/her support and maintenance under the terms of the trust, the trust principal is a resource for Medicaid purposes.

- M1120.200, B, 11
- M1140.402, Medicaid Qualifying Trust

b. Authority to Revoke Trust or Use Assets

- Grantor

  In some cases, the authority to revoke a trust is held by the grantor. Even if the power to revoke a trust is not specifically retained, a trust may be revocable in certain situations. (See B.8. above and 3. below for information on grantor trusts.) Additionally, State law may contain presumptions as to the revocability of trusts. If the trust principal reverts to the grantor upon revocation and can be used for support and maintenance, then the principal is a resource.

- Beneficiary

  A beneficiary generally does not have the power to revoke a trust. However, the trust may be a resource to the beneficiary, in the rare instance, where he/she has the authority under the trust to direct the use of the trust principal. (The authority to control the trust principal may be either specific trust provisions allowing the beneficiary to act on his/her own or by ordering actions by the trustee.) In such a case, the beneficiary's equitable ownership in the trust principal and his/her ability to use it for support and maintenance means it is a resource.

  While a trustee may have discretion to use the trust principal for the benefit of the beneficiary, the trustee should be considered a third party and not an agent of the beneficiary, i.e., the actions of the trustee are not the actions of the beneficiary, unless the trust specifically so provides.

- Trustee

  Occasionally, a trustee may have the legal authority to revoke a trust. However, the trust is not a resource to the trustee unless he/she becomes the owner of the trust principal upon revocation. The trustee should be considered a third party. Although the trustee has access to the principal for the benefit of the beneficiary, this does not mean that the principal is the trustee's resource. If the trustee has the legal authority to withdraw and use the trust principal for his/her own support and maintenance, the principal is the trustee's resource for Medicaid purposes in the amount that can be used.

- Totten trust

  The creator of a Totten trust has the authority to revoke the financial account trust at any time. Therefore, the funds in the account are his/her resource.

2. Trusts Which May Not Be A Resource

If an individual does not have the legal authority to revoke the trust or direct the use of the trust assets for his/her own support and maintenance, the trust principal is not the individual's resource.

The revocability of a trust and the ability to direct the use of the trust principal depends on the terms of the trust agreement and/or on State or federal law. If a trust is irrevocable by its terms and under State law cannot be used by an individual for support and maintenance, it may not be a resource. Evaluate the trust in accordance with the following sections.

- M1120.201, Trusts Established on or after August 11, 1993
- M1120.202, Trusts Established for Disabled Individuals on or after August 11, 1993.
- M1130.520, Trusts Established Between July 1, 1993 and August 10, 1993
- M1140.400, Trust Created By A Will
- M1140.402, Medicaid Qualifying Trust (created prior to August 11, 1993)
- M1140.403, Trusts Created After July 1, 1993 and before August 11, 1993 with Corpus in Excess of $25,000

3. Revocability of Grantor Trusts

Virginia follows the general principle of trust law that if a grantor is also the sole beneficiary of a trust, the trust is revocable regardless of language in the trust document to the contrary.

Virginia recognizes the irrevocability of a grantor trust if there is a named "residual beneficiary" in the trust document who would, for example, receive the principal upon the grantor's death or the occurrence of some specific event.

NOTE: The above policies regarding grantor trusts may or may not apply in some States.

E. Policy – Disbursements from Trusts

1. When Trust Principal Is Not a Resource

If the trust principal is not a resource, disbursements from the trust may be income to the Medicaid *enrollee*/beneficiary, depending on the nature of the disbursements. Regular rules to determine when income is available apply.

a. Disbursements Which are Income

Cash paid directly from the trust to the individual is unearned income.

b. Disbursements Which Result in Receipt of In-kind Support and Maintenance

Food, clothing or shelter received as a result of disbursements from the trust by the trustee to a third party are income in the form of in-kind support and maintenance *and are not counted for Medicaid purposes*.

c. Disbursements Which Are Not Income

Disbursements from the trust by the trustee to a third party that result in the individual receiving items that are not food, clothing or shelter are not income. For example, if trust funds are paid to a provider of medical services for care rendered to the individual, the disbursements are not income for Medicaid purposes.

2. When Trust Principal Is a Resource – Trusts Created By Will or Prior to Aug. 11, 1993

If the trust principal is a resource to the individual, disbursements from the trust principal received by the individual are not income, but conversion of a resource. See S1110.100 for instructions pertaining to conversion of resources from one form to another and F.2. below for treatment of income when the trust principal is a resource.

3. When Trust Principle is a Resource – For Trust Created on or After August 11, 1993

Effective August 11, 1993:

- payments for the benefit of the individual are counted as unearned income;
- corpus is a resource, and
- payments to other individual(s) are evaluated as asset-transfer;
- trust earnings, e.g., interest, are income.

F. Policy Earnings/Additions to Trusts

1. Trust Principal Is Not a Resource

a. Trust Earnings

Trust earnings are not income to the trustee or grantor unless designated as belonging to the trustee or grantor under the terms of the trust; e.g., as fees payable to the trustee or interest payable to the grantor.

Trust earnings are not income to the Medicaid claimant or recipient who is a trust beneficiary unless the trust directs, or the trustee makes, payment to the beneficiary.

b. Additions to Principal

Additions to trust principal made directly to the trust are not income to the grantor, trustee or beneficiary. Exceptions to this rule are listed in c. and d. below.

c. Exceptions

Certain payments are non-assignable by law and, therefore, are income to the individual entitled to receive the payment under regular income rules. They may not be paid directly into a trust, but individuals may attempt to structure trusts so that it appears that they are so paid. Non-assignable payments included:

- Aid to Families with Dependent Children (AFDC);
- Railroad Retirement Board-administered pensions;
- Veterans pensions and assistance;
- Federal employee retirement payments (CSRS, FERS) administered by the Office of Personnel Management;
- Social Security title II and SSI payments; and
- Private pensions under the Employee Retirement Income Security Act (ERISA) (29 U.S.C.A. section 1056(d)).

d. Assignment of Income

A legally assignable payment (see c. above for what is not assignable), that is assigned to a trust, is income for Medicaid purposes unless the assignment is irrevocable. If the assignment is revocable, the payment is income to the individual legally entitled to receive it.

2. Trust Principal Is a Resource

a. Trust Earnings

Trust earnings are income to the individual for whom the trust principal is a resource, unless the terms of the trust make the earnings the property of another. See S0810.030 for when income is counted.

b. Additions to Principal

Additions to principal may be income or conversion of a resource, depending on the source of the funds. If funds from a third party are deposited into the trust, the funds are income to the individual. If funds are transferred from an account owned by the individual to the trust, the funds are not income, but conversion of a resource from one account to another.

G. References

- Agency Relationships, S1120.020, S0810.120
- Financial Institution Accounts, S1140.200
- Third Party Vendor Payments, S0835.360

M1120.201 TRUSTS ESTABLISHED ON OR AFTER AUGUST 11, 1993

A. Introduction

The enactment of OBRA 93 affects the treatment of trusts. For purposes of determining an individual's eligibility for Medicaid, the rules specified in this section shall apply to a trust established by such individual on or after August 11, 1993.

EXCEPTION: Certain trusts established for disabled individuals. See M1120.202.

B. Definitions

1. Assets

Assets means both income and resources of an individual and an individual's spouse. Assets of a trust established other than by a will may be countable as income, resources, or as asset transfers.

2. Revocable Trust

A revocable trust is a trust that can be legally revoked by the individual who established it. If a trust is revocable, the entire amount of the principle or corpus is counted as a resource.

3. Irrevocable Trust

An irrevocable trust is a trust that cannot be legally revoked by the individual who established it.

C. Policy

1. Who Established Trust

An individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by a will:

- the individual,
- the individual's spouse,
- a person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse,
- a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse.

NOTE: The individual does not establish a trust when a funeral home director is named as the "grantor" on the trust document. See M1140.404.

2. Treatment of Trust Assets

In the case of a trust the corpus of which includes assets of an individual and assets of any other person or persons, the provisions of this section shall apply to the portion of the trust attributable to the assets of the individual.

This section shall apply without regard to:

- the purpose for which a trust is established,
- whether the trustees have or exercise any discretion under the trust,
- any restrictions on when or whether distributions may be made from the trust, or
- any restriction on the use of *or* distribution from the trust.

a. In the case of a **revocable trust:**
   - the corpus of the trust shall be considered resources available to the individual.

   - Payments from the trust to or for the benefit of the individual shall be considered income of the individual.

- Any other payments from the trust shall be considered assets disposed of by the individual.

b. In the case of an **irrevocable trust** if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual, the portion of the corpus from which, or the income on the corpus from which, payment to the individual could be made shall be considered

   - resources available to the individual, and

   - payments from that portion of the corpus or income to or for the benefit of the individual, shall be considered income of the individual, and

   - payments from that portion of the corpus or income for any other purpose, shall be considered a transfer of assets by the individual.

   Any portion of the trust from which, or any income on the corpus from which, no payment could under any circumstances be made to or for the benefit of an individual shall be considered,

   - as of the date *the trust is established* (or, if later, the date on which payment to the individual was foreclosed) to be assets disposed by the individual for evaluation of asset transfers, and

   - the value of the trust shall be determined for purposes of such asset transfer by including the amount of any payments made from such portion of the trust after such date.

M1120.202 TRUSTS ESTABLISHED FOR DISABLED INDIVIDUAL ON OR AFTER AUGUST 11, 1993

A. Introduction

Irrevocable trusts established after August 11, 1993 solely for the benefit of disabled individuals will not affect Medicaid eligibility. The following policy must be met for trusts of disabled individuals.

Disability must be met as defined by SSA or SSI.

B. Policy

1. Trusts for Disabled Individual Under Age 65 (Individual Trust)

A trust containing the assets of an individual under age 65 who is disabled and which is established for the benefit of such individual by a

- a parent,
- a grandparent
- legal guardian of the individual, or
- a court,

The trust policy in M1120.201 will not be applied, if

- the State will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual.

2. Trusts for Disabled Individuals ("Pooled" Trust Funds)

A trust containing the assets of a disabled individual (no age requirement) must meet the following conditions, to be exempt from the trust policy in M1120.201.

- The trust is established and managed by a non-profit association.
- A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of funds, the trust pools these accounts.
- Accounts in the trust are established solely for the benefit of disabled individuals by the parent, grandparent, or legal guardian of such individuals, by such individuals or by a court.
- To the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the State from such remaining amounts in the account an amount equal to the total amount of medical assistance paid on behalf of the beneficiary under the State Plan.

NOTE: *For an individual who meets the definition of an institutionalized individual in M1410,010 B.2, the placement of the individual's funds into a pooled trust when the individual is age 65 years or older must be evaluated as an uncompensated transfer, if the trust is structured such that the individual irrevocably gives up ownership of funds placed in the trusts. See M1450.550 D for additional information.*

S1120.205 UNIFORM GIFTS TO MINORS ACT

A. Introduction

1. General

Virginia like most states has adopted the Uniform Gifts to Minors Act (**UGMA)** which permits making to minors gifts which are free of tax burdens. The UGMA is sometimes called the Uniform Transfers to Minors Act.

When a gift is made to a minor under the Uniform Gifts to Minors Act (U.G.M.A.), the minor does not have the right to liquidate the property until he/she reaches an age (age of majority) specified by State law.

In Virginia the age of majority was lowered from age 21 to age 18 for gifts, under the U.G.M.A., made after June 30, 1973. A 1984 amendment, which became effective July 1, 1984, extended the definition of "minor" to include a person who has not attained the age of 21 years if the gift to the minor expressly provides that the custodial property shall be conveyed to the minor on his/her attaining the age of 21 years. Such provisions may be made by making the gift under the "Virginia Uniform Gifts to Minors Act (21)."

2. UGMA Provisions

Under UGMA legislation:

- an individual (donor) makes an **irrevocable gift** of money or other property to a minor (the donee);
- the gift, plus any earnings it generates, is under the **control of a custodian** until the donee reaches the age of majority established by State law;
- the **custodian has discretion** to provide to the minor or spend for the minor's support, maintenance, benefit, or education as much of the assets as he/she deems equitable; and
- the donee **automatically receives control** of the assets upon attainment of majority.

B. Policy Principles

1. UGMA and Resources

a. General

Since a custodian of UGMA assets cannot legally use any of the funds for his or her own personal benefit, they are not his or her resources. Similarly, once there is a gift under UGMA, additions to or earnings on the principal are not income to the custodian who has no right to use them for his/her own support and maintenance. (Additions to the principal may be income to the donor prior to becoming part of the UGMA principal.) For example, if the donor is a deemor who receives rental income and adds it to a child's UGMA funds, we would have to consider the rental income as income for deeming purposes.

b. While Donee Remains a Minor

- UGMA property, including any additions or earnings, is not income to the **minor;**
- the custodian's UGMA disbursements to the minor **are income to the minor**;
- the custodian's UGMA disbursements on behalf of the minor may be income to the latter if used to make certain third party-vendor payments.

c. When Donee Reaches Majority

All UGMA property becomes available to the donee and subject to evaluation as income in the month of attainment of majority.

*M*1120.210 RETIREMENT FUNDS

A. Definitions

1. Retirement Funds

Retirement funds are annuities or work-related plans for providing income when employment ends (e.g., pension, disability, or retirement plans administered by an employer or union). Other examples are funds held in an individual retirement account (IRA) and plans for self-employed individuals, sometimes referred to as Keogh plans. Also, depending on the requirements established by the employer, some profit sharing plans may qualify as retirement funds.

2. Periodic Retirement Benefits

Periodic retirement benefits are payments made to an individual at some regular interval (e.g., monthly) and which result from entitlement under a retirement fund.

3. Value of a Retirement Fund

The value of a retirement fund is the amount of money that an individual can currently withdraw from the fund. If there is a penalty for early withdrawal, the fund's value is the amount available to an individual after penalty deduction. However, any taxes due are not deductible in determining the fund's value.

B. Policy Principle

A retirement fund owned by an eligible individual is a resource if he/she has the option of withdrawing a lump sum even though he/she is not eligible for periodic payments. However, if the individual is eligible for periodic payments, the fund may not be a countable resource.

A previously unavailable retirement fund is not income to its recipient when the fund becomes available. The fund is subject to resources counting rules in the month following the month in which it first becomes available.

C. Operating Policies

1. Termination of Employment

A retirement fund is not a resource if an individual must terminate employment in order to obtain any payment.

2. Fund Not Immediately Available

A resources determination for the month following that in which a retirement fund becomes available for withdrawal must include the fund's value. A delay in payment for reasons beyond the individual's control (e.g., an organization's processing time) does not mean that the fund is not a resource since the individual is legally able to obtain the money. It is a nonliquid resource.

3. Claim of Periodic Payment Denied

If an individual receives a denial on a claim for periodic retirement payments but can withdraw the funds in a lump sum, include the fund's lump sum value in the resources determination for the month following that in which the individual receives the denial notice.

D. Development and Documentation

1. Evidence

If an individual has a retirement fund, obtain evidence of the availability of payments from the retirement fund. Determine if the individual is eligible for lump sum or periodic payments.

2. Determination

If the individual can withdraw a lump sum, the retirement fund is a resource in the amount that is currently available.

E. Related Policies

***1.* Nonliquid Resource**

Absent evidence to the contrary, assume that resources in the form of retirement funds are nonliquid (S1110.300 B.).

***2.* Deeming Exclusion**

If an ineligible spouse, or parent, owns a retirement fund, we exclude it from the deeming process. See S0830.500 regarding the treatment of interest income.

NOTE: If the individual is a married institutionalized individual with a community spouse, the retirement funds are evaluated as resources in the resource assessment and the eligibility determination (see M1480).

F. Example

1. Situation Jeff Grant currently works 3 days a week for a company where he has been employed full-time for 20 years. Under his employer's pension plan, Mr. Grant has a $4,000 retirement fund. The EW confirms that Mr. Grant could withdraw the funds now, but there would be a penalty for early withdrawal and he would forfeit eligibility for an annuity when he stopped working.

2. Analysis Since Mr. Grant can withdraw the retirement funds without terminating employment, they are a resource in the amount available after penalty deduction. This is true despite the fact Mr. Grant forfeits eligibility for periodic annuity payments in the future. All sources of available support (unless otherwise excluded) are considered in determining eligibility.

M1120.215 INHERITANCES AND UNPROBATED ESTATES

A. Introduction Property in the form of an interest in an undivided estate is to be regarded as an asset when the value of the interest plus all other resources exceed the applicable resource limit, unless it is considered unsalable for reasons other than being an undivided estate. An heir can initiate a court action to partition. If a partition suit is necessary (because at least one other owner of or heir to the property will not agree to sell the property) in order for the individual to liquidate the interest, estimated partition costs may be deducted from the property's value. However, if such an action would not result in the applicant/recipient securing title to property having value substantially in excess of the cost of the court action, the property would not be regarded as an asset. An ownership interest in an unprobated estate may be a resource if an individual:

- is an heir or relative of the deceased; or
- receives any income from the property; or
- under State intestacy laws, has acquired rights in the property due to the death of the deceased.

The procedure for determining the countable value of an unprobated or undivided estate is found in Appendix 1 to subchapter S1130.

B. For QDWI, QMB, SLMB, QI and ABD 80%FPL The policy for treatment of an unprobated or undivided estate for the QDWI covered group is in Appendix 1 to chapter S11. The policy for treatment of an unprobated or undivided estate for the QMB, SLMB, QI and ABD 80% FPL covered groups is in Appendix 2 to chapter S11.

C. Operating Policies

1. When to Develop We develop for this type of resource only if:

- the property in question is not excludable under any of the provisions in S1110.210 B.; and

- counting the property's value would result in excess resources.

2. Ownership Interest

There is an ownership interest in an unprobated estate if:

- documents (e.g., a will or court records) indicate an individual is an heir to property of a deceased; or
- an individual has use of a deceased's property or receive income from it; or
- documents establish, or the individual alleges, a relationship between himself and the deceased which, under State intestacy laws, awards the individual a share in the distribution of the deceased property; and
- the inheritance, use of income, and distributions are uncontested.

3. When Unprobated Estate Can Be a Resource

We do not consider that an inheritance is a resource until the month following the month in which it meets the definition of income. See S0830.550 for the income rules on inheritances. Thereafter, if retained, we evaluate the property as a resource.

S1120.220 LOANS, PROMISSORY NOTES, AND PROPERTY AGREEMENTS

A. Definitions

1. Bona Fide Agreement

A *bona fide* agreement is an agreement that is legally valid and made in good faith.

2. Negotiable Agreement

A *negotiable* agreement is an agreement whereby the legal title to the instrument itself and the whole amount of money expressed on its face can be transferred from one person (holder) to another.

B. Policy--General

The following rules relate only to the principal amounts involved in the credit arrangements described in A. above. They do not include a creditor's receipt of interest which is unearned income.

1. Debtor/ Buyer

a. Bona Fide Agreement

- An agreement to make payment is neither income nor a resource.
- The goods or money represented in the agreement are not income but may be resources if retained.

b. Agreement Not Bona Fide

The goods or money represented in the agreement may be income upon receipt and resources if retained.

2. Creditor/ Seller

a. Bona Fide, Negotiable Agreement

- A bona fide, negotiable agreement by a debtor to make payment is a resource.
- The goods or money represented in the agreement are not resources since the creditor cannot access them for his/her own use; the agreement replaces them as his/her resource.
- The debtor's payments against the principal are conversion of a resource, not income.

b. Agreement Not Bona Fide or Not Negotiable

- The agreement is not a resource.
- Payments against the principal are income, not conversion of a resource.
- The goods or money specified in the agreement may be resources if the creditor can access them for his/her own use.

C. Policy--Informal Loans

Consider an informal loan as bona fide if it includes:

- borrower's acknowledgement of his obligation to repay;
- schedule and plan for repayment; e.g., borrower plans to repay when he receives anticipated income in the future; and
- borrower's express intent to repay by pledging either real or personal property or anticipated income.

D. References

- Interest income, S0830.500.
- Relationship between income and resources, M1120.005 and S1120.005
- Loan proceeds not being income, S0815.350 B.1.
- Promissory Note definition, S1140.300 A.2.
- Loan definition S1140.300 A.3.
- Property Agreement definition, S1140.300 A.4.

E. Example--Contractor Sale

1. Situation

Mr. Dottle, an aged applicant, tells the EW that he has an agreement to sell unused farmland in a nearby county to a neighbor for $1,800 plus interest. His neighbor has already paid $1,200 to Mr. Dottle. The sales contract specifies that Mr. Dottle will receive one additional payment of $600 plus interest.

2. Analysis

The EW correctly recognizes that the farmland is no longer Mr. Dottle's resource even though it is still his property; because he is bound by an agreement to sell that land, he cannot transfer title to anyone else. Mr. Dottle has converted his ownership interest in the land into a contract. Unless there is a legal restriction against converting the contract into cash, it is his resource in the amount of the $600 principal balance (absent convincing evidence of a lesser CMV).

If the contract is a resource, any payment against the principal represents a conversion of that resource.

If the contract is not a resource, payment against the principal is income.

Regardless of the resource status of the contract, any interest payment he receives is income.

F. Example--Installment Sale Contract

1. Situation

Henry Little, a Medicaid applicant, recently became a widower and moved out of the family home to live in a rented apartment. He has just entered into an installment sale contract on his former home with Thomas Higgins, a Medicaid recipient. Mr. Higgins made a $6,000 down payment on the house, using retroactive SSI benefits paid under a court order, and immediately moved into his new home in which he already has an equitable ownership interest, even though he does not yet have title. The outstanding principal balance on the installment agreement is $8,000.

2. Analysis

The EW must determine resources eligibility for both men. Although Mr. Little still has title to the house, he cannot sell it; rather, its value as a resource to Mr. Little has folded into the value of the installment contract. However, the installment sale contract (which the EW confirms has no legal restrictions against its sale) is Mr. Little's resource in the amount of the outstanding principal balance unless he presents convincing evidence that its CMV is a lower amount.

The installment sale contract has no bearing on Mr. Higgins' eligibility, as either income or resources. His ownership interest in the house he is buying from Mr. Little is an excluded resource since it is his principal place of residence.

M1120.225 REVERSE MORTGAGES

A. Definition

A reverse mortgage is a contract with a bank or other lending institution whereby the bank provides the borrower with monthly payments which do not have to be repaid as long as the individual lives in the home. These payments are a loan against the equity in the home and must be repaid when the individual dies, sells his home, or moves.

B. Policy

The payments from a reverse mortgage are loan proceeds and are not income to the borrower. Proceeds retained after the month of receipt are a resource.

CHAPTER 011
RESOURCES EXCLUSIONS
SUBCHAPTER 30

S1130 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	Table of Contents, page ii pages 4, 73, 74 Appendix 1, pages 1-14 Appendix 2, page 1 Appendix 4, pages 1-8 added
TN #95	3/1/11	pages 28, 29, 33
TN #94	9/1/10	pages 20, 20a, 28-29a
TN #93	1/1/10	pages 63-65 pages 70, 74, 75
TN #91	5/15/09	page 13

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S1130.000 RESOURCES EXCLUSIONS

REAL PROPERTY

M1130.100 THE HOME

A. Policy Principles -- General Rules

This policy only applies to SSI Recipients, ABD Individuals with Income ≤ 300% SSI, and ABD Medically Needy (MN) covered groups. It does NOT apply to the following ABD covered groups:

- *Qualified Disabled and Working Individuals (QDWI),*
- *Qualified Medicare Beneficiaries (QMB),*
- *Special Low-income Medicare Beneficiaries (SLMB),*
- *Qualified Individuals (QI), and*
- *ABD 80% FPL.*

The home property resource exclusion for the QDWI covered group is in Appendix 1 to Chapter S11. The home property resource exclusion for the QMB, SLMB, QI and ABD 80% FPL covered groups is in Appendix 2 to Chapter S11.

1. Home Exclusion

Ownership of a dwelling occupied by the applicant as his home does not affect eligibility.

2. Definition of the Home

An individual's home is property that serves as his or her principal place of residence.

A home means the house and lot used as the principal residence and all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000.

In any case in which the definition of home as provided here is more restrictive than that provided in the State Plan for Medical Assistance in Virginia as it was in effect on January 1, 1972, then a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value.

3. Principal Place of Residence

An individual's principal place of residence is the dwelling the individual considers his established or principal home and to which, if absent, he intends to return. It can be real or personal property, fixed or mobile, and located on land or water. Only one resource can be exempted as home property.

4. Individual Owns the Land but Not the Shelter

For purposes of excluding "the land on which the shelter is located" (see A.2. above), it is not necessary that the individual own the shelter itself.

EXAMPLE: If an individual lives on his own land in someone else's trailer, the land meets the definition of home and is excluded.

B. Operating Policy -- Home Lot

1. Land

The home exclusion applies to the plot of land on which the home is located. The excluded home lot size may vary according to the locality's building requirements.

For localities with set minimum building lot size use the lesser of:

- *the* plat;
- *the* survey; or
- *the* locality's minimum size for a building lot.

For localities with no minimum building lot requirements, use the lesser of:

- *the* plat;
- *the* survey; or
- one acre.

2. Buildings

The home exclusion applies to all buildings on land excluded in B.1. above.

C. Operating Policy -- Contiguous Property Allowed Under Home Exclusion

The home exclusion may be applied to property contiguous to the home. Property adjoining the home lot may come under the home exclusion by using one of two different calculations. Apply the calculation which is most advantageous.

1. $5,000 Assessed Value of Contiguous Land

The home exclusion applies to land adjoining the home plot if not completely separated from it by land in which neither the individual nor his or her spouse has an ownership interest. **$5,000 of assessed value of land contiguous to the home lot can be included in the home exclusion**.

Easements and public rights of way (utility lines, roads, etc.) do not separate other land from the home plot.

2. Contiguous Property Essential to the Operation of the Home

The equity value of countable contiguous property may cause resources to exceed the maximum limit. In these cases, reevaluate the home property applying the definition of the home used in the State Plan for Medical Assistance in Virginia in effect on January 1, 1972. At that time a home means the house and lot used as the principal residence and all contiguous property essential to the operation of the home regardless of value.

Property essential to the operation of the home means:

a. land used for regular production of any food/goods for the household's consumption only, including:

- vegetable gardens;
- pastureland for livestock raised for milk or meat;
- land to raise chickens, pigs, etc;
- outbuildings used to process and/or store any of the above.

The amount of land necessary to support animals named above is established by the local extension service. However, only actual land being used to support the animals will be allowed.

b. driveways connecting the homesite to public roadways.

c. land necessary to **the** homesite to meet local zoning requirements (e.g. building site, mobile home sites, road frontage, distance **from** road, etc.).

d. land necessary for compliance with state local health requirements (e.g., distance between home and septic tank(s));

e. water supply for the household.

f. existing burial plots.

g. outbuildings used in connection with dwelling, such as garages or tool sheds.

3. ABD Home Property Evaluation Worksheet

See Appendix 2 to this subchapter for the "ABD Home Property Evaluation Worksheet**."**

D. Limitations On Home Property Exclusion

1. Property That No Longer Serves as the Principal Place of Residence

Property ceases to be the principal place of residence, *and is no longer* excludable as the home, as of the date that *an* individual *who has* left *the home determines that he* does not intend to return to it.

Such property, if not excluded under another provision, will be included in determining countable resources.

2. 6-Month Exemption

An institutionalized individual's former residence is an excluded resource for six months beginning with the month following the month of the *individual's* admission to a medical institution. *The following are types of medical institutions:*

- *chronic disease hospitals,*
- *hospitals and/or training centers for the mentally retarded,*
- *institutions for mental diseases (IMDs),*
- *intermediate care facilities(ICFs),*
- *nursing facilities, and*
- *rehabilitation hospitals.*

After six months the former residence is counted as an available resource.

The six-month home exclusion allowed for an institutionalized individual's former home also applies to the home owned by an individual receiving Medicaid community-based care (CBC) services in another person's home, providing the individual resided in the home prior to receipt of Medicaid CBC. See M1460.530 for additional information.

3. Extended Exclusion for Institutionalized Individual

An institutionalized individual's home property continues to be excluded if it is occupied by his:

- spouse;
- minor dependent child under age 18;
- dependent child, **under** age 19, **who attends** school or vocational training; or
- parent or adult child who is disabled (per Medicaid disability definition) and was living in the home with the person for at least one year prior to person's institutionalization, and who is dependent upon the person for his shelter needs.

E. Development and Documentation-- Initial Applications

1. Ownership

a. Verify Ownership

Verify an individual's allegation of home ownership. Have the individual submit one of the items of evidence listed in b.- d. below.

b. Evidence of real property ownership;

- tax assessment notice;
- recent tax bill;
- current mortgage statement;
- deed;
- report of title search;
- evidence of heirship in an unprobated estate (e.g., receipt of income from the property, a will, or evidence of relationship recognizable under State intestate distribution laws in cases where the home is unprobated property).

c. Evidence of personal property ownership (e.g., a mobile home):

- title,
- current registration.

d. Evidence of life estate or similar property rights:

- a deed,
- a will,
- other legal document.

e. Equitable Ownership

If an individual alleges equitable ownership (e.g., an unwritten ownership interest or right of use for life) obtain any pertinent documents and a signed statement from each of the parties involved regarding any arrangement that has been agreed to. Forward the document to a *medical assistance program consultant* for an opinion from legal counsel.

2. Principal Place of Residence--Operating Assumption

If the individual does not own more than one residence *and there is no* evidence that raises a question about *his principal place of residence*, assume that the alleged home is the individual's principal place of residence.

3. Indication of More than One Residence

If an individual alleges or other evidence indicates ownership of more than one residence, obtain his signed statement concerning such points as:

- how much time is spent at each residence;
- where he is registered to vote;
- which address he uses as a mailing address or for tax purposes.

Determine the principal place of residence accordingly and document the determination in the case file.

4. Evidence Indicates Non-adjoining Property

a. Individual Agrees With Evidence

If evidence indicates that land the individual owns does not adjoin the home plot, and the individual agrees that it does not:

- **obtain** his statement to that effect; and
- **develop** the non-adjoining portion per S1140.100 (Non-home Real Property) or S1130.500 (Property Essential to Self-Support), as applicable.

b. Individual Disagrees With Evidence

If the individual maintains that all the land adjoins the home plot, document the file with:

- a sketch of the land showing the boundaries of the various plots and the location of the shelter used as the home; and
- evidence of how the land is treated for tax assessment purposes.

The sketch may be by the individual, from public records, or by EW (from direct observation).

The tax assessment information may be in the form of a tax assessment notice or obtained from the appropriate tax jurisdiction.

c. Combined or Single Holding for Tax Assessment

Assume that the land is a single piece of property in which all the land adjoins the home plot if:

- it is recorded and treated as a single holding for tax assessment purposes; or
- the original holding has been subdivided, but still is treated as a single holding for tax assessment purposes.

d. More Than Single Holding for Tax Assessment

If the land is recorded and treated as two or more holdings for tax assessment purposes, use the sketch to determine whether other holdings adjoin the home plot.

5. Absences From The Home

a. Summary of Development

If the individual is in an institution, determine whether a spouse or dependent relative is living in the home (see b. below).

If no spouse or dependent relative is living in the home, or if the absence is for a reason other than institutionalization, determine *if the individual intends to return when the purpose of the absence (such as medical care, rehabilitation, vacation/visit, education, employment, military service) is completed.*

NOTE: If a previously undeveloped absence from the home has ended, assume that the individual always intended to return. The absence, regardless of duration, will not affect the home exclusion.

b. Spouse or Dependent Relative Development

Obtain a signed statement from the individual as to:

- whether anyone is living in the home while the individual is in the institution;
- if so, how that person is related to the individual, if at all; and
- if related (except for the individual's spouse), how that person is dependent on the individual for shelter needs, if at all.

Absent evidence to the contrary, accept the allegation.

6. Value of Home Lot

Verify the current assessed value of the home lot from the locality's Real Estate Assessment Office.

NOTE: The home lot assessed value is usually more than the value assessed to the contiguous property. Therefore, prorating the total assessed land value on the real estate tax assessment bill may not give the true assessed value of the home lot.

7. Total Home Exclusion Value

a. Add Together:

- the assessed value of the home lot as verified in 6. above, and
- $5,000 of contiguous assessed property value.

This total equals the amount of assessed land value allowed under the Home Exclusion.

If excess resources exist and any countable contiguous property was included in the evaluation, the Home Exclusion must be re-evaluated.

b. Add Together:

- the assessed value of the home lot as verified in 6. above, and
- the assessed value of contiguous property essential to the operation of the home.

This equals the amount of assessed property value allowed under the Home Exclusion used under the State Plan for Medical Assistance in Virginia in effect on January 1, 1972.

F. Procedure – Post-eligibility

If, after Medicaid eligibility is established, an individual receives real property—for example, as an inheritance or gift—which may be excludable as his home, apply the policy and procedures in A. and B. above to determine whether the home exclusion applies.

Redevelop the exclusion from resources of an individual's home only if something raises a question about the correctness of the original determination or indicates that the exclusion may no longer apply (e.g., a change of address).

G. References

- Home replacement funds, S1130.110
- Real property whose sale would cause undue hardship due to loss of housing, to a co-owner, Appendix 2 to chapter S11.
- Real property following reasonable but unsuccessful efforts to sell it, **M1130.140.**

S1130.110 HOME REPLACEMENT FUNDS

A. Policy Principles

1. General

When an individual sells an excluded home, the proceeds of the sale are excluded resources if the individual:

- plans to use them to buy another excluded home, and
- does so within 3 full calendar months of receiving them.

2. Installment Sales Contracts

If an individual receives the proceeds under an installment contract, the contract is an excluded resource for as long as the individual:

- plans to use the entire down payment and the entire principal portion of a given installment payment to buy another excluded home; and
- does so within 3 full calendar months of receiving such down payment or installment payment.

B. Operating Policy

1. Proceeds Defined

a. If Paid in a Lump Sum

The proceeds are the net amount the seller receives at settlement.

b. If Paid in Installments The proceeds consist of:

- any downpayment; and
- that portion of any subsequent payment that is not interest.

2. Allowable Uses of Proceeds

Use of proceeds to buy another excluded home includes payment of any costs that stem from the purchase. These include, but are not necessarily limited to:

- downpayment;
- settlement costs;
- loan processing fees and points;
- moving expenses;
- necessary repairs to or replacements of the new home's structure or fixtures (e.g., roof, furnace, plumbing, built-in appliances) that are identified and documented prior to occupancy; and
- mortgage payments.

Use of proceeds to pay other costs will warrant their exclusion if such costs are identified and documented prior to occupancy and stem directly from the purchase or occupancy of the new home.

3. Timely Use of Proceeds

a. Timely
"Within 3 full calendar months" means by the end of the last day of the third month after the month in which the proceeds are received.

b. Use
"Using" the proceeds includes obligating them by contract as well as actually paying them out.

c. Proceeds Not Used Timely --Lump Sum
The exclusion of the unused funds will be revoked retroactively to the date of their receipt.

d. Proceeds Not Used Timely--Installment Payments
The exclusion of the installment contract itself, and of the unused portion of any installment payments, will be revoked retroactively to the date the unused proceeds were received.

4. Reinstatement of Exclusion After Revocation

a. General
The exclusion of an installment contract, once revoked, will be reinstated if the individual intends to and does use the entire principal portion of a subsequent installment payment toward the purchase of another excluded home within 3 full calendar months of receiving such installment payment.

b. Effective Date
Reinstatement of the exclusion is effective as of the date the individual signs a new statement of intent (see C.2.b. below) and affects resource determination for that month.

5. Example--Installment Payments Not Used Timely

An installment contract has a principal balance of $5,000 as of July 1. On July 10, the buyer makes a payment of $200. As of October 31, the recipient has used only $150 of the July payment in connection with the purchase of a new home.

The exclusion of the unused $50 - and of the installment contract itself - is revoked back to July 10. As a result, the $50 and the value of the contract as of August 1 ($4,800) are included in a revised determination of resources for August.

C. Development and Documentation--Initial Applications

1. Explanation To Individual

Explain the home replacement exclusion to any individual who has sold an excluded home (if it is not too late to exclude any of the proceeds) or who plans to do so. Include the date, if known, by which the proceeds must be used in order to qualify for exclusion.

2. Statement Of Intent

a. General

Obtain a signed statement from the individual as to whether he or she intends to use the proceeds to buy another home by the date specified. If so, the statement also must reflect his or her understanding that the exclusion of any funds not used by the date specified will be revoked retroactively.

b. Installment Contracts

When the proceeds are being paid in installment, the individual's statement of intent must reflect his or her understanding that, if the noninterest portion of any payment is not used within 3 months of its receipt, the exclusion of

- the unused portion of such payment and
- the contract itself will be revoked retroactively to the date of receipt of such payment.

3. Documenting Proceeds Of Sale

Document the file with a copy of the settlement sheet, contract for sale and/or other evidence that shows the net proceeds of the sale and how paid or payable, i.e.: paid in full at statement, dates and amounts of downpayment and installment payments, interest, etc.

a. Lump-Sum Proceeds

Set a special review to contact the individual in the month in which the exclusion period for the proceeds expires.

b. Installment Contact

Set the special review for the month in which the exclusion period for the downpayment on the prior home expires. If no downpayment is made, review the case the month in which the exclusion period for the first monthly payment expires.

c. Required Evidence Document the file with the same types of evidence used to document the proceeds of the sale of the prior home (see 3. above) and, if necessary, with bills, receipts, or other evidence of related allowable expenses.

4. Proceeds Used to Replace Home

a. Lump-Sum Proceeds
If the amount paid at settlement for the new home equals or exceeds the lump sum received for the old home, and there is no question about where any excess came from, cease development.

b. Installment Payments
Unless there is a question of unstated income or previously undetected resources, cease current development if:

- the downpayment on the new home equals or exceeds the downpayment received from the sale of the prior home; and
- monthly payments on the new home equal or exceed the noninterest portion of the installment payments being received on the prior home.

5. Proceeds Not Used to Replace Home

a. Lump Sum Proceeds or Downpayment
Document use of proceeds for related allowable expense (B.2. above) if:

- the amount paid at settlement for the new home is less than the lump-sum proceeds of the sale of the prior home; or
- the downpayment on the new home is less than the downpayment received from the sale of the prior home.

If not all of the proceeds will be used timely, redetermine resources for the months after the proceeds were received. Do not exclude:

- the unused portion of the lump-sum proceeds or downpayment; or
- the value of an installment contract.

NOTE: Any proceeds spent at all, whether or not for an allowable use, will not affect the resources determination for the month after they were spent.

b. Installment Payments
If the noninterest portion of the payments the individual receives on the old home exceeds the amount of the payments he or she makes on the new home, document use of the excess for related allowable expenses.

If the individual cannot provide evidence of allowable expenses for which a given month's excess can be earmarked for timely use, the installment contract cannot be excluded for that month.

D. Development and Documentation--Post-Eligibility

Do not develop for the continuing applicability of the home replacement funds exclusion unless something indicates that less than the entire noninterest portion of the installment payments is being applied to the purchase of the replacement home.

1. Federal Disaster Assistance

See S1130.620 regarding the exclusion of funds received under the Disaster Relief and Emergency Assistance Act of 1974 or under some other Federal statute because of a catastrophe declared by the President to be a major disaster.

2. Commingled Funds

See S1130.700 if funds excluded under this provision are commingled with other funds.

3. Interest

Interest earned on funds excluded under this provision is not excluded from income or resources by this provision. See S0830.500 for its treatment as income.

E. Related Policies

1. Federal Disaster Assistance

See S1130.620 regarding the exclusion of funds received under the Disaster Relief and Emergency Assistance Act of 1974 or under some other Federal statute because of a catastrophe declared by the President to be a major disaster.

2. Commingled Funds

See S1130.700 if funds excluded under this provision are commingled with other funds.

3. Interest

Interest earned on funds excluded under this provision is not excluded from income or resources by this provision. See S0830.500 for its treatment as income.

S1130.130 REAL PROPERTY WHOSE SALE WOULD CAUSE UNDUE HARDSHIP, DUE TO LOSS OF HOUSING, TO A CO-OWNER FOR QDWI, QMB, SLMB, QI and ABD 80% FPL ONLY

A. Policy Principles

1. Exclusion

*The value of an individual's ownership interest in jointly owned real property is an excluded resource **for as long as** sale of the property would cause undue hardship, due to loss of housing, to a co-owner.*

2. Undue Hardship

Undue hardship would result if such co-owner:

- *uses the property as his or her principal place of residence;*
- *would have to move if the property were sold; and*
- *has no other readily available housing.*

3. Exclusion Applies to Certain Groups

This exclusion only applies to:

Qualified Disabled Working Individuals (QDWI)

- *Qualified Medicare Beneficiary (QMB)*
- *Special Low Income Beneficiary (SLMB)*
- *Qualified Individuals (QI-1 and QI-2)*
- *ABD with Income ≤ 80% FPL (ABD 80% FPL).*

This exclusion does not apply to other ABD covered groups.

B. Development and Documentation--Initial Applications and Post-Eligibility

1. Allegations of Loss of Housing for Co-Owner

If someone alleges that the sale of certain real property would force a co-owner living on it to move, obtain:

- *the individual's signed statement to that effect, and*
- *evidence of joint ownership (see S1130.100 E.1.b.-d.).*

If co-ownership is not proven, skip to 3. below. Otherwise, obtain the statement in 2. below.

2. Required Statement from Resident Co-Owner

Obtain a statement from the co-owner regarding whether he or she:

- *uses the property as his or her principal place of residence;*
- *would have to move if the property were sold; and*
- *has other living quarters readily available.*

Apply the policy principle in A. above to determine whether, on the basis of the statements of the individual and the co-owner, the sale of the property would cause undue hardship to the co-owner.

Accept any reasonable allegation from the co-owner that there is no readily available housing (e.g., no other affordable housing available or no other housing with necessary physical modifications for a handicapped individual).

3. Determination-Not Undue Hardship

If the property cannot be excluded on the basis of undue hardship:

- *document the file to that effect;*
- *issue appropriate notice.*

4. Determination-Undue Hardship

If the property can be excluded on the basis of undue hardship:

- *document the file to that effect;*
- *issue appropriate notice.*

M1130.140 REAL PROPERTY FOLLOWING REASONABLE BUT UNSUCCESSFUL EFFORTS TO SELL

A. Policy Principles

1. Exclusion

Real property, including a life estate in real property *created on or after August 28, 2008 but before February 24, 2009,* that an individual has made reasonable but unsuccessful efforts to sell, will continue to be excluded for as long as:

- the individual continues to make reasonable efforts to sell it; and
- including the property as a countable resource would result in a determination of excess resources.

This exclusion is effective the first of the month in which the most recent application was filed or up to three months prior if retroactive coverage is required.

B. Operating Procedure

The "current market" value (CMV) of real property located in Virginia is the tax assessed value of the property. For property located outside of Virginia the CMV is determined by applying the tax assessed value of the property to the local assessment rate, if the rate is not 100%.

1. Initial Effort Established

The following criteria define reasonable efforts to sell. The listing price must not exceed 100% of CMV.

A reasonable effort to sell is considered to have been made:

a. As of the date the property becomes subject to a realtor's listing agreement if, it is listed at current market value, **AND** the listing realtor verifies that it is unlikely to sell within 90 days of listing given particular circumstances involved; for example

- owner's fractional interest;
- zoning restrictions;
- poor topography;
- absence of road frontage or access;
- absence of improvements;
- clouds on title;
- right of way or easement;
- local market conditions; or

b. When at least two realtors refuse to list the property. The reason for refusal must be that the property is unsalable at CMV (other reasons are not sufficient); or

c. *When the* applicant has personally advertised his property at or below CMV for 90 days by use of a "Sale by Owner" sign located on the property and by other reasonable efforts, such as newspaper advertisements, reasonable inquiries with all adjoining land-owners, or other potential interested purchasers.

d. For property owned by an individual who is incompetent if no general power of attorney exists:

When court action is initiated for appointment of a guardian or *conservator* to secure the court's approval to dispose of the property, an initial effort to sell shall be deemed to have been made beginning the date the hearing for appointment of a guardian is placed on the court docket and continuing until the court authorizes sale of the property or six months, whichever is less.

Any period of time in excess of six months to secure appointment of a guardian and authorization to sell by the court is not deemed reasonable and the property loses this exemption. Upon authorization, and only upon authorization, the guardian must make a continuing reasonable effort to sell the property as described in paragraph B.3.

e. For property which is an interest in an undivided estate and for jointly owned property when a co-owner refuses to sell:

An initial reasonable effort to sell shall have been made when all other co-owners have refused to purchase the applicant's or recipient's share, and at least one of the other co-owners has refused to agree to sell the property. After an initial effort to sell has been made, the individual must immediately make a continuing effort to sell in accordance with 3.d. below.

2. Retroactive Exclusion

There will be applications received with property already listed for sale. Inform the applicant of Reasonable Efforts to Sell policy.

Reasonable efforts to sell may have been made if the property was listed at more than 100% CMV. The following criteria will be applicable to property already listed for sale when the application is received. To receive the Reasonable Efforts to Sell exclusion for the month of application and the retroactive period when property has already been listed, the following criteria must be met:

- If the property was listed **at** or **below** 150% of CMV, the Reasonable Efforts to Sell exclusion will be granted for the month of application and the retroactive time period when the requirements in B.1., except for the listing price, are met.

- If property was listed **higher** than 150% of CMV, reasonable effort to sell *cannot be established in the retroactive period.*

The above is a screening trigger to determine if property may be excluded.

3. Continuing Effort to Sell

Notwithstanding the fact that the recipient made a reasonable effort to sell the property and failed to sell it, and although the recipient has become eligible, the recipient must make a continuing reasonable effort to sell *until the property is sold or Medicaid coverage is canceled. Continuing effort to sell is established by one of the following means:*

a. Continually renewing a listing agreement at no more than 100% of the taxed assessed value, until the property is sold. If the list price was initially higher than the tax-assessed value, the listed sales price must be reduced to no more than 100% of the tax-assessed value.

b. In the case where at least *two* realtors have refused to list the property, the recipient must personally try to sell the property by efforts described in B.1.c. above, for 12 months.

c. In the case of recipient who has personally advertised his property for a year without success (the newspaper advertisements, "for sale" sign, do not have to be continuous; these efforts must be done for at least 90 days within a 12 month period), the recipient must then:

- subject his property to a realtor's listing agreement priced at or below current market value; or
- meet the requirements of B.1.b. above, which are that the recipient must try to list the property and at least two realtors must refuse to list it because it is unsaleable at current market value; other reasons for refusal to list are not sufficient.

d. For jointly owned property or interest in an undivided estate:

When a partition suit is necessary in order to liquidate the property, a continuing reasonable effort to sell property shall be demonstrated by filing suit with the court to partition the property within 60 days of proving the property is otherwise unsaleable (in accordance with section B.1.e.) and shall continue until the property is sold or 9 months, whichever is less. Any period of time in excess of 9 months to sell shall not be deemed reasonable and the property loses this exemption.

4. After Continuing Effort Has Been Established

If the recipient has made a continuing effort to sell the property for 12 months, then the recipient may sell the property between 75% and 100% of its tax assessed value and such sale shall not result in disqualification under the transfer of assets rule. If the recipient requests to sell his property at less than 75% of assessed value, he must submit documentation from the listing realtor, or knowledgeable source if the property is not listed with a realtor, that the requested sale price is the best price the recipient can expect to receive for the property at this time. Sale at such a documented price shall not result in disqualification under the transfer of property rules.

5. Date Property is Disregarded

After the applicant has demonstrated that his property is unsalable by following the procedures in Section B., the property is disregarded in determining eligibility starting the first day of the month in which the most recent application was filed, or up to three months prior to the month of application if the applicant met all other eligibility requirements in the period. A recipient must continue his reasonable efforts to sell the property as required in B.3.

S1130.150 INTERESTS OF INDIVIDUAL INDIANS IN TRUST RESTRICTED LANDS

A. Policy

In determining the resources of an individual (and spouse, if any) who is of Indian descent from a federally recognized Indian tribe, **any** interests of the individual (or spouse) in trust or restricted lands are excluded from resources.

B. Procedure

If an individual Indian alleges an interest in trust or restricted land:

- obtain for the file a copy of any document or documents that might identify it as such; and/or
- verify the allegation with the appropriate Indian agency.

If verification is by phone, document the case record. Prepare a determination on the basis of the evidence.

C. References

- Income derived from individuals interests in trust or restricted lands, S0830.850
- Other resource exclusions from members of Indian tribes, S0830.830

M1130.160 OTHER REAL PROPERTY

A. Policy Principles

1. Countable

Ownership of other real property generally precludes eligibility. The property's equity value is counted with all other countable resources.

2. Exceptions

a. When equity value of the property, plus all other resources, does not exceed the appropriate resource limit;

b. The property is smaller than the county or city zoning ordinances allow:

- for home sites or building purposes, or
- property has less than the amount of road frontage required by the county or city for building purposes, and
- adjoining land owners will not buy the property;

c. The property has no access, or the only access is through the exempted home site;

d. The property is contiguous to the recipient's home site and the survey expenses required for its sale reduce the value of such property, plus all other resources, below applicable resource limitations; or

e. The property cannot be sold after a reasonable effort to sell it has been made.

B. Procedures for Determining the Countable Value of Real Property

The procedures for determining the countable value of real property, and examples, are found in Appendix 1 to this subchapter.

PERSONAL PROPERTY

M1130.200 AUTOMOBILES

A. Policy Principles

1. Automobile Defined

For ABD Medicaid purposes, "automobile" means any vehicle used for transportation. It thus can include, in addition to cars and trucks: boats, snowmobiles, animal-drawn vehicles, and animals *that are used for transportation. Animals that are kept primarily for recreational purposes, such as horses, are not considered vehicles if they are not used primarily for transportation.*

2. Current Market Value Defined

The CMV of an automobile is the average trade-in value listed in the NADA Guide.

3. Exclusion Regardless of Value

Ownership of one motor vehicle does not affect eligibility. One automobile, regardless of value, is excluded for the individual or a member of the individual's household.

4. Other Automobiles

Any automobile an individual owns in addition to the one excluded will be evaluated as a countable resource.

5. Rebuttal of NADA Value

If the individual disagrees with the NADA value, *he* must be given the opportunity to rebut it. Rebuttal evidence consists of one written appraisal for the automobile's value from a knowledgeable source, such as a used vehicle dealer or an automobile insurance company.

6. Rebuttal of Ownership

Assume that the individual owns the automobile if his name appears on the title or note or if he is listed as the owner in Division of Motor Vehicles' records. The principle of "equitable ownership," however, applies to situations in which one individual's name appears on the records of ownership but another person actually paid for and uses the automobile. If the applicant or enrollee wishes to rebut ownership of a vehicle, he must be given the opportunity to provide evidence that he does not have equitable ownership in the vehicle. Rebuttal evidence consists of:

- *a statement from the applicant/enrollee **and** the other individual indicating why the automobile is listed in the applicant's/enrollee's name, including the person who actually uses the automobile and in whose possession it is kept, and*
- *cancelled checks or records from the lender indicating that the other individual has made all payments on the automobile.*

*If the applicant/enrollee does not use the automobile and can provide documentation that another person has made all the payments on the automobile, it is **not** a resource to the applicant/enrollee.*

B. Operating Policy-- More than One Automobile Owned

1. General Rule

If more than one automobile is owned, one automobile will be excluded and the other will be a countable resource. The exclusion will apply to the automobile with the highest equity value.

2. Determining Equity Value

Use the following method to determine equity value:

- Determine the average trade-in value for each automobile from the NADA Guide. In the event the automobile is not listed, the value assessed by the locality for tax purposes may be used.
- Determine the equity value in each automobile by subtracting the debt from NADA value.
- Exempt the automobile with the highest equity value.

3. References

See M1110.400 for what values apply to resources.
See Appendix 1 for QDWI development.

M1130.300 LIFE INSURANCE

A. Definitions

1. Life Insurance Policy

A life insurance policy is a contract. Its purchaser (the owner) pays premiums to the company that provides the insurance (the insurer). In return, the insurer agrees to pay a specified sum to a designated beneficiary upon the death of the insured (the person on whom, or on whose life, the policy exists).

2. Face Value

Face value (FV) is the amount of basic death benefit contracted for at the time the policy is purchased. The face page of the policy may show it as such, or as the "amount of insurance"," the amount of the policy," "the sum insured," etc. A policy's FV does not include:

- the FV of any dividend addition, which is added after the policy is issued (see 5. below);
- additional sums payable in the event of accidental death or because of other special provisions; or
- the amount(s) of term insurance, when a policy provides whole life coverage for one family member and term coverage for the other(s).

3. Cash Surrender Value

A policy's cash surrender value (CSV) is a form of equity value that it accrues over time. The owner of a policy can obtain its CSV only by turning the policy in for cancellation before it matures or the insured dies. A loan against a policy reduces its CSV.

4. Dividends

Periodically (annually, as a rule), the insurer may pay a share of any surplus company earnings to the policy owner as a dividend.

Depending on the life insurance company and type of policy involved, dividends can be applied to premiums due or paid by check or by an addition or accumulation to an existing policy.

5. Dividend Additions and Accumulations

a. Additions

Dividend additions are amounts of insurance purchased with dividends and added to the policy, increasing its death benefit and CSV.

The table of CSV's that comes with a policy does not reflect the added CSV of any dividend additions.

b. Accumulations

Dividend accumulations are dividends that the policy owner has constructively received but left in the custody of the insurer to accumulate as interest, like money in a bank account. They are not a value of the policy per se; the owner can obtain them at any time without affecting the policy's FV or CSV.

Dividend accumulations cannot be excluded from resources under the life insurance exclusion, even if the policy that pays the accumulations is excluded from resources. Unless they can be excluded under another provision (e.g., as set aside for burial), they are a countable resource.

6. Proceeds

Proceeds of a life insurance policy are the FV of the policy plus any additions payable at maturity or death.

Proceeds do not include dividends or interest that are left to accumulate in the policy (see 5.b. above). Also, proceeds do not include a policy's CSV.

7. Supplementary Contract

A supplementary contract is not a life insurance policy. It is an agreement whereby, when the policy matures or the insured dies, the proceeds are paid not in a lump sum, but in an alternative manner selected by the individual, usually as an annuity (see B.5. below).

8. Burial Insurance

A burial insurance policy is a contract whose terms preclude the use of its proceeds for anything other than payment of the insured's burial expenses.

NOTE: If a policy has a CSV to which the owner has access, the policy is not burial insurance for Medicaid purposes.

9. "Accelerated Life Insurance Payments"

Accelerated life insurance payments are proceeds paid to a policyholder prior to death. Although accelerated payment plans vary from company to company, all of the plans involve early payout of some or all of the proceeds of the policy.

Most accelerated payment plans fall into three basic types, depending on the circumstances which cause or "trigger" the payments to be accelerated. These are the:

- **long-term care model**, which allows policyholders to access their death benefits should they require extended confinement in a care facility or, in some instances, health care services at home;
- **dread disease or catastrophic illness model,** which allows policyholders to access their death benefits if they contract or acquire one of a number of specified covered conditions; and
- **terminal illness model,** which allows policyholders to access their death benefits following a diagnosis of terminal illness where death is likely to occur within a specified number of months.

Some companies refer to these payments as "living needs", "accelerated death", or “viatical” payments.

Depending on the type of accelerated payment plan, receipt of accelerated payments may reduce the policy's FV by the amount of the payments and may reduce CSV in a manner proportionate to the reduction in FV. In some cases, a lien may be attached to the policy in the amount of the accelerated payments and a proportionate reduction in CSV results.

See B.6. below for policy regarding accelerated payments and E. below for procedures.

B. Policy

1. Life Insurance as a Resource

A life insurance policy owned by the individual is a resource if it generates a CSV. Its value as a resource is the amount of the CSV.

A life insurance policy which is irrevocably assigned to another person is not a resource to the individual, but it needs to be evaluated as an asset transfer (subchapter M1450). When the life insurance policy is irrevocably assigned to a funeral home or trust to fund the individual's burial contract, go to section M1130.425.

2. Limited Exclusion

A life insurance policy is an excluded resource, **for individuals age 21 and over,** if its FV and the FV of any other life insurance policies the individual owns on the same insured total $1,500 or less. However, the FV of some policies does not count toward this $1,500 total (see 3. below). **Life insurance policies on individuals under age 21 are excluded from resource evaluations.**

We do **not** include the FV of dividend additions in determining whether a policy is a countable or excludable resource. If the policy is a countable resource, we include the **CSV** of dividend additions in determining the resource value of the policy.

3. FV of Burial and Certain Term Insurance Not Counted

In determining whether the total FV of the life insurance policies an individual owns on a given insured is $1,500 or less, the FV of the following are not taken into account:

- burial insurance policies; and
- term insurance policies that do not generate a CSV.

4. Relation to Burial Fund Exclusion

The maximum of *$3,500* that can be excluded as set aside for the burial expenses of an individual must be reduced by the FV of:

- any burial insurance policy for the burial expenses of the individual;

  Exceptions: *Huff-Cook Mutual Burial Association life insurance policies (which may be designated as Care Plans on the policy) sold prior to April 7, 1993 do not reduce the $3,500 burial fund exclusion. Huff Cook life insurance policies sold from April 7, 1993 through November 30, 1993 reduce the burial fund exclusion. Huff-Cook/Settlers life insurance policies sold on or after December 1, 1993 do not reduce the $3,500 burial fund exclusion unless they are assigned to pay for a pre-need funeral contact.*

- any insurance policy on the life of the individual that is excluded under the life insurance exclusion in B.2. above;

- a life insurance policy of any value that was assigned to a funeral provider or of which a funeral provider has been made the irrevocable beneficiary, if the policy owner has irrevocably waived his or her right to, and cannot obtain, any CSV the policy may generate. The amount by which the $3,500 exclusion is reduced equals the face value of the policy MINUS the total cost of burial space items identified in the contract.

(See **M1130.410** for instructions regarding the burial fund exclusion and **M1130.410** C.1.d. for more discussion of burial insurance.)

5. Eligibility for Other Benefits

a. Supplementary Contracts

Supplementary contracts normally provide for an annuity. We treat such contracts in accordance with the instructions on filing for other benefits, for any benefit with choices about method of payment.

b. Accelerated Life Insurance Payments

Accelerated payments are not "benefits" for purposes of the Medicaid "filing for other benefits" provision. We do not require a policyholder to apply for accelerated payments as a condition of obtaining or retaining Medicaid eligibility.

6. Accelerated Life Insurance Payments

a. Income and Resources Treatment

Since accelerated payments can be used to meet food, clothing, or shelter needs, the payments are income in the month received and a resource if retained into the following month and not otherwise excludable.

b. Payments Not "Conversion of a Resource"

The receipt of an accelerated payment is not treated as a conversion of a resource for Medicaid purposes. This is because, under an accelerated arrangement, an individual receives proceeds from the policy, not the policy's resource value--which is its CSV.

C. Procedure Initial Application

1. Using the Individual's Records for Verification

a. Ask the individual to submit:

- all the life insurance policies he or she owns; and
- the most recent annual dividend statement issued for each policy.

b. For countable and excludable policies, use these records to verify:

- the owner;
- the insured;
- the FV;
- whether the policy pays dividends and, if it does, what option the individual selected for their disposition (i.e., accumulations, additions, applied to premiums, paid by check); and
- if dividend accumulations, their current amount.

c. Additionally, for countable policies, use these records to verify:

- whether the policy generates a CSV and, if it does,
- the current CSV (including the CSV of any dividend additions and any loans on the policy which reduce the CSV).

2. Contacting an Insurance Company or Agent for Verification

If examination of a policy does not reveal an item of information listed in 1. above, obtain that information from the individual's agent or the insurance company, subject to the operating assumptions in 4. below. Do so by phone, if possible, and document the information in the case record.

3. Exception to Verification

Do **not** verify employer-provided term insurance.

4. Operating Assumptions

Apply the following assumptions in determining what development is required. Absent evidence to the contrary, assume that a:

- term policy without a table of CSV's, if it appears otherwise complete, does **not** generate a CSV;
- policy that does not generate a CSV also does **not** pay dividends;
- policy issued by a nonparticipating or stock company does **not** pay dividends;
- policy issued by a participating or mutual company pays dividends.

NOTE: Identification of the kind of company usually follows its name on the face page of the policy.

5. Determination

a. General

Apply the policy in B. above to determine whether each insurance policy owned is a resource and, if it is, whether to count or exclude its CSV in the resource determination.

b. Dividend Additions

Do **not** include the **FV** of dividend additions in determining whether a policy in a countable or excluded resource (B.2. above)

If the policy is a **countable** resource, do include the **CSV** of dividend additions in determining the resource value of the policy.

If the policy is a **excluded** resource, do **not** include the CSV of dividend additions in determining the individual's countable resources.

c. Dividend Accumulations

Do not exclude dividend accumulations under the life insurance provision, even if you exclude the policy that pays the accumulations.

Count the accumulations as resources, even if you exclude the policy itself because the policy's FV is $1,500 or less unless the accumulations are excludable under another provision (for example, because they have been set aside for burial).

d. Income Treatment of Dividends

See S0830.500 C. regarding the income treatment of life insurance policy dividends.

D. Procedure Accelerated Life Insurance Payments

If an individual receives accelerated payments, and the payments do **not** preclude Medicaid eligibility due to excess income or resources, determine whether the FV and/or CSV of the policy must be verified.

Reverify the policy if, prior to receipt of the accelerated payments:

- the policy's CSV precluded Medicaid eligibility, but the individual may now be resource-eligible; or

- the policy was an excluded resource and its FV reduced the maximum burial fund exclusion available to the individual (see B.4. above).

If reverification is necessary, examine the policy and any other relevant documentation in the individual's possession to determine the effect of the accelerated payments on FV and CSV. If necessary, contact the life insurance company for the necessary information.

If the individual expects to receive accelerated payments in the future, explain the effect of any further reduction in the policy's FV on the maximum burial fund exclusion available (if applicable).

E. References

- Income treatment of life insurance dividends, S0830.500 C.
- Life insurance funded burial contracts, **M1130.425**.

M1130.400 BURIAL SPACES

A. Policy –The Exclusion

1. General

A burial space or agreement which represents the purchase of a burial space held for the burial of the individual, his or her spouse, or any other member of his or her immediate family is an excluded resource, regardless of value.

Cemetery plots are not *counted as resources, regardless of the number owned,* except when evaluating eligibility as QDWI. For QDWI, exclude one cemetery plot (see Appendix 1 to chapter S11).

2. No Effect on Burial Funds Exclusion

The burial space exclusion is in addition to, and has no effect on, the burial funds exclusion (M1130.410).

3. Multiple Burial Spaces

When items *other than cemetery plots* serve the same purpose, exclude only one per person. For example, exclude a cemetery plot and a casket for the same person, but not a casket and an urn.

B. Definitions

1. Burial Space

A burial space is a(n).

- Gravesite (*either an existing grave or a plot);*
- crypt;
- mausoleum;
- casket;
- urn;
- niche; or
- other repository customarily and traditionally used for the deceased's bodily remains.

The term also includes necessary and reasonable improvements or additions to such spaces, including but not limited to:

- vaults;
- headstones, markers, or plaques;
- burial containers (e.g., for caskets); and
- arrangements for the opening and closing of the gravesite.

For example, a contract for care and maintenance of the gravesite, sometimes referred to as endowment or perpetual care, can be excluded as a burial space.

2. Agreement Which Represents the Purchase of a Burial Space

An agreement which represents the purchase of a burial space is a contract with a burial provider for a burial space held for the eligible individual or a member of his/her immediate family.

3. Individual's Immediate Family

"Individual" means the Medicaid recipient or **applicant**. **" Immediate family" means:**

- parents, including adoptive parents;
- minor or adult children; including adoptive and stepchildren;
- siblings (brothers and sisters), including adoptive and stepsiblings.

"Immediate family" also includes the spouse of the above relatives. If the relative's relationship to the recipient is by marriage only, the marriage must be in effect in order for the burial space exclusion to continue to apply. For example, a burial space held for a sister-in-law is no longer excludable if she and the recipient's brother divorce.

4. Held For

A burial space is "held for" an individual when someone currently has:

- title to and/or possesses a burial space intended for the individual's use (e.g., has title to a burial plot or owns a burial urn stored for his or her own use); or

- a contract with a funeral service company for specified burial spaces for the individual's burial (i.e., an agreement which represents the individual's current right to the use of the items at the amount shown).

Until the purchase price is paid in full, a burial space is not "held for" an individual under an installment sales contract or similar device if:

- the individual does not **currently** own the space;
- the individual does not **currently** have the right to use the space; and
- the seller is not **currently** obligated to provide the space.

Until all payments are made on the contract, the amounts paid may be considered burial funds. See M1130.410.

C. Procedure--Development and Documentation

1. General

The following procedures do **not** apply to installment burial contracts or insurance funded burial contracts. For installment contracts, see **M1130.420**. For insurance funded contracts, see **M1130.425**.

a. If an individual alleges owning only one burial space, or an individual and spouse allege owning no more than two spaces, **assume** that the spaces are excluded.

b. If an individual or individual and spouse allege owning more than one or two spaces, respectively, obtain a signed statement showing;

- the name of the person for whose burial each space is intended; and
- the relationship of each such person to the individual. Exclude only those spaces that are alleged to be for the burial of the individual, the spouse, or a member of the immediate family.

2. Agreements Which Represent the Purchase of a Burial Space

a. General

If the contract shows the purchase of a specified burial space at a specified price, determine whether such space is held for the individual or member of the individual's immediate family per B.4. above.

If the space is held for the individual, determine if the contract is irrevocable or revocable. If irrevocable, it is not a resource. If the contract is revocable, it is an excludable resource. (See M1130.420 C.3. on single-purpose burial space contracts.)

b. Installment Contract

If the contract calls for installment payments, determine whether the value of the burial space has to be treated as burial funds (**M1130.420** C.5.c.).

D. References

Burial funds exclusion, M1130.410.
Prepaid burial contracts, **M1130.420**.
Interest earned on excluded burial space purchases agreements, S0830.501.

M1130.410 BURIAL FUNDS EXCLUSION

A. Policy Principle

Up to $3,500 of burial funds may be excluded for each member of the ABD assistance unit (i.e., the individual and the individual's spouse, if living together).

NOTE: Burial funds exclusion is separate and apart from burial space exclusion.

For QDWI, see Appendix 1 to chapter S11.

B. Definitions

1. Burial Funds

Burial funds are resources that have been specifically set aside and clearly designated in writing for the cremation or other burial-related expenses of the individual or the individual's spouse.

Burial funds may be:

- irrevocable burial trusts established on or after August 11, 1993 *(irrevocable burial trusts established **before** August 11, 1993 are not countable based on the law in effect at that time);*
- revocable burial trusts;
- revocable burial contracts;
- other revocable burial arrangements (including the value of certain installment sales contracts for burial spaces);
- cash;
- financial accounts (e.g., savings or checking accounts);
- other financial instruments with a definite cash value (e.g., stocks, bonds, certificate of deposit, life insurance policies, etc.); or

Property other than that listed in this definition will not be considered burial funds and may not be excluded under the burial funds provisions. For example, a car, real property, livestock, etc., are **not** burial funds.

NOTE: The entire amount of an irrevocable trust established on or after 8/11/93 by a funeral director for an individual for the purpose of paying for funeral and burial expenses is excluded if the following two step process is followed:

1) the individual signs a pre-need contract with a funeral home director promising prepayment in return for specific funeral merchandise and services and pays the agreed upon amount in the form of a direct cash payment or purchase of a life insurance policy or annuity to the funeral director, and

2) the funeral home director in turn places the money, life insurance policy or annuity into a trust.

2. Expenses for Burial Funds Exclusion Purposes

a. Expenses Included

Expenses included for burial funds exclusion purposes are generally those related to preparing a body for burial and any services prior to burial.

They usually include, for example: transportation of the body, embalming, cremation, flowers, clothing, services of the funeral director and staff, etc.

b. Expenses Not Included

Usually, expenses for items used for interment of the deceased's remains are not included for burial funds exclusion purposes. Such items may be subject to the burial space exclusion (**M1130.400**). However, items that do not qualify for the burial space exclusion, e.g., a space being purchased by installment contract, may be excluded under the burial fund exclusion.

C. Policy--General

1. Amount of Funds That Can Be Excluded

a. Maximum Exclusion

We can exclude up to $3,500 each in funds set aside for:

- the burial expenses of the individual; and
- the burial expenses of the individual's spouse (eligible or ineligible) .

This exclusion is separate from and in addition to the burial space exclusion.

Funds paid on an installment contract do **NOT** qualify for the **burial space exclusion.**

Funds paid on an installment contract for burial spaces may qualify for the burial fund exclusion.

b. Reductions in Maximum Exclusion

The maximum $3,500 that can be excluded from countable resources is reduced by:

- the face value of life insurance (not including term policies) owned by and insuring the individual and/or the individual's spouse, if the cash surrender value of such policies has been excluded from countable resources (cash surrender value of life insurance is excluded when the total face value per insured individual aged 21 or over does not exceed $1,500), and
- the face value (not including the value of burial space items) of an irrevocable burial trust established before 8/11/93 *or other irrevocable arrangement specifically designated for the purpose of meeting the individual's or spouse's burial expenses*, regardless of whether the arrangement is owned by the individual or someone else, and
- the face value of burial insurance, regardless of whether the burial insurance is owned by the individual or someone else, and

- the face value of burial contracts (not counting the value of burial space items), regardless of whether the contract is owned by the individual or someone else.

c. Exceptions Related to Huff-Cook/Settlers Policies

Huff-Cook Mutual Burial Association life insurance policies (which may be designated as Care Plans on the policy) sold prior to April 7, 1993 **do not reduce** the $3,500 burial fund exclusion.

Huff-Cook life insurance policies sold from April 7, 1993 through November 30, 1993 **reduce** the burial fund exclusion.

Huff-Cook/Settlers life insurance policies sold on or after December 1, 1993 **do not reduce** the $3,500 burial fund exclusion unless they are assigned to pay for a pre-need funeral contact.

d. EXAMPLE – Burial Fund Exclusion

Mrs. Brown has the following burial resources:

$2,000 designated savings account
$ 200 irrevocable burial contract

$3,500 maximum exclusion
- 200 irrevocable burial contract
$3,300 available exclusion
-2,000 excluded burial funds
$1,300 still available for exclusion

Treatment - We exclude the $2,000 savings account. Two years later, Mrs. Brown wants to add to her designated burial savings account, which now has a balance of $2,150 due to accumulated interest. She can increase the amount of excluded funds in the account by up to $1,300. Note that when determining the amount still available for burial fund exclusion, we disregard the amount of interest which accumulated in the account.

e. Subsequent Purchase of Excluded Life Insurance or Irrevocable Burial Contract

A subsequent purchase of an excluded life insurance policy or an irrevocable burial contract reduces the amount of the available burial funds exclusion as described in b. above. The reduction is effective the month after the month in which the life insurance or the irrevocable burial contract was purchased.

f. Burial Insurance

Burial insurance policies are not life insurance policies (see **M1130.300** for a definition of burial insurance). For Medicaid purposes, burial insurance is an irrevocable arrangement whose face value reduces the maximum burial funds exclusion by the policy's face value.

Exceptions: Huff-Cook Mutual Burial Association life insurance policies sold prior to April 7, 1993 do not reduce the $3,500 burial fund exclusion.

Huff-Cook/Settlers life insurance policies sold on or after December 1, 1993 do not reduce the $3,500 burial fund exclusion unless they are assigned to pay for a pre-need funeral contact.

e. Increases in Value of Burial Funds

Any appreciation in the value of excluded burial funds is excluded from resources (and from income), even if the total of the burial funds thus excluded exceeds the $3,500 maximum. This includes interest earned by burial funds, provided the interest is left to accumulate as part of the funds.

2. Increases in Amount of Excluded Burial Funds

a. Designated Amount is $3,500

Interest earned on excluded burial funds and appreciation in the value of excluded burial arrangements are excluded from resources if left to accumulate and become part of the separate burial fund.

b. Designated Amount is Less than $3,500

Until $3,500 (or such other lesser amount established in accordance with C.1.b.) in burial funds has been designated, additional amounts can be excluded under the burial funds provision if the individual designates them for burial expenses. Interest on excluded burial funds is not included in determining if the $3,500 maximum has been reached.

c. *Designated Amount is greater than $3,500*

While an individual may designate greater than $3,500 for burial, only up to $3,500 may be excluded for burial. The remainder of the designated amount will be evaluated as a countable resource. If the individual is determined eligible, interest and appreciation that accumulates on the excluded portion of the burial fund will be excluded. Interest and appreciation that accrue over time on the non-excluded portion will be evaluated as a countable resource.

3. Burial Funds Must Be Kept Separate from Non-burial-Related Assets

a. If burial funds are commingled with nonburial-related assets, the exclusion does not apply.

b. Examples

A single burial contract for $4,500 of burial services and $2,000 in burial spaces does not have to be separated into 2 contracts since the whole amount is burial-related, even though we can only exclude $3,500 of the contract as a burial fund.

A bank account containing $1,200, $500 of which is designated for burial and $700 of which is other funds the individual uses for living expenses, is **not** allowable and the $500 may **not** be excluded as a burial fund. If the $500 is moved to a separate account, the exclusion may be applicable the month in which the funds are separated.

4. Funds Used for Another Purpose

a. General

If some or all of the excluded funds were withdrawn and used for another purpose, the funds withdrawn may have been either transferred or retained as a resource. If the funds were transferred, the asset transfer policies in subchapter M1450 are applicable. If the funds have been retained as a resource, the resource policies in Chapter S11 are applicable. Any excluded funds remaining in the designated burial fund continue to be excluded.

b. Change of Form

Transferring excluded burial funds from one form to another (e.g., from a certificate of deposit to a burial contract) is not use for another purpose.

c. Examples - Use for Another Purpose

A loan against the cash surrender value (CSV) of a life insurance policy that has been designated for burial expenses **is not** use for another purpose **if** the loan is for the purchase of another burial fund.

Use of a burial fund as collateral for a loan **is** use for another purpose because the loan creates an encumbrance on the funds. Since the funds are not available for the individual's burial as long as they are encumbered, the funds cannot be considered set aside for the individual's burial.

5. When to Develop Use for Another Purpose

Determine if excluded burial funds have been used for some purpose other than as burial funds only if:

- there is some indication that excluded funds may have been used for another purpose, and
- the sum of the excluded funds (including any that may have been spent) and countable resources exceeded the applicable (individual or couple) resources limit as of the month in which the excluded funds may have been used for another purpose, and
- the individual was eligible for the month in which the excluded burial funds may have been used for another purpose.

6. How to Develop Use for Another Purpose

If the criteria in 1. above indicate a need to pursue the issue of use for another purpose:

- obtain the individual's signed statement as to whether any of the funds were so used and, if so, the amount;
- obtain any pertinent evidence, including signed statements from other individuals who may know about the funds in question.
- follow resource policy if funds have been retained as a resource.
- follow asset transfer policy if funds were transferred.

7. Deeming Considerations

If the individual is a blind or disabled child under age 21 who lives with his parent, resources (and income) of the parent are deemed to the child. The burial funds exclusion applies to resources that belong to the parent and are designated as set aside for the burial expenses of the parent and/or his or her spouse.

D. Designation of Burial Funds

1. How Designation May Be Made

Burial funds may be designated by the applicant at the time of application or during the initial application processing period or by an enrollee at any time after eligibility has been determined. Burial funds may be designated by:

- an indication on the burial fund document (e.g., the title on a bank account); or
- a signed statement.

See Appendix 3 for a sample burial funds designation form. A printable version of the form is located on the Virginia Institute for Social Services Training Activities (VISSTA) web site at: http://www.vcu.edu/vissta/bps/bps_resources/medicaid/burial_fund_designation.pdf.

2. Signed Statement Designating Burial Funds

A signed statement must include:

- the value and owner of the resources;
- for whose burial the resources are set aside;
- the form(s) in which the resources are held (burial contract, bank account, etc.); and
- the date the individual first considered the funds set aside for the burial of the person specified.

3. Date of Intent

We accept the individual's allegation as to the date he or she first considered the funds set aside for burial unless there is evidence that the funds were used and replaced after that date.

4. Effective Date of Exclusion

Once the date that burial funds were considered set aside for burial has been established, the first month for which the exclusion affects resource determination is the latest of:

- the month in which the funds were considered to have been set aside, or
- the month of application, if the funds were considered set aside before the month (or first month of retroactive period, if retroactive coverage is requested).

5. Designating Life Insurance as a Burial Fund

When designating a countable life insurance policy as a burial fund, the policy itself is designated. However, because the countable value of the policy is its cash surrender value, it is the cash surrender value at the time of designation that is applied toward the burial funds exclusion when determining countable resources.

If life insurance is designated as a burial fund, the individual can also designate any dividend accumulations on the life insurance policy (**M1130.300 *A*.5.b.**) as a burial fund. Dividend accumulations are a separate resource (i.e. **not** considered as an increase in the value of the CSV) and must be designated as burial funds separate from the life insurance policy itself.

6. Designation Remains

Once a burial fund is designated, it remains a burial fund until:

- *eligibility terminates or*
- *the individual states in writing that the funds are no longer set aside for burial.*

E. Procedure-Initial Applications Development and Documentation

1. Ask About Burial Funds

Unless the individual is ineligible for a reason other than resources, inquire to determine the presence of excluded burial funds.

NOTE: Make sure the individual understands what we mean by a burial fund and the effect a burial fund could have on countable resources and income.

2. Verify Form and Separation of Funds

Verify that the funds meet the definition of burial funds in B.1. above and that the funds are separated from all other non-burial-related assets (C.3. above). Burial funds must meet both of these requirements before we can exclude them. If funds cannot be excluded, tell the individual why (e.g., if the funds are not separate from non-burial assets).

3. Determine Date Funds Set Aside for Burial

If an individual alleges having set aside funds for burial, determine the date they were first considered as set aside and document the file with supporting evidence.

- If the funds are already clearly designated (e.g., by the title of a savings account), accept any official record which shows the title of the account and which establishes that the designation was in effect prior to the month of application.
- If the funds are **not** already clearly designated, obtain the statement described in D. above.
- See D.4. above regarding effective date of the exclusion for funds considered set aside for burial prior to filing.

4. Verify Value of Funds

Verify the value of any burial funds to be excluded, using the instructions that apply to the specific resources in question.

5. Determine Amount of Exclusion Available

Document the file with evidence of:

- the face value of life insurance owned by and insuring the individual or the individual's spouse if the cash surrender value of such policies has been excluded from countable resources (cash surrender value of life insurance is excluded when the total face value per insured individual age 21 or over does not exceed $1,500), and
- the face value (not including the value of burial space items) of an irrevocable burial trust established before 8/11/93 *or other irrevocable arrangement specifically designated for the purpose of meeting the individual's or spouse's burial expenses,* regardless of whether the arrangement is owned by the individual or someone else, and
- the face value of burial insurance whether owned by the individual or someone else, and
- the face value of burial contracts (not counting the value of burial space items) whether the contract is owned by the individual or someone else.

Should the $3,500 maximum exclusion be reduced by life insurance, any irrevocable arrangement including an irrevocable burial trust established before 8/11/93, burial insurance, or a burial contract, document the amount by which the exclusion will be reduced, including the computation of the amount. To make this computation, you may use the electronic Burial Funds Exclusion Worksheet located on the VCU-VISSTA website: http://www.vcu.edu/vissta/bps/bps_resources/medicaid/abd_medicaid/master_bfe_worksheet.xls

F. Procedures-Renewal or a Reported Change

1. Verify Funds Already Excluded

If the case record shows excluded burial funds, verify the current amount. W*hen $3,500 or less was initially designated as a burial fund,* increases *in the burial fund* due to appreciation or accumulated interest are exclud*ed* even if they *result in* the total burial fund exclus*ion* exceed*ing the* $3,500 maximum.

If more than $3,500 was initially designated for burial funds exclusion, interest and appreciation that have subsequently accrued on the excluded portion of the burial fund are excluded. Interest and appreciation that have subsequently accrued on the countable portion are countable. To calculate the countable value of a burial fund at renewal or when a change is reported you may use the electronic "BFE Increased Value Determination Worksheet". The worksheet is located on the Virginia Institute for Social Services Training Activities (VISSTA) web site at: http://www.vcu.edu/vissta/bps/bps_resources/medicaid/abd_medicaid/master_bfe_increased_value_determination_worksheet.xls.

Also, inquire whether designated burial funds continue to be maintained separately from non-burial-related assets (C3. above).

If the funds have decreased, see G. below.

2. Enrollee Wishes to Designate Funds

If an enrollee wishes to designate funds for burial, proceed as you would for an initial application. This applies whether no funds are currently excluded or less than $3,500 (excluding appreciation or accumulated interest) is currently excluded.

3. Apply Burial Funds-Related Income/ Resources Exclusions

See H. below.

G. Procedure-Burial Funds Are Used for Another Purpose

1. When to *Evaluate* Use for Another Purpose

Determine if excluded burial funds have been used for some other purpose only if:

- there is some indication that excluded funds may have been used for another purpose, *and*
- the sum of the excluded funds (including any that may have been spent) and countable resources exceeded the applicable (individual or couple) resources limit as of the month in which the excluded funds may have been used for another purpose, *and*
- the individual was eligible for the month in which the excluded burial funds may have been used for another purpose.

2. How to *Evaluate* Use for Another Purpose

If the criteria in 1. above indicate a need to pursue the issue of use for another purpose:

- obtain the individual's signed statement as to whether any of the funds were so used and, if so, the amount;
- obtain any pertinent evidence, including signed statements from other individuals who may know about the funds in question.

H. Procedure--Posteligibility Application of Burial Fund - Related Income/Resource Exclusions

1. Recipient Is Eligible for All Months During Period of Review

If the individual remained eligible throughout the period of review:

- exclude from income any interest earned on the excluded burial funds if that interest has been allowed to accumulate as part of such funds; and
- exclude from resources, in addition to the funds previously excluded, any interest on such excluded burial funds that has been excluded from income and any appreciation in the value of such excluded funds.

I. References

Burial space exclusion, M1130.400.`
Prepaid burial contracts, M1130.420.
Burial insurance, M1130.300.
Interest on excluded burial funds, S0830.501.
Insurance funded burial contracts, M1130.425.

M1130.411 BURIAL FUNDS EXCLUSION-- JULY 1, 1988 THROUGH JULY 31, 1994

A. Introduction

The instructions in **M1130.410** apply to the burial funds exclusion for July 1, 1988 through June 30, 1994 with the exceptions noted below**.**

B. Policy

1. Form of Burial Funds

For months prior to August 1, 1994 burial funds could be in the form of **any** resource, liquid or nonliquid.

2. Commingled Funds

For months prior to August 1, 1994, burial funds could be commingled with other resources (burial-related or nonburial-related), but the funds had to be separately identifiable in order to be excluded (S1130.700).

M1130.420 PREPAID BURIAL CONTRACTS

A. Definition

A prepaid (or preneed) burial contract is an agreement whereby the buyer pays in advance for a burial that the seller agrees to furnish upon the death of the buyer or other designated individual.

B. Policy--General

1. Contract Is a Resource

If a burial contract is revocable or salable, it is a resource. However:

- any portion of the contract that clearly represents the purchase of burial spaces may be excludable, regardless of value (**M1130.400**); and
- some or all of any remaining value of the contract may be excludable as burial funds (**M1130.410**).

2. Contract Is Not a Resource

a. Contract Not Saleable

When a burial contract is funded totally by an irrevocable trust, irrevocably assigned life insurance policy or annuity, the contract is NOT saleable. Do not develop the prepaid burial contract further. Determine whether the trust, the life insurance policy or annuity is a resource using the following policy:

- trusts in sections M1120.200 through 202, M1140.400 through 404.
- life insurance in sections M1130.300 and M1140.310.

b. Contract Issued in Another State

If a burial contract is issued in another State and cannot be revoked or be sold without significant hardship, it is not a resource. However:

- any portion of the contract that represents burial **funds** reduces the $3,500 maximum otherwise available for the burial funds exclusion; but
- any portion that represents the purchase of burial spaces has no effect on the burial funds exclusion.

3. Contract Revocability

State law determines whether a contract is revocable. Some burial contracts may be partly revocable. For example, if the total value of an otherwise irrevocable contract exceeds the limit set for irrevocability by State law, the excess is revocable.

4. Burial Insurance and Burial Trusts

Prepaid burial contracts do not include burial insurance as defined in **M1130.300** or burial trusts as described in M1120.200.

5. Provider Places Funds in Trust

If an individual contracts with a provider of burial services and the **provider** places the funds in trust with the funeral provider named as the grantor on the trust document, this individual has purchased a preneed contract; this is a compensated "transfer" of funds.

C. Policy --Evaluations Contracts

1. Conditions for Liquidation

A prepaid burial contract may have conditions attached to its liquidation or revocation. If either of the following conditions exists, the contract is not a resource.

- Significant hardship may result from the conditions required for selling or revoking a contract. Significant hardship means an unrealistic demand on the buyer; e.g., having to move out of state. If an EW determines that such would be the case, the file must contain a determination to that effect.

- State law or contractual terms may require **mutual consent** of buyers and seller in order to sell or revoke a contract. If the seller will not consent, or will consent only under conditions that would pose a significant hardship to the buyers, the file must reflect those facts.

NOTE: If a condition creating hardship or some other obstacle to liquidation is not evident on the face of the contract, assume it is revocable or salable and, therefore, a resource. The burden is on the applicant/recipient to provide evidence to the contrary.

2. Value of Contract as a Resource

If a burial contract is a resource, use as its value:

- the amount payable to the owner upon revocation; or

- if the contract is not revocable but is salable, its CMV.

3. Single Purpose Burial Space Contracts

a. General

Apply the burial space exclusion to any single-purpose burial space contract that is a resource **if:**

- the contract lists all of the burial spaces **and** either includes a value for each space or the total value of all the spaces combined; and

- the seller's obligation to provide those items is not contingent on further payment (as in certain installment contracts); i.e., the items are actually being held for the individual's future use.

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b. Exception
Treat as burial funds (i.e., as subject to the *$3,500* maximum or as reducing that maximum):

- the unidentified portion of a contract that implies it covers only burial spaces but does **not** identify some or all of the spaces, or does not include either a value for each burial space or the total value of all the spaces combined; and
- the amount paid on an installment contract for burial spaces if the contract does not entitle the person to the spaces until the full purchase price has been paid.

NOTE: Once full payment has been made, these items can become subject to the unlimited burial space exclusion because at the point of full payment the contract becomes an agreement representing the purchase of a burial space (M1130.400).

4. Single-Purpose Contracts for Burial Expenses

A single-purpose contract for burial expenses (M1130.410) includes only services that are consider burial **funds** and that are subject to, or reduce the amount of, the burial funds exclusion.

5. Contracts for Both Burial Spaces and Burial Expenses

a. Irrevocability Designation
If a combined contract designates which portion is irrevocable and which is not, that designation is controlling. That is, if the contract designates only the burial space purchase as irrevocable, the portion dealing with burial funds is revocable and is subject to the burial funds exclusion.

b. Maximum on Irrevocable Amount
Virginia does not have a set maximum irrevocable amount set by law. However, if a State has a law which sets a maximum on the amount that can be irrevocable, but the contract does not designate which part is irrevocable and the contract value exceeds the State maximum, we apply the maximum to burial **spaces** first.

- If space purchases exceed the maximum, we consider the excess revocable but subject to the burial space exclusion.
- If space purchases are less than the maximum, we apply the remainder of the maximum to burial funds items.

NOTE: Irrevocable burial funds reduce the amount available for excluding other burial funds.

c. Installment Contracts

We treat as burial funds the amount **paid** for any spaces and services in a combined contract being purchased in installments **if** the contract.

- does not entitle the individual to the spaces and services listed until the full purchase amount has been paid ; or
- relieves the seller of the obligation to provide the spaces and services listed at the price listed until the contract is paid in full.

Once the contract has been paid in full, we apply the space and funds exclusions as appropriate.

D. Procedure--Development and Documentation

1. General

a. **Develop** initially whether a prepaid burial contract exists and is a resource.

b. **Document** the file with respect to:
- revocability;
- liquidity (as needed); and
- value, if the contract is a resource or involves burial funds

c. In **posteligibility** situations:
- **develop and document** any newly acquired contract per a. and b. above;
- **do not redevelop** a contract if prior development showed that it is not a resource and does not contain burial funds;
- **redevelop and document** a contract if prior development showed that installment payments could affect applicability of the funds/space exclusions or that it included burial funds (revocable or irrevocable).

2. Valuing a Revocable Contract

For revocable burial contracts, State law usually sets refund guidelines that may vary by contract. If you cannot determine the refund amount by examining the contract, have the individual contact the provider or, if necessary, make the contact yourself.

3. Valuing an Irrevocable but Transferrable Contract

If a contract is irrevocable but can be liquidated some other way (e.g., through sale), **assume** that the contract's CMV is the amount that has been paid on it.

If the individual disagrees with this assumption, he or she can rebut it with an estimate from a disinterested knowledgeable source such as the State Funeral Directors Association or a local funeral director.

4. Single-Purpose Contract

Develop and document the factors outlined in 1. above, following the guidelines above, as appropriate.

5. Contract for Both Spaces and Funds

a. Determine whether the contract designates which portion (if any) is irrevocable.

b. If designated, develop each portion as appropriate per **M1130.400** or **M1130.410.**

c. If the contract does not designate, apply the State maximum for irrevocability, if any, first to the total value of all burial spaces and then to the value of the burial funds. (See E. below for examples.)

Any burial spaces not covered are subject to the burial space exclusion. Any burial funds not covered are subject to the burial funds exclusion.

d. If you cannot determine which amounts represent the purchase of spaces and which represent burial funds, and which parts of the contract, if any, are irrevocable, the individual has not satisfactorily identified funds versus spaces. In that event, consider the entire contract as a resource in the form of burial funds.

E. Examples--

1. Installment Contract

a. Situation

An individual owns a revocable contract for his own burial. The contract, which covers both spaces and funds, gives the following breakout:

$ 700	- casket
350	- vault
200	- opening/closing
225	- embalming
300	- use of facilities
525	- services of director and staff
$2,300	- total value of contract

The contract provides that, until the full price of the contract has been paid, the seller has the option to be released from any obligation to provide the items and services at the contract price. Rather, the seller can charge prices current at the time of death, allowing a credit for amounts already paid.

b. Treatment

Until the contract has been paid in full, we consider all payments to be funds set aside for burial. Amounts paid in excess of the maximum available for exclusion as burial funds are countable resources.

When the contract has been paid in full, the spaces listed in a. above are subject to the burial space exclusion. The $1,050 value of the remaining items is subject to the burial funds exclusion.

M1130.425 LIFE INSURANCE FUNDED BURIAL CONTRACTS AND THE BURIAL SPACE/FUNDS EXCLUSIONS

A. Definitions

1. Life Insurance Funded Funeral Arrangements

A life insurance funded burial contract involves an individual purchasing a life insurance policy on his or her own life and then assigning, revocably or irrevocably, either the proceeds or ownership of the policy to a third party, generally a funeral provider. The purpose of the assignment is to fund a burial contract.

Life insurance funded burial contracts are **not** burial insurance (**M1130.300** A.8.).

2. Proceeds

Proceeds of a life insurance policy are the face value of the policy plus any additions payable at maturity or death. This does not include dividends, cash surrender value (CSV) or interest.

B. Policy-General

1. Operating Assumptions

We assume that the burial contract itself (without the insurance policy assigned to fund it) has no resource value. We also assume that the contract is not salable because it is a part of a larger arrangement involving life insurance that has been assigned to another party as payment for contract goods and services. This means that the value of the burial arrangement is the value of the life insurance policy.

2. State Limits on the Amount of Funeral Contracts That May Be Made Irrevocable

State limits on the amount of funeral contracts that can be made irrevocable generally address the face amount of the contract that can be made irrevocable. Since we are concerned with the irrevocable assignment of ownership of an insurance policy to fund a burial contract and not with the face amount of the contract itself, State dollar limits are usually of no consequence in evaluating the policy for Medicaid purposes unless State law specifically limits irrevocable assignment of ownership of insurance polices funding burial contracts.

3. Dividend Accumulations

We do not exclude from resources dividend accumulations of a life insurance policy as part of the value of the policy or the burial contract. Dividend accumulations are separate resources and must be designated separately in order to qualify for the burial funds exclusion. (See **M1130.300 A.5.b.** and **C.5.c**)

If ownership of the life insurance policy has been irrevocably assigned, we assume, absent evidence to the contrary, that the dividend accumulations are also assigned.

C. Policy--Effect Of Assignment of Ownership On Burial Exclusions

1. Revocable Assignment

a. Burial Spaces

The burial space exclusion does not apply. This is because the funeral provider has not received any payment and no purchase of burial spaces has been made. The provider has no obligation to provide any spaces until the individual dies and therefore no spaces are being held for the individual.

b. Burial Funds

The burial funds exclusion may apply. The resource value of the burial contract is equal to the CSV of the life insurance policy, subject to the *$3,500* burial funds exclusion.

c. Example

Mrs. Emma White has a burial contract funded by the revocable assignment of ownership of a life insurance policy. The face value of both the burial contract and the life insurance policy is *$5,000* and the CSV of the life insurance policy is currently *$3,700*. The total resource value of Mrs. White's burial contract is equal to the CSV of *$3,700.*

The burial space exclusion does not apply to Mrs. White's contract (per above). However, we can exclude *$3,500* of the CSV under the burial funds exclusion. The remaining $200 of the CSV will be considered a countable resource.

2. Irrevocable Assignment

a. Burial Spaces

The burial space exclusion may apply, depending on the nature of the contract (**M1130.400**.). Any portion of the contract that represents the purchase of a burial space has no effect on the burial funds exclusion.

b. Burial Funds

The life insurance policy and the burial contract are not resources for Medicaid purposes because the Medicaid recipient no longer owns them. The face value of the burial funds portion of the contract (if any) offsets the *$3,500* burial funds exclusion because the contract represents an irrevocable arrangement available to meet the individual's burial.

c. Example Mr. Bill Atkins made provision for his burial by irrevocably assigning ownership of a life insurance policy on his life to a funeral home to fund a burial contract. The face value of the life insurance policy is *$5,000.*

The burial contract identifies the purchase of $1,300 of burial spaces and *$3,700* of burial funds. The *$3,700* burial funds portion of the contract is not a resource, but, since the assignment of policy ownership is irrevocable, the *$3,700* burial funds portion exceeds the *$3,500* burial funds exclusion that he is entitled to so Mr. Atkins may not have any other excluded burial funds. The $1,300 space purchase is not a resource either, and does not reduce the burial funds exclusion.

D. Policy--Effect Of Assignment Of Proceeds On Burial Exclusions

1. Revocable Assignment

a. Burial Spaces
The burial space exclusion does not apply to the CSV of the life insurance policy. This is because the funeral provider has not received any payment and no purchase of burial spaces has been made. The provider has no obligation to provide any spaces until the individual dies and, therefore, no spaces are being held for the individual.

b. Burial Funds
The resource value of the burial contract is equal to the CSV of the life insurance policy. Treat the CSV according to the policy described in c. below.

c. Treatment of CSV

- If the face value of all life insurance policies on the individual's life is $1,500 or less, exclude the CSV under the life insurance exclusion (**M1130.300 B**.).

- If the face value of all policies exceeds $1,500, treat the CSV of the policy according to the burial funds exclusion, if applicable. See **M1130.410** for instructions on the burial funds exclusion.

d. Examples

- Ms. Lydia Fisher has a $1,300 burial contract funded by the revocable assignment of the proceeds of an insurance policy with a face value of $1,300 on her life. The CSV of the policy is $1,000. If this is the only life insurance policy she owns on her life, then the life insurance policy would be excluded under the life insurance exclusion and the burial exclusions would not apply.

The life insurance policy's face value of $1,300 reduces the maximum *$3,500* burial fund exclusion by that same amount. Ms. Fisher may have an additional *$2,200* in excluded burial funds.

- If Ms. Fisher has another life insurance policy on her life and the total face value of the two policies exceeds $1,500 (the life insurance exclusion does not apply), then the CSV may be excludable under the burial funds exclusion. No burial space exclusion applies per a. above.

2. Irrevocable Assignments

We are not aware of insurance companies that permit irrevocable assignment of policy proceeds without requiring the irrevocable assignment of ownership. Should you encounter this type of policy, submit a copy of the policy to the Regional Coordinator.

E. Policy--Life Insurance Policy Placed in a Trust

A life insurance company may provide an individual with the option of irrevocably transferring ownership of a revocable life insurance policy that funds a burial contract to a trust established by the company.

1. Treatment of Policy's CSV

If an individual assigns a life insurance policy to a trust the CSV (if any) will not continue to be a countable resource; if

- the individual neither owns nor has the legal right to direct the use of trust assets to meet his or her maintenance needs and
- **a revocably assigned life insurance policy funds a funeral contract and the policy is placed irrevocably in a trust then the policy's CSV is not a resource for Medicaid purposes.**

2. Treatment Of Dividends

If the policy's CSV is not a resource, assume, absent evidence to the contrary, that any dividends paid on the policy are also not a resource.

3. Individual Retains Right to Change Funeral Firm

Under an irrevocable trust arrangement, the life insurance policy's CSV is not a resource even if the individual retains the right to change the funeral firm that will provide the burial goods and services.

4. Burial Fund Exclusions Offset

A revocably assigned life insurance policy placed in an irrevocable life insurance trust is treated the same as a life insurance policy for which the ownership has been irrevocably assigned to fund a burial contract (see C.2 above). This means that the value of the burial funds portion of the contract (IF ANY) reduces the *$3,500* burial funds exclusion.

This is the case because the burial funds portion of the contract represents an irrevocable arrangement that is available to meet the individual's burial expenses.

F. Procedure--General

1. Development and Documentation

Follow instructions in **M1130.410** E. regarding the development and documentation of burial funds. See additional instructions below.

a. Life Insurance Policy

Examine the life insurance policy and document whether the ownership/proceeds of the policy have been assigned (revocably or irrevocably) and, if so, to whom.

If ownership or proceeds of the life insurance policy have been **revocably** assigned, follow regular life insurance development procedures. (See **M1130.300** C. for further development and documentation requirements.)

If ownership of the life insurance policy has been **irrevocably** assigned, apply the policy principles in C.2. above to determine the policy's resource status.

If an insurance policy that funds a funeral arrangement is placed **irrevocably in trust**, apply the policy principles in E. above to determine the policy's resource status. For out-of-state contracts contact the regional specialist.

In all cases, document the file with a copy of:

- the life insurance policy;
- the assignment; and
- any other related documents.

b. Options for Developing Policies Issued by Nonparticipating or Stock Companies

If the insurance policy funding the burial contract is issued by a nonparticipating or stock company (and therefore does not pay dividends), you may be able to curtail development as to the policy's CSV. You can use the CSV chart attached to the policy instead of contacting the life insurance company. See **M1130.300** C.5. for more information.

c. Burial Contract

Examine the burial contract and determine what items and/or arrangements have been contracted. Document the file with a copy of the burial contract.

2. Determine Applicability of Burial Space/Fund Exclusions

Apply the policy principles in C. and D. above and determine:

- the value of the contract that is excludable as a burial space (if any) (**M1130.400**); and
- the value of the contract that is excludable as burial funds (if any) (**M1130.410**).

Put your determination in the file.

G. Procedures-- Redetermination Development

For a previously developed life insurance funded burial contract, redevelop and document the value of the contract using applicable life insurance development procedures if:

- ownership and/or proceeds of the policy have been **revocably** assigned (i.e., the CSV of the policy must be reverified); or
- ownership of the policy has been **irrevocably** assigned (or a revocably assigned policy has been placed irrevocably in trust) and the individual has other excluded burial funds (i.e., the value of the contract reduces the amount of other funds that may be excluded).

M1130.430 HOUSEHOLD GOODS AND PERSONAL EFFECTS

A. Policy Principle

Household goods and personal effects are excluded resources for Medicaid evaluations.

B. Definitions

1. Household Goods

Household goods are items of personal property customarily found in the home and used in connection with the maintenance, use, and occupancy of the premises as a home. They include, but are not limited to: furniture, appliances, televisions sets, carpets, cooking and eating utensils, dishes, etc.

2. Personal Effects

Personal effects are items of personal property that are worn or carried by an individual or that have an intimate relation to him or her. They include, but are not limited to: clothing, jewelry, personal care items, prosthetic devices, and educational or recreational items such as books, musical instruments, or hobby materials.

REAL OR PERSONAL PROPERTY

S1130.500 PROPERTY ESSENTIAL TO SELF-SUPPORT – OVERVIEW

A. Introduction

The Social Security Act provides for the exclusion from resources of property that the Secretary determines is so essential to an individual's means of self-support as to warrant exclusion.

B. Policy Principles

1. Categories Of Property Excluded Under This Provision

Resources excluded under this provision generally fall into 3 categories. Each is listed below and then described in more detail in a subsequent section.

a. Property Excluded Regardless of Value or Rate of Return

This category encompasses:

- property used in a trade or business (effective 5/1/90);
- property that represents government authority to engage in an income producing activity;
- property used by an individual as an employee for work (effective 5/1/90); and
- property required by an employer for work (before 5/1/90).

See S1130.501.

b. Property Excluded up to $6,000 Equity, Regardless of Rate of Return

This category includes **nonbusiness** property used to produce **goods** or **services** essential to daily activities. For example, it covers land used to produce vegetables or livestock **solely** for consumption by the individual's household. See S1130.502.

c. Property Excluded up to $6,000 Equity if it Produces a 6% Rate of Return

This category encompasses:

- property used in a trade or business in the period before 5/1/90;
- nonbusiness income-producing property. However, the exclusion does not apply to equity in excess of $6,000 and does not apply if the property does not produce an annual return of at least 6% of the excluded equity. If there is more than one potentially excludable property, the rate of return requirement applies individually to each. See S1130.503.

2. Current Use Criterion

Resources that are excluded under this provision must be in current use in the type of activity described. If not in current use, there must be a reasonable expectation that the required use will resume. See S1130.504.

3. Liquid Resources

Liquid resources are not considered property essential to self-support except when used as part of a trade or business.

C. Policy--Limitations On Development

It is not necessary to develop for the exclusion of property essential to self-support if:

- the combined value of the self-support property and other countable resources does not exceed the applicable resource limit;
- the value of other countable resources (including any equity over
- $6,000 when B.1.b. or c. is involved) exceeds the applicable resource limit;
- the individual is ineligible for a **nonfinancial** reason; or
- the property was excluded under the State plan in effect for October 1972 and the individual meets the "grandfathering" criteria.

D. Related Policies

1. Home Property

When an individual uses home property to perform self-support activities, the property is excluded under S1130.100, regardless of its value, rate of return, or current use.

2. Plan For Achieving Self-Support (PASS)

The primary differences between the exclusion of property essential to self-support and the exclusions provided for under a PASS (see *M0810.430*) are that the PASS exclusions:

- cover income as well as resources;
- apply to the blind and disabled, but not to the aged;
- have a time limit; and
- do not have an inherent dollar limit.

Consider the overall resource situation to ensure that the individual receives the benefit of the most advantageous exclusion for him or her.

*M*1130.501 ESSENTIAL PROPERTY EXCLUDED REGARDLESS OF VALUE OR RATE OF RETURN

A. Policy Principles

1. The Exclusion

The properties described in 2, 3, and 4 below are excluded as essential to self-support regardless of value or rate of return. However, they must be in current use or, if not in use for reasons beyond the individual's control, there must be a reasonable expectation that the required use will resume.

2. Trade Or Business Property

Property essential to self-support used in a trade or business is excluded from resources regardless of value or rate of return effective 5/1/90.

3. Government Permits

Government permits represent authority granted by a government agency to engage in income producing activity. Examples are commercial fishing permits granted by a State Commerce Commission and tobacco crop allotments issued by the U.S. Department of Agriculture.

4. Personal Property Used by an Employee

Personal property used by an employee for work is excluded from resources. Excluded items include tools, safety equipment, uniforms, etc.

B. Development and Documentation--General

The rules in C., D., and E. below apply unless development can be eliminated in accordance with S1130.500 C.

C. Development and Documentation -- Property Used in a Trade or Business

1. Trade or Business Not Being Excluded

When an individual alleges owning trade or business property not already being excluded, consider if a valid trade or business exists, and if the property is in current use (see S1130.504). Obtain a statement giving the information below. Absent evidence to the contrary, accept the responses to items a.-d. Verify e. with the business tax returns.

a. a description of the trade or business;
b. a description of the assets of the trade or business;
c. the number of years it has been operating (see 4. below);
d. the identity of any co-owners;
e. the estimated gross and net earnings of the trade or business for the current tax year (see 3. below).

2. Redetermination of Excluded Trade or Business Property

Consider current use of the property in the trade or business. Obtain and verify the individual's allegations as to the estimated gross and net earnings of the trade or business for the current tax year for income purposes (see S0820.230).

3. Use of Tax Returns

a. Use Most Recent Tax Return

Obtain a copy of the business tax return (i.e., Form 1040 and the appropriate schedules) for the tax year prior to the application or redetermination. Use the return to determine the net earnings from self-employment and validity of the trade or business. The following can be particularly helpful:

- Schedule C, Profit or Loss from Business or Profession;
- Schedule SE, Computation of Social Security Self-Employment;
- Schedule F, Farm Income and Expenses;
- Form 4562, Depreciation and Amortization; and
- Form 1065, U.S. Partnership Return of Income.

b. Current Tax Return Not Available

If the current tax return is not available, obtain a copy of the latest tax return available.

4. Questionable Trade or Business

If a trade or business has operated a year or less, or there is a question of bona fides, develop to determine whether a trade or business actually exists.

5. Liquid Resources Used in a Trade or Business

Effective May 1, 1990, all liquid resources used in the operation of a trade or business are excluded as property essential to self-support. Obtain an individual's signed allegation that liquid resources are used in the trade or business.

D. Development and Documentation Government Permits

1. Individual's Statement

Permit Alleged

If an individual alleges owning a government license, permit, or other property that represents government authority to engage in an income producing activity, and that has value as a resource, obtain his or her signed statement as to:

- the type of license, permit or other property;
- the name of the issuing agency, if appropriate;
- whether the law requires such license, permit, or property for engaging
- in the income producing activity at issue; and
- how the license, permit, or other property is being used; or
- if it is not being used, why not.

If the property is not being used, see S1130.504 for development.

2. Supporting Evidence

Have the individual submit a copy of the license, permit and/or other pertinent documents. For example, an individual engaged in fishing in Alaska would have to have a permit. In North Carolina, a person growing flue-cured tobacco would

have to have a "marketing sales card" to sell it. If the individual cannot submit the necessary evidence, verify his or her allegations with the issuing agency. Do this by telephone if possible.

3. Common Government Permits

a. Alaska Limited Entry Fishing Permit (ALEFP)
An ALEFP is one of the two most commonly encountered types of property representing required government authority to engage in an income producing activity. Alaska's Commercial Fisheries Entry Commission first issued ALEFP's in 1973 to control commercial salmon fishing. These permits are required for individuals who engage in the fishing trade.

b. Tobacco Crop Allotment (TCA)
The TCA is the other most commonly encountered type of property representing government authority to engage in an income producing activity. It is issued by the U.S. Department of Agriculture's *(USDA)* Agricultural Stabilization and Conservation Services. It is required for the growing and selling of flue-cured tobacco, which is grown mostly in the southeastern United States. Do not confuse a TCA with a price support or subsidy, or a soil bank program.

Exclude a TCA only when the grower who has it is restricted to growing a certain quantity of the crop.

c. Tobacco Quota Buy-Out Program

The Tobacco Quota Buy-Out Program is administered by the USDA. The program involves a contract between the USDA and the land owner and/or the producer (the individual, other than the land owner, who grows the crop) and provides payments to the land owner and/or producer for their tobacco "base" or quotas. The unpaid balance of the contract is a countable resource.

E. Development and Documentation -- Personal Property Used by an Employee

1. Individual's Statement

If an individual alleges owning items that are used in his or her work as an employee, obtain his or her statement to include:

- the name, address, and telephone number of the employer;
- a general description of the items;
- a general description of his or her duties; and
- whether the items are currently being used.

If the individual is temporarily not working (e.g., job loss, seasonal employment), or the property is not otherwise in current use, see S1130.504.

2. Supporting Evidence

Absent evidence to the contrary, accept the individual's statement.

S1130.502 ESSENTIAL PROPERTY EXCLUDED UP TO $6,000 EQUITY REGARDLESS OF RATE OF RETURN

A. Policy Principles

1. The Exclusion

Up to $6,000 of the equity value of nonbusiness property used to produce goods or services essential to daily activities is excluded from resources.

- CMV less balance of any recorded liens against the property

There is no requirement that the property produce a certain rate of return. The property must be in current use or, if it is not in use for reasons beyond the individual's control, there must be a reasonable expectation that the required use will resume.

2. Equity Exceeds $6,000

Any portion of the property's equity value in excess of $6,000 is not excluded under this provision.

3. Nonbusiness Property Producing Essential Goods or Services

Nonbusiness property essential to self-support can be real or personal property. It produces goods or services essential to daily activities if, for example, it is used to:

- grow, produce or livestock solely for personal consumption in the individual's household; or
- perform activities essential to the production of food solely for home consumption.

NOTE: While this category of property may encompass a vehicle used solely in a nonbusiness self-support activity (e.g., a garden tractor, or a boat used for subsistence, fishing), it does not include any vehicle that qualifies as an automobile (see S1130.200 A.).

B. Development and Documentation--Initial Applications and Posteligibility

1. Individual's Statement

When an individual alleges owning property that he or she uses to produce goods or services necessary for daily activities, obtain his or her statement giving:

- a description of the property;
- how it is used; and
- an estimate of its CMV and any encumbrances on it.

Absent evidence to the contrary, accept the statement.

2. Supporting Evidence of Value

a. Real Property
Determine the CMV and, if necessary, the EV of real property in accordance with S1140.100.

b. Personal Property
Have the individual obtain a CMV estimate from a knowledgeable source. The estimate must:

- clearly identify the source;
- contain a description of the item whose CMV is being estimated; and
- show the basis for the estimate.

NOTE: If a knowledgeable source provides a value range, use the lower edge of the range.

3. Current Use Criterion

If the property is not in current use, see S1130.504 for development.

S1130.503 ESSENTIAL PROPERTY EXCLUDED UP TO $6,000 EQUITY IF IT PRODUCES A 6 PERCENT RATE OF RETURN

A. Policy Principles

1. The Exclusion

Up to $6,000 of the equity value of nonbusiness income producing property (and business income producing property for months of eligibility before May 1, 1990) can be excluded from resources if the property produces a net annual return equal to at least 6% of the excluded equity.

2. Equity Exceeds $6,000

Any portion of the property's equity value in excess of $6,000 is not excluded under this provision.

3. Rate of Return Less Than 6%

If the property produces less than 6% return, the exclusion can apply only if:

- the lower return is for reasons beyond the individual's control (e.g.,
- crop failure or illness); and
- there is a reasonable expectation that the property will again produce
- 6% return (see C. below).

Otherwise, none of the EV is excluded under this provision.

4. More Than One Income Producing Property

If an individual owns more than one piece of income producing property;

- the 6% return requirement applies individually to each; and
- the $6,000 EV limit applies to the total EV of all the properties meeting the 6% return requirement.

If all properties meet the 6% test but the total EV exceeds $6,000, that portion of the total EV in excess of $6,000 is not excluded under this provision.

B. Examples

1. Rental Property Whose EV Exceeds $6,000

At redetermination, Mr. Cameron states that he now lives in an apartment and is renting out his formerly excluded home, which has an EV of $10,000. Even if the property produces a 6% return, $4,000 of its equity cannot be excluded under this provision.

2. Multiple Income Producing Activities

Mr. Patterson owns a mobile home (not his residence) that has a CMV and EV of $3,000. He owns other property that has a CMV and EV of $2,000. The mobile home produces a net annual rental income of $750, and the other property produces less than $50 a year.

Since the mobile home produces more than 6% return, its EV is excluded. Since the other property produces less than a 6% return, its EV is not excluded.

C. Operating Policy--Time Limit for Resumption of 6% Return

1. General Rule

If the earnings decline was for reasons beyond the individual's control, up to 24 months can be allowed for the property to resume producing a 6% return. The 24 month period begins with the first day of the tax year following the one in which the return dropped to below 6%. See E. below for development.

2. Initial Applications

In an initial application, if the tax returns show that the activity has operated at a loss for the 2 most recent years or longer, the property cannot be excluded unless the individual submits current receipts and records to show that it currently is producing a 6% return.

3. Trade of Business In Operation for 1 Year or Less

If a trade or business has operated a year or less, develop to determine whether a trade or business actually exists.

D. Development and Documentation--Non-Business Property

1. Income Producing Real Property

a. Individual's Statement

When an individual alleges owning nonbusiness real property that produces income (e.g., land or house for rent), obtain his or her signed statement concerning:

- the number of years he or she has owned the property;
- any co-owners of the property;
- a description of the property;
- the estimated CMV of the property and any encumbrances on it;
- and
- the estimated net and gross income from the property for the
- current tax year.

b. Supporting Evidence

- Absent evidence to the contrary, accept the statement with respect
- to years of ownership, identity of owners, and description of the property.
- Determine rate of return based on income and value figures
- shown on the individual's Schedule E (Supplemental Income Schedule) of Form 1040 for the year prior to filing of the application. If no tax return is available, obtain other appropriate evidence from the individual (e.g., a copy of the lease agreement for the period in question). If it is necessary to verify EV, see S1140.042.

NOTE: When redetermining the status of property already excluded under this provision, only the value and income need to be redeveloped.

2. Income-Producing Personal Property

See S1130.502 B. for development of the property's use and value. In addition, obtain the individual's statement giving net and gross income from the property for the current tax year. Verify the property's rate of return by reviewing a copy of Schedule E of Form 1040 for the tax year prior to filing or redetermination. If no tax return is available, obtain the appropriate evidence from the individual to establish the income alleged.

E. Development and Documentation--Rate of Return Less Than 6%

Apply these instructions in determining the excludability of nonbusiness income producing property (and business property for periods before May 1, 1990) when the tax return shows an earnings rate of less than 6%.

1. Individual's Explanation

Record the individual's explanation of the earnings decline in the file.

2. Supporting Evidence

Obtain evidence of prior years' earnings (e.g., tax returns for at least 2 years prior to the current tax year) to determine whether the activity has produced a 6% rate of return before.

NOTE: When no tax returns are available, use other evidence such as receipts, check registers, invoices, sales slips, bank statements, etc.

3. Circumstances Beyond The Individual's Control

a. Special Review

If evidence establishes that the earnings decline is for reasons beyond the individual's control, he or she has up to 24 months from the end of the tax year in which the earnings went below 6% to meet the 6% requirement. Set a special review to check progress after 12 months.

b. 12-Month Follow-up

- If the 12-month follow-up shows that the activity is again
- producing a 6% return, further follow-up is necessary.

- If the activity still is not producing 6% return but the individual is actively pursuing it, allow an additional 12 months.

- If the individual has ceased actively pursuing the activity, include the value of the property in determining resources for the month after the month of review.

c. 24-Month Period Ends

If the property still is not producing a 6% return, include the value of the property in determining resources for the month following the month in which the 24-month period ends.

S1130.504 ESSENTIAL PROPERTY--CURRENT USE CRITERION

A. Policy Principle

Property, including property used by an individual as an employee, must be in current use in the type of activity that qualifies it as essential to be excluded as essential to self-support. Current use is evaluated on a monthly basis. Property not in current use can be excluded as essential to self-support only if:

- it has been in use; and
- there is a reasonable expectation that the use will resume.

B. Policy--Time Limit for Resumption of Use

1. 12-Month Rule

Resumption of use must be expected within 12 months of last use. For example, if property was last used in October, resumption of use must reasonably be expected to occur before the end of the following October.

2. 12-Month Extension

The 12-month period can be extended for an additional 12 months if nonuse is due to a disabling condition (see D. below).

C. Procedure--General

1. Individual's Statement

If property is not in current use, obtain the individual's signed statement as to:

- the date of last use;
- the reason(s) the property is not in use; and
- when the individual expects to resume the self-support activity, if at all.

2. Explanation to Individual

Explain that we can exclude the property for up to 12 months if resumption of the self-support activity can reasonably be expected to occur within that time.

3. No Intent to Resume Activity

If the individual does not intend to resume the self-support activity, the property is a countable resource for the month after the month of last use. However, see 5. below.

4. Intent To Resume Activity

a. Special Review Set
If the individual intends to resume use of the property, prepare a special review for 12 months from the date of last use.

b. Special Review Evaluation
In the month of special review, contact the individual to see whether he or she has resumed use of the property. If not, the property is a countable resource for the month after the month in which the 12-month period expired.

5. Change of Intent

If, after property has been excluded because an individual intends to resume self-support activity, the individual decides not to resume such activity, the exclusion ceases to apply as of the date of the change of intent. Thus, unless excluded under another provision, the property is a resource for the following month.

D. Procedure -- Disabling Condition

1. Individual's Statement

If an individual alleges that self-support property is not in current use because of a disabling condition, obtain the individual's signed statement as to:

the nature of the condition;
the date he or she ceased the self-support activity; and
when he or she intends to resume the activity, if at all.

2. Special Review

Prepare a special review as to whether up to an additional 12 months will be allowed for resuming use of the property.

NOTE: Medical review is not an indicator of an individual's intent or ability to do at least some work.

S1130.510 RESOURCES SET ASIDE AS PART OF A PLAN FOR ACHIEVING SELF-SUPPORT

A. Introduction

A plan for achieving self-support (PASS) allows blind and disabled (but not aged) individuals to set aside income and/or resources necessary for the achievement of its goals.

B. Policy Principle

Resources set aside as part of an approved PASS are excluded.

C. Development and Documentation

PASS resources are determined by SSI. See *M0810.430 for additional information about PASS.*

M1130.520 TRUSTS ESTABLISHED BETWEEN JULY 1, 1993 AND AUGUST 10, 1993

A. Introduction

Trusts established between July 1, 1993 and August 10, 1993 can have up to $25,000 disregarded from countable resources.

B. Definitions

1. MQT

A trust or similar legal device (SLD) is a legal instrument established other than by a will which:

- Is established by an individual or spouse (also includes trusts established by a guardian or representative payee for an incompetent adult or any child);
- The individual may be beneficiary of all or part of the funds;
- Is either revocable or irrevocable;
- Trustees have discretion (whether or not the discretion is actually exercised) in distributing funds to the beneficiary;
- May or may not be established for purposes other than to enable the beneficiary to qualify for medical assistance.

2. "SLD"

An "SLD" is a legal instrument:

- Under which the individual transfers or surrenders property to another individual;
- In which a second individual has legal responsibility to manage the property for the first individual;
- Which can include oral trusts, constructive trusts, and trusts created in law, in addition to trusts created by a written legal document; and
- Which may not be labeled a "trust" but seems to meet all of the MQT criteria listed above.

C. Policy

Some trusts have provisions which place limits on the discretion of the trustee either directly or indirectly to make payments from the trust to the grantor when the grantor makes a Medicaid application, or requires medical, hospital, or long-term care services. **Any restricting clauses in trusts created after July 1, 1993, are void if they limit the discretion of the trustee when the grantor applies for Medicaid or needs medical, hospital, or long-term care services.**

1. Trusts Less Than $25,000

Trust(s) Less than $25,000 created after July 1, 1993 and before August 11, 1993

None of the principle is counted as a resource for single or multiple trusts created after July 1, 1993 and before August 11, 1993 when corpus or corpora **is less than $25,000.** The maximum **amount** of income payable from the trust according to its terms is considered available income whether or not it is actually paid to the applicant or recipient.

2. Trusts Greater Than $25,000

Trust(s) Greater than $25,000 created after July 1, 1993 and before August 11, 1993

A single trust or multiple trust created after July 1, 1993 and before August 11, 1993, when the corpus or corpora is more than $25,000, may have partial exclusion of the corpus.

D. Development/ Documentation

1. Verify Trust(s)

- **Obtain copy of trust(s) document(s).**
- Verify **current value of the** corpus or corpora of the trust(s).

2. Apply Disregard

a. Prorate $25,000 by the number of trusts

b. Subtract prorated amount from corpus or corpora of the trust(s).

3. Countable Resource

The remainder of the corpus or corpora of the trust(s)

- that may be paid under the terms of the trust
- without any limits imposed by **any** void restrictive clause
- is counted as an available resource to the applicant or recipient regardless
- of whether or not:
- the trust is irrevocable; or
- the trust was established for purposes other than to make the individual eligible for Medicaid; or
- the trustee exercises his discretion to distribute trust payments to the applicant/recipient.

E. References

Trusts Created After July 1, 1993 and Before August 11, 1993 with Corpus in Excess of $25,000, M1140.403.

RETAINED CASH AND IN-KIND PAYMENTS

S1130.600 RETROACTIVE SSI AND *SS* PAYMENTS

A. Definitions

1. Retroactive SSI Benefits

Retroactive SSI benefits -- which include any federally administered State supplementation -- are SSI benefits issued in any month after the calendar month for which they are paid. Thus, benefits for January that are issued in February are retroactive.

2. Retroactive SS Benefits

Retroactive *SS* benefits are those issued in any month that is more than a month after the calendar month for which they are paid. *Therefore, SS* benefits for January that are issued in February are not retroactive, but *SS* benefits for January that are issued in March are retroactive.

B. Policy Principles

1. *9-Month Exclusion*

The unspent portion of retroactive SSI and SS benefits received on or after 11/01/05 is excluded from resources for the nine (9) calendar months following the month in which the individual receives the benefits.

2. **6-Month Exclusion**

The unspent portion of retroactive SSI and *SS* benefits *received before 11/01/05* is excluded from resources for the six *(6)* calendar months following the month in which the individual receives the benefits.

C. Related Policies

1. Interest

Interest earned by funds excluded under this provision is not excluded from income under this provision. Develop interest per S0830.500.

2. Commingled Funds

See S1130.700 if excluded funds have been commingled with other funds.

S1130.605 NETHERLANDS WUV PAYMENTS TO VICTIMS OF PERSECUTION

A. Background

The Netherlands' Act on Benefits for Victims of Persecution 1940-1945, WUV (Wet Uiterking Vervlgingsslachtoffers), provides payments to individuals who, during the German and Japanese occupation of the Netherlands and the Netherlands East Indies (now the Republic of Indonesia), were victims of persecution during World War II because of their race, religion, belief or homosexuality and, as a result of that persecution presently are suffering from illnesses or disabilities. There are 4 types of payments available to individuals who meet the eligibility rules for payment under the WUV program--periodical income, NMIK (compensation for non-definable disability expenses), reimbursements of persecution-related disability expenses and partial compensation for persecution related disability expenses.

B. Policy

1. The Resource Exclusion

Unspent WUV payments made by the Dutch government are excluded from resources.

2. Interest on Unspent Payments

Interest earned on unspent WUV payments *prior to July 1, 2004* is not excluded from income or resources. *Interest earned on unspent WUV payments on or after July 1, 2004 is excluded from income and resources* (See S0830.500 for development.)

C. Procedure

1. When to Develop

When an individual would otherwise be ineligible due to excess resources, determine if applying this exclusion would permit eligibility. If the exclusion would permit eligibility, develop per 2. below.

NOTE: If the individual is resources-eligible even without the application of this exclusion, it is not necessary to develop under this section.

2. Development and Documentation

If an individual alleges that his/her resources include unspent Netherlands WUV payments:

a. Using the documents in the individual's possession, document the date(s), and amount(s) of such payment(s). If the individual has no documentation or it is incomplete, contact the Consulate General of the Netherlands to verify payment date(s) and amount(s). See S0830.725C. for the address and phone number. If the individual has no documentation and the Consulate General of the Netherlands is unable to provide the information, then accept the individual's signed allegation of the amount(s) and the date(s) of receipt.

b. Obtain a statement as to the date(s) and amount(s) of any account deposits corresponding to the payments; and
c. Document the case record that the individual's resources include unspent WUV payments that are excludable.

D. References

Excluded funds commingled with nonexcluded funds, S1130.700
Income exclusion, Netherlands WUV payments, S0830.725

S1130.610 GERMAN REPARATIONS PAYMENTS

A. Introduction

"German reparations payments" are made to certain survivors of the Holocaust under the Federal Republic of Germany's Law for Compensation of National Socialist Persecution, or German Restitution Act. These payments may be made periodically or in a lump sum.

B. Policy

1. The Exclusion

Unspent German reparations payments are excluded from resources. The exclusion applies only if it would affect eligibility for Medicaid.

2. *Interest on Unspent Payments*

Interest earned on unspent German reparations payments prior to July 1, 2004 is not excluded from income or resources. Interest earned on unspent German reparation payments on or after July 1, 2004 is excluded from income and resources.

C. References

Excluded funds have been commingled with other funds, S1130.700.
Interest earned by conserved German reparations payments is not excluded from income by this provision, S0830.260.
The exclusion of German reparations payments from income, S0830.710.

D. Development and Documentation--Initial Application

If an individual alleges that his or her resources include German reparations payments, obtain a statement to:

the date(s) and amount(s) of such payment(s); and
the date(s) and amount(s) of any corresponding account deposit(s).

Absent evidence to the contrary, accept the allegation.

E. Development and Documentation--Posteligibility

The redetermination development for German reparations payments is the same as the initial application development.

S1130.615 AUSTRIAN SOCIAL INSURANCE PAYMENTS

A. Background

The nationwide class action law suit, Bondy v. Sullivan, involved Austrian social insurance payments which were based, in whole or in part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act. These paragraphs grant credits to individuals who suffered a loss (i.e., were imprisoned, unemployed, or forced to flee Austria) during the period of March 1933 to May 1945 for political, religious, or ethnic reasons. Not all Austrian social insurance payments are based on Paragraphs 500-506.

B. Policy

1. The Resource Exclusion

Unspent Austrian social insurance payments based, in whole or in part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act are excluded from resources.

Austrian social insurance payments **not** based on wage credits granted under Paragraphs 500-506 are **not** excluded from resources under this provision.

2. Interest On Unspent Payments

Interest earned on unspent Austrian social insurance payments *prior to July 1, 2004 is not excluded from income or resources. Interest earned on unspent* Austrian social insurance payments *on or after July 1, 2004 is excluded from income and resources.*

C. Procedure--Initial Applications and Posteligibility

1. When to Develop

When an individual would otherwise be ineligible due to excess resources, determine if applying this exclusion would permit eligibility. If the exclusion would permit eligibility, develop per 2. below.

If the individual is resources-eligible even without the application of this exclusion, it is not necessary to develop under this section.

2. Development and Documentation

If an individual alleges that his or her resources include unspent Austrian social insurance payments:

a. Determine whether the payments are counted as income, per S0830.715.

   If the payments **are** counted as income, this resource exclusion does **not** apply. If the payments are **not** counted as income, go to b.

b. Obtain a signed statement from the individual as to the date(s) and amount(s) of any account deposits corresponding to the Austrian social insurance payments. Apply the policy in B. above and exclude the unspent payments from the determination of countable resources.

D. References

Excluded funds commingled with nonexcluded funds, S1130.700
Income exclusion, Austrian social insurance payments, S0830.715

S1130.620 DISASTER ASSISTANCE

A. Policy

1. The Exclusion--December 1, 1988 and Continuing

Unspent assistance received from the following sources is permanently excluded from resources:

- **the Disaster Relief and Emergency Assistance Act (P.L. 100-707);**
- **another Federal statute because of a presidentially-declared major disaster;**
- **comparable assistance received from a State or local government; or**
- **from a disaster assistance organization.**

To be excluded from resources, the funds must be excludable from income per S0830.620.

2. Interest on Excluded Funds

Interest earned on funds excluded under this provision is excluded from income and from resources. (For months prior to December 1988, interest was excluded from income and resources for as long as the funds themselves were excluded.)

B. Procedure

1. When to Develop

Develop this exclusion only when an individual alleges the receipt of assistance excludable under this provision and the exclusion would permit eligibility.

2. Evidence of Excludability

Follow the instructions in S0830.620. If the file contains evidence that the disaster assistance is excluded from income, use the same evidence to establish that the assistance is excluded from resources.

3. Document the Determination

Summarize the basis for the exclusion in the case record. Show the amount excluded and the first month and year that the exclusion applies.

C. References

Payments for repair or replacement of lost, damaged, or stolen excluded resources, S1130.630.

Identifying excluded funds that have been commingled with nonexcluded funds, S1130.700.

S1130.630 CASH AND IN-KIND ITEMS RECEIVED FOR THE REPAIR OR REPLACEMENT OF LOST, DAMAGED, OR STOLEN EXCLUDED RESOURCES

A. Policy-Time Periods

1. The Policy

Cash and in-kind receipts (ISM or other) from any source for the replacement or repair of lost, damaged, or stolen excluded resources are themselves not treated as resources for 9 months from the date of their receipt.

2. Extension for Good Cause

a. General

For cash receipts, the initial 9 month period can be extended for a reasonable period up to an additional 9 months if the individual shows good cause why repair or replacement was not possible during the first 9 months.

b. Definition-Good Cause

Good cause is present if circumstance beyond the individual's control:

- **prevent repair or replacement of the lost, damaged, or stolen property; or**
- **keep the individual from contracting for such repair or replacement.**

c. Victims of Hurricane Andrew

Effective March 17, 1994, for victims of Hurricane Andrew only (which occurred in August 1992 and affected South Florida and Louisiana), the period within which the cash or in-kind replacement is not treated as resources can be extended for up to an additinal 12 months beyond the 9-month extension in a. above if the individual continues to show good cause.

NOTE: The total exclusion period for victims of Hurricane Andrew cannot exceed 30 months (9-month initial period, 9-month good cause extension period, additional 12-month good cause extension).

B. Policy-Funds Not Treated as Resources

1. Funds Subject to Policy

There are no restrictions on where cash and/or in-kind items come from for purpose of this policy (e.g., it may come from an insurance company, a Federal or State agency, a public or private organization, or an individual).

However, funds received from the following sources are to be excluded in accordance with S1130.620 rather than these instruction:

- **the Disaster Relief and Emergency Assistance Act;**
- **some other Federal statute because of a presidentially declared major disaster,**
- **comparable assistance received from a state or local government; or**
- **a disaster assistance organization.**

(See S0830.620 for income treatment)

2. Interest on Funds Not Treated as Resources

Interest earned by funds not treated as resources under this provision is not treated as income and resources for the period during which the funds themselves are not considered resources.

3. Funds for Temporary Housing

This policy applies to funds received for the purchase of temporary housing.

4. Personal Injury Payments

This policy does not apply to funds received on account of personal injury.

C. Policy-Intended Use

1. During First 9 Months

What the individual intends to do with the funds does not affect their treatment for the first 9 months.

2. Role in Extension for Good Cause

An individual cannot qualify for an extension of the initial 9-month period unless he/she intends to use the funds for their designated purpose, i.e., repair or replacement of excluded resources.

3. Change of Intent During Extension

The good cause extension will terminate as of the date of the change of intent. The funds previously not treated as resources will be taken into account in determining resources for the following month.

D. Procedure

1. When to Develop

When an individual would otherwise be ineligible due to excess resources, determine if applying this policy would permit eligibility. If the policy would permit eligibility, develop per the following instructions.

Note: If the individual is resources-eligible even without the application of this policy, it is not necessary to develop under this section.

2. Evidence

a. General
Make sure the evidence show the source, value, date(s), and intended purpose of the items received, including whether any cash received is for a purpose other than the replacement or repair of the lost, damaged, or stolen (and excluded) resource.

b. Individual's Records
Obtain a copy of any evidence the individual has.

c. Verification from Source
If the individual cannot provide evidence that suffices for a determination, obtain the necessary information from the source of the payment(s). Do so by telephone, if possible.

3. Recontact

a. Initial 9-Month Period
Contact the individual at least 30 days before the initial 9-month period expires to determine if a good cause extension is necessary and if the individual qualifies for the extension.

b. Victims of Hurricane Andrew
For victims of Hurricane Andrew only, recontact the individual at least 30 days before the expiration of the 9-month extension, if applicable, to determine if an additional extension is needed.

If, after the 9-month extension for good cause, you grant an additional extension under the Hurricane Andrew provision and that extension is:.

- **for 6 months or less: Review at least 30 days before the extension period expires to determine if continuation of the good cause extension is warranted.**
- **in excess of 6 months: At the mid-point of the extension period recontact the individual.**

4. Recontact Evidence Requirements

a. Obtain evidence of the amount of payment(s) not treated as resources that are still unspent.

b. If payment(s) remain unspent, but the individual alleges:

- **good cause (see A.2. above); and**
- **the intent to use the funds for their designated repairs or replacement;**

obtain his/her signed statement regarding intent. Also have the individual submit evidence to substantiate the allegation of good cause, e.g., letters from contractors, etc.)

5. Determination

a. No Extension for Good Cause
If the evidence does not establish good cause, include the unspent payment(s) in determining countable resources as of the first moment of the first month after the month in which the policy is no longer applicable.

b. Extension
If such evidence shows good cause, discuss with the individual how much additional time is needed and why. On the basis of that discussion, extend the initial 9-month period for a reasonable period up to an additional 9 months (plus up to an additional 12 months in the case of victims of Hurricane Andrew), repeating development steps 3. and 4. above, as appropriate.

E. References

- **Excluded funds commingled with nonexcluded funds, S1130.700.**
- **Income treatment of items to replace or repair resources that have been lost, damaged, or stolen, S0815.200.**

S1130.640 BENEFITS EXCLUDED FROM BOTH INCOME AND RESOURCES BY A FEDERAL STATUTE OTHER THAN TITLE XVI

A. Introduction Many Medicaid income and resource exclusions are specified by Federal statutes other than title XVI.

B. Procedure See S0830.099 for a list of exclusions and a guide to instructions about exclusions specified by other Federal statutes. Follow those instructions.

C. Reference Funds excluded by other statutes are commingled with other funds, see S1130.700.

S1130.660 AGENT ORANGE SETTLEMENT PAYMENTS

A. Background See S0830.730.

B. Policy -The Exclusion Unspent Agent Orange settlement payments are excluded from resources.

C. Policy-Applicability The exclusion applies only if it would permit eligibility.

D. Policy - General

1. Income Exclusion See S0830.730.

2. Interest *on Unspent Payments* Interest earned *on unspent* Agent Orange settlement payments *prior to July 1, 2004* is not excluded *from income or resources. Interest earned on unspent Agent Orange settlement payments on or after July 1, 2004 is excluded from income and resources.* See S0830.500 for development.

3. Commingled Funds See S1130.700.

E. Development and Documentation -- Initial Applications If an individual alleges that his or her resources include unspent Agent Orange settlement payments:

- verify the date(s) and amount(s) of such payment(s) in accordance with S0830.730; and
- obtain a statement as to the date(s) and amount(s) of any account deposits corresponding to the payments.

Absent evidence to the contrary, accept the allegation regarding deposits.

F. Development and Documentation --- Post Eligibility The redetermination development for Agent Orange payments is the same as the initial applications development.

S1130.665 VICTIM'S COMPENSATION PAYMENTS

A. Policy

1. The Exclusion

Effective for resource determination made for the month of May 1991 and any subsequent months, unspent payments received from a fund established by a State to aid victims of crime are excluded from resources for 9 months.

To be excluded from resources under this provision, the individual must demonstrate that the payment was compensation for expenses incurred or losses suffered as the result of crime.

2. Interest on Unspent Payments

Interest earned on unspent victim's compensation payments is **not** excluded from income or resources by this provision (S0830.500).

B. Procedure--Initial Claims and Post-Eligibility

1. When to Develop

Develop this exclusion only when an individual alleges the receipt of compensation excludable under this provision and the exclusion would permit eligibility.

2. Development and Documentation

If an individual alleges that his or her resources include unspent victim's compensation payments, ask the individual to submit evidence that:

- verifies the source, date(s), and amount(s) of such payment(s); and
- establishes that the payment was paid as compensation for expenses incurred or losses suffered as the result of a crime.

Obtain a statement as to the date(s) and amount(s) or any account deposits corresponding to the victim's compensation payment(s).
Assist the individual as necessary.

3. Acceptable Evidence

Accept the following as evidence establishing that the payment was paid for expenses incurred or losses suffered as the result of a crime:

- a letter or check stub accompanying the payment indicating the reason for the payment;
- a subsequent letter requested by the claimant/recipient to clarify the reason for the payment; or
- any other document indicating the reason for the payment.

If the individual is unable to submit acceptable evidence, attempt to obtain the needed information over the phone through a contact with the agency that issued the victims' compensation payment.

C. Reference

Commingled funds, S1130.700.

S1130.670 RELOCATION ASSISTANCE PAYMENTS

A. Policy --Federal Relocation Assistance

1. The Exclusion

Relocation assistance is provided to persons displaced by projects which acquire real property. Federal relocation assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 (subchapter II, chapter 61, title 42 of the U.S. Code) is excluded from resources. Unlike state or local, there is no time limit on the exclusion for federal relocation assistance (see B.1. below). To be excluded under this provision, the payments must be of the type described in S0830.655B.

2. Interest on Unspent Payments

Interest earned on unspent relocation assistance payments is **not** excluded from income or resources by this provision (S0830.500).

B. Policy -- State or Local Relocation Assistance

1. The Exclusion

Effective for resource determinations made for the month of May 1991 and subsequent months, unspent relocation assistance payments from a State or local government are excluded from resources for 9 months.

To be excluded from resources under this provision, the payments must be of the type described in S0830.655C.

2. Payments Received Prior to May 1991

Payments received in August 1990 through April 1991 also can be excluded from resources under this provision beginning in May 1991. The payments can be excluded only for the number of months that remain in the 9-month period following the month of receipt as of May 1991.

EXAMPLE: The 9-month period for a relocation assistance payment received in January 1991 would be February through October 1991. However, the payment may be excluded from resources only for the months of May through October 1991.

3. Interest on Unspent Payments

Interest earned on unspent relocation assistance payments is **not** excluded from income or resources by this provision (S0830.500).

C. Procedure -- Initial Applications and Posteligibility

1. When to Develop

When an individual would otherwise be ineligible due to excess resources, determine if applying this exclusion would permit eligibility. If the exclusion would permit eligibility, develop per 2. below.

NOTE: If the individual is resources-eligible even without the application of this exclusion, it is not necessary to develop under this section.

2. Development and Documentation

If an individual alleges that his/her resources include unspent relocation assistance payments:

- follow the procedures in S0830.655D.;
- document the date(s), type(s) and amount(s) of such payments(s); and
- obtain a statement as to the date(s) and amount(s) of any account deposits corresponding to the payments.

D. References

Commingled funds, S1130.700.

*M*1130.675 TAX ADVANCES AND REFUNDS RELATED TO EARNED INCOME TAX CREDITS *AND THE TAX RELIEF, UNEMPLOYMENT INSURANCE REAUTHORIZATION AND JOB CREATION ACT OF 2010*

A. Policy

1. *EITC Related Refunds*

Effective with resource determinations made for the month of January 1991, an unspent Federal tax refund or payment made by an employer related to Earned Income Tax Credits (EITC's) is excluded from resources **only for the month following the month** the refund or payment is received.

Interest earned on unspent tax refunds related to EITC's is **not** excluded from income or resources by this provision (S0830.500).

2. *Tax Relief…Act of 2010 Related Refunds and Advance Payments*

*Federal tax refunds or advance payments received after December 31, 2009 are **not** to be counted as resources for **12 months following the month** of receipt according to Section 728 of the Tax Relief, Unemployment Insurance Reauthorization and Job Creation Act of 2010 (P.L. 111-312). This provision applies to tax refunds or advance payments received after December 31, 2009 but before January 1, 2013.*

*Interest earned on unspent tax refunds related to the Tax Relief Act is **not** excluded from income or resources by this provision (S0830.500).*

B. Procedure--Initial Claims and Post-Eligibility

1. When to Develop

Develop *these* exclusions only when an individual alleges the receipt of assistance excludable under this provision and the exclusion would permit eligibility.

2. Development and Documentation

If an individual alleges that his or her resources include unspent EITC and/*or Tax Relief Act related* refunds or payments:

- verify the source, date(s), and amount(s) of such refund(s) or payment(s) in accordance with S0820.400, and
- obtain a statement as to the date(s) and amount(s) of any account deposits corresponding to the EITC *and/or Tax Relief Act* refunds or payments.

C. References

Commingled funds, S1130.700.

S1130.680 RADIATION EXPOSURE COMPENSATION TRUST FUND PAYMENTS

A. Background

Fallout emitted during the U.S. Government's atmospheric nuclear testing in Nevada during the 1950's and during a brief period in 1962 exposed some individuals to doses of radiation that put their health at risk. In addition, some individuals employed in uranium mines during the period January 1, 1947 to December 31, 1971 were exposed to large doses of radiation. Public Law 101-426 created the Radiation Exposure Compensation Trust Fund (RECTF) and authorizes the Department of Justice (DOJ) to make compensation payments to individuals (or their survivors) who were found to have contracted certain diseases after exposure. The payments will be made as a one-time lump sum. Generally, the exposure occurred in parts of Arizona, Colorado, Nevada, New Mexico, Utah, and Wyoming.

B. Policy

1. Resource Exclusion

Unspent payments received from the RECTF are excluded from resources.

2. Interest On Unspent RECTF Payments

Interest earned on unspent RECTF payments prior to July 1, 2004 is not excluded from income or resources. Interest earned on unspent RECTF payments on or after July 1, 2004 is excluded from income and resources.

C. Procedure

1. When to Develop

When an individual would otherwise be ineligible due to excess resources, determine if applying this exclusion would permit eligibility.

If the exclusion would permit eligibility, develop per 2. below.

NOTE: If the individual is resources-eligible even without the application of this exclusion, it is not necessary to develop under this section.

2. Development and Documentation

a. Obtain Documentation

If an individual alleges that his or her resources include unspent RECTF payments:

- document such payments in accordance with S0830.740; and
- obtain a statement as to the date(s) and amount(s) of any financial institution (e.g., checking or savings) account deposits corresponding to the RECTF payments.

b. If Necessary, Contact DOJ

If the individual does not have, and cannot obtain, the documentation in 2.a. above, contact the DOJ. Address correspondence to:

The Radiation Exposure Compensation Program
U.S. Department of Justice
P.O. Box 146
Benjamin Franklin Station
Washington, DC 20044-0146

Provide the DOJ with the individual's name and Social Security number (SSN). When writing on behalf of a survivor, include the survivor's name and SSN.

D. References

- Excluded funds commingled with non-excluded funds, S1130.700.
- Exclusion of RECTF payments from income, S0830.740.

M1130.685 WALKER V. BAYER SETTLEMENT PAYMENTS

A. Policy

Section 4735 of the Balanced Budget Act of 1997 (P.L. 105-33) states that payments described in this subsection from the settlement of the Susan Walker v. Bayer Corp., et.al., class action lawsuit are NOT counted as income in determining eligibility for Medicaid. Payments described in this subsection are:

a. payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corp., et.al., 96-C-5024 (N.D.III.); and

b. payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement of Walker v. Bayer Corp., et.al., and that is signed by all affected parties on or before the later of

- December 31, 1997, or
- the date that is 270 days after the date on which such release is first sent to the persons to whom the payment is to be made.

Any interest earned on these funds *prior to July 1, 2004* is not excluded. *Any interest earned on these funds on or after July 1, 2004 is excluded from income and resources.*

B. Procedure

Information received by claimants in this lawsuit shows that claimants can choose to receive the payment in one of three ways - in a lump sum, a structured settlement, or a special needs trust. Regardless of which form the individual chooses, the payment(s) are excluded if the above requirements are met.

Verify the source of the funds from a letter from the individual's attorney or a copy of the check which identifies the payor as a Walker v. Bayer settlement account.

COMMINGLED FUNDS

S1130.700 IDENTIFYING EXCLUDED FUNDS THAT HAVE BEEN COMMINGLED WITH NONEXCLUDED FUNDS

A. Policy Principle

Otherwise excludable funds must be identifiable in order to be excluded.

B. Operating Policy

1. Identified vs. Segregated

Identifiability does not require that excluded funds be kept physically apart from other funds (e.g., in a separate bank account).

2. Operating Assumption

Always assume, when withdrawals are made from an account with commingled funds in it, that **nonexcludable funds are withdrawn first,** leaving as much of the excluded funds in the account as possible.

3. Effect of Account Transactions

If excluded funds are withdrawn, the excluded funds left in the account can be added to only by:

- deposits of subsequently received funds that are excluded under the same provision; and
- excluded interest (see 4. below).

4. Interest

If interest on the excluded funds is excluded (as with disaster assistance), the percent of an interest payment to be excluded is the same as the percent of funds in the account that is excluded **at the time the interest is posted**. The excluded interest is then added to the excluded funds in the account.

C. Development and Documentation - Initial Application and Posteligibility

1. Evidence

Obtain a **complete** history of account transactions back to the initial deposit of excluded funds. Use the individual's own records if possible.

2. Determination

a. Accept the individual's allegation as to the date and amount of a deposit of excluded funds if it agrees with the evidence in file on the receipt of the funds.

b. Record in case record:

- each deposit of excluded funds;
- each withdrawal that reduces the amount of excluded funds;
- each computation of excluded interest and its addition to the excluded funds.

D. Examples

1. One Time Receipt and Deposit of Excluded Funds

An individual deposits a $1,000 SSA check ($800 for the preceding 4 months and $200 for the current month) in a checking account. The account already contains $300 in nonexcluded funds.

- Of the new $1,300 balance, $800 is excluded as retroactive SSI
- benefits.
- The individual withdraws $300. The remaining $1,000 balance still contains the excluded $800.
- The individual withdraws another $300, leaving a balance of $700. All $700 is excluded.
- The individual deposits $500, creating a new balance of $1,200. Only $700 of the new balance is excluded.

2. Periodic Receipt and Deposit of Excluded Funds

An individual deposits $200 in excluded funds in a non-interest bearing checking account that already contains $300 in nonexcluded funds.

- The individual withdraws $400. The remaining $100 is excluded.
- The individual then deposits $100 in nonexcluded funds. Of the
- resulting $200 balance, $100 is excluded.
- The individual next deposits $100 in excludable funds. Of the new $300 balance, $200 is excluded.

3. Interest

A $1,000 savings account includes $800 in excluded disaster assistance when a $10 interest payment is posted. Since 80 percent of the account balance is excluded at the time the interest is posted, 80 percent of the interest ($8) is excluded. The amount of excluded funds now in the account is $808.

DETERMINING THE COUNTABLE VALUE OF *HOME & CONTIGUOUS* PROPERTY

Definitions

1. *"Assessed value" means the tax assessed value that a tax assessor's office places on real property for tax purposes; the tax assessed value is the current fair market value (FMV) of real property. In Virginia, all real property is assessed at 100% of its current FMV, so the assessed value of real property is the current FMV of the property.*

2. *"Equity value" means the property's assessed value minus the balance due on the lien (a mortgage or a court-ordered judgment) against the property,* ***when the lien is in the Medicaid applicant's name, when the Medicaid applicant is one of the individuals listed on the lien, or when the Medicaid applicant is one of the owners subject to the lien, meaning that he is responsible for paying the lien. If the Medicaid applicant is not subject to the lien, the balance due on the lien is not subtracted from the value of the property. If the Medicaid applicant is one of two or more individuals subject to the lien, then ONLY the Medicaid applicant's fractional share of the lien balance is deducted from the applicant's share of the property's value.***

3. *"Home property exclusion" means an exclusion for the plot of land on which the home is located. The excluded home lot size may vary according to the locality's building requirements. For localities with a set minimum building lot size, use the lesser of:*
   - *the plat;*
   - *the survey; or*
   - *the locality's minimum size for a building lot.*

   For localities with no minimum building lot requirements, use the lesser of:
   - *the plat;*
   - *the survey; or*
   - *one acre.*

   If the equity value of countable contiguous property causes resources to exceed the maximum limit, re-evaluate the home property applying the definition of the home used in the State Plan for Medical Assistance in Virginia in effect on January 1, 1972. At that time, a "home" meant the house and lot used as the individual's principal residence and all contiguous property ***essential to the operation of the home regardless of value (M1130.100 B.2)****.*

4. *"Life estate interest" is a limited type of ownership in real property. A life estate conveys to the individual to whom it is given certain property rights for the duration of his or her life, or someone else's life. In some cases, it may be conditional: e.g., for life or until remarriage. The owner of a life estate can sell the life estate interest but does not have title to the property and normally cannot sell the property or pass it on as an inheritance.*

5. *"Remainderman" is the term used when an individual has an ownership interest in the real property, but does not have the right to possess and use the property until termination of the life estate interest.*

A. Procedure #1: Property Owned by One Owner

Step 1 - Determine the *whole* property's assessed value, the assessed value of the excluded house and homesite, and *determine* the balance due on all liens against the property *if the Medicaid applicant is subject to the lien(s).*

Step 2 - Assessed value of excluded house and homesite
+ $5,000 Exclusion
Excluded property value

Step 3 - *Whole* property assessed value
- Excluded property value
Contiguous property *assessed* value

Step 4 - Contiguous property *assessed* value
÷ *Whole* property assessed value
Portion of *whole* property value represented by the contiguous property
x Balance due on the lien(s) *in applicant's name*
Contiguous property lien amount

Step 5 - Contiguous property *assessed* value
- Contiguous property lien amount
Contiguous property equity value = *Contiguous property countable value*

Step 6 – If the contiguous property's countable value causes excess resources, determine if the contiguous property can be excluded for another reason, such as income-producing. Re-evaluate the home property applying the definition of the home used in the State Plan for Medical Assistance in Virginia in effect on January 1, 1972. At that time, a "home" meant the house and lot used as the principal residence and all contiguous property ***essential to the operation of the home regardless of value****.*

EXAMPLE #1 (one-owner property, *not re-evaluated*):

Example #1, Step 1:

Whole property assessed value = $81,500
Assessed value of homesite (the excluded house, homesite, buildings, etc.) = $64,000
Balance due on property's mortgage *(applicant is the only owner subject to the lien)* = $72,000

Example #1, Step 2:

$64,000 Assessed value of *house &* homesite
+ 5,000 Exclusion
69,000 Excluded property value

Example #1, Step 3:

$81,500 *Whole* property assessed value
- 69,000 Excluded property value
$12,500 Contiguous property *assessed* value

Example #1, Step 4:

$ 12,500.00 Contiguous property *assessed* value
÷ 81,500.00 Total property assessed value
.1533 Portion of *whole* property value represented by the contiguous property
x 72,000.00 Balance due on lien
11,037.60 Contiguous property lien amount

Example #1, Step 5:

$12,500.00 Contiguous property *assessed* value
- 11,037.60 Contiguous property lien amount
$ 1,462.40 Contiguous property equity value

Example #1, Step 6:

The property does not produce any income and is not used to produce goods or services that are essential to the operation of the home.

$ 1,462.40 contiguous property *countable* value

B. Procedure #2: Joint Ownership, Undivided Estate or Unprobated Estate, *one owner subject to lien*

Step 1 - Determine the *whole* property's assessed value, the assessed value of the excluded house and homesite, and *determine* the balance due on all liens against the property *if the Medicaid applicant is subject to the lien(s).*

Step 2 - **When a partition suit is necessary to liquidate the property** *because at least one owner does not agree to sell the contiguous property***:** Determine the shared partition costs for liquidating the property. Use the average cost of partitioning in the locality where the property is located, based on the **assessed** (not equity) value of the *whole* property.

If a partition suit is NOT necessary to liquidate the property (all the owners agree to sell it), **do not** subtract any partition costs or attorneys' fees; insert zeros in the formula in place of partition costs and attorney's fees.

Step 3 - Assessed value homesite property
+ $5,000 Exclusion
Excluded property value

Step 4 - *Whole* property assessed value
- Shared partition costs
Countable assessed value
- Excluded property value
Contiguous property *assessed* value

Step 5 - Contiguous property *assessed* value
÷ *Whole* property assessed value
Portion of *whole* property value represented by the contiguous property
x Balance due on the lien(s)
Contiguous property lien amount
÷ *Number of owners subject to lien*
Applicant's share of contiguous property lien amount

Step 6 - Contiguous property *assessed* value
÷ *Applicant's ownership share*
Applicant's share of contiguous property assessed value
- *Applicant's share of contiguous property lien amount*
Applicant's share contiguous property equity value
- Applicant's attorney fees
Contiguous property countable value

Step 7 – If the contiguous property's countable value causes excess resources, determine if the contiguous property can be excluded for another reason, such as income-producing. Re-evaluate the home property applying the definition of the home used in the State Plan for Medical Assistance in Virginia in effect on January 1, 1972. At that time, a "home" meant the house and lot used as the principal residence and all contiguous property ***essential to the operation of the home regardless of value****.*

EXAMPLE #2 (undivided joint ownership, ***one owner subject to lien, not re-evaluated*****):**

An applicant owns a 1/3 interest in his home, lot, and 4 acres of contiguous property. There is a lien on this property with a balance due of $10,000. *The applicant is the only owner subject to the lien.* The assessed value of the house and homesite lot is *$40,000* and the 4 acres of contiguous property has an assessed value of $60,000 ($100,000 *is the whole property's* assessed value). *One owner, not the applicant, does not agree to sell the contiguous property.* The estimated shared cost of partitioning is $2,000 and the applicant's attorney's fees will be $1,000.

Example #2, Step 1:

Whole property's assessed value = $100,000
Assessed value of homesite (the excluded house, homesite, buildings, etc.) = $40,000
Contiguous property (4 acres) = $60,000
Balance due on *whole* property's mortgage = $10,000

Example #2, Step 2:

Shared partition costs = $2,000
Applicant's attorney's fees = $1,000

Example #2, Step 3:

$ 40,000 Assessed value of homesite
+ 5,000 Exclusion
45,000 Excluded property value

Example #2, Step 4:

$100,000 *Whole* property assessed value
- 2,000 Shared partition costs
98,000 Countable assessed value
- 45,000 Excluded property value
53,000 Contiguous property *assessed* value

Example #2, Step 5:

$ 53,000 Contiguous property *assessed* value
÷ 100,000 *Whole* property assessed value
.53 Portion of *whole* property value represented by the contiguous property
x 10,000 Balance due on the lien(s)
5,300 Contiguous property lien amount
÷ *1 Number of owners subject to lien*
5,300 Applicant's share of contiguous property lien amount

Example #2, Step 6:

$ 53,000.00 Contiguous property *assessed* value
÷ 3 *Applicant's ownership share*
17,666.67 Applicant's share of contiguous property assessed value
- *5,300.00 Applicant's share of contiguous property lien amount*
12,366.67 Applicant's share contiguous property equity value
- 1,000.00 Applicant's attorney fees
$11,366.67 **Contiguous property *equity* value**

Example #2, Step 7:

The property does not produce any income and is not used to produce goods or services that are essential to the operation of the home.

***$11,366.67 c*ontiguous property countable value**

C. Procedure #3: Re-evaluated homesite, *partition required, multiple owners subject to lien*

Step 1 - Determine the *whole* property's assessed value, the assessed value of the excluded house and homesite, and *determine* the balance due on all liens against the property *if the Medicaid applicant is subject to the lien(s). If another owner is subject to the lien, calculate the applicant's share of the lien balance by dividing the lien balance by the number of owners subject to the lien. The formula will calculate the applicant's share of the lien balance that is against the contiguous property.*

Step 2 - **When a partition suit is necessary to liquidate the property:** Determine the shared partition costs for liquidating the property. Use the average cost of partitioning in the locality where the property is located, based on the **assessed** (not equity) value of the *whole* property.

If a partition suit is NOT necessary to liquidate the property (all the owners agree to sell it), do not subtract any partition costs or attorney's fees; insert zeros in the formula in place of partition costs and attorney's fees.

Step 3 - Assessed value *house &* homesite property
+ $5,000 exclusion
Excluded property value

Step 4 - Total property assessed value
- Shared partition costs
Countable assessed value
- Excluded property value
Contiguous property *assessed* value

Step 5 - Contiguous property *assessed* value
÷ *Whole* property assessed value
Portion of *whole* property value represented by the contiguous property
x Balance due on the lien(s)
Contiguous property lien amount
÷ *Number of owners subject to lien*
Applicant's share of contiguous property lien amount

Step 6 - Contiguous property *assessed* value
÷ *Applicant's ownership share*
Applicant's share of contiguous property assessed value
- *Applicant's share of contiguous property lien amount*
Applicant's share contiguous property equity value
- Applicant's attorney fees
Contiguous property countable value

Step 7 – If the applicant's countable equity in the contiguous property causes excess resources, re-evaluate the *property using the 1972 definition of* homesite to determine if the use of the contiguous land would mean more property excluded as the homesite. The $5,000 exclusion is NOT *applied* when the homesite is re-evaluated *using the 1972 definition of home and homesite*.

Determine how much of the contiguous property is actually used by the household as part of the homesite.

Step 8 - Assessed value of house and homesite
+ Value of additional contiguous property used for homesite
Excluded property value

Step 9 - *Whole* property assessed value
- Excluded property value
Contiguous property *assessed* value

Step 10 - Contiguous property *assessed* value
÷ *Whole* property assessed value
Portion of *whole* property value represented by the contiguous property
x Balance due on the lien(s)
Contiguous property lien amount
÷ *Number of owners subject to lien*
Applicant's share of contiguous property lien amount

Step 11 – Contiguous property *assessed* value
÷ *Applicant's ownership share*
Applicant's share of contiguous property assessed value
- *Applicant's share of contiguous property lien amount*
Applicant's share contiguous property equity value
- Applicant's attorney fees
Re-evaluated contiguous property countable value

Use the lesser of the Contiguous Property Countable Value *and the Re-evaluated Contiguous Property Countable Value*.

Step 12: If the individual still has excess resources, evaluate the contiguous property to determine if it can be excluded for another reason or a disregard applied, such as the exclusion or disregard applicable to income-producing property.

EXAMPLE #3 (re-evaluated homesite, *partition required, multiple owners subject to lien*):

Example #3, Step 1:

Applicant owns a 1/3 undivided share in his house, homesite and 10 contiguous acres; the *whole* property is *assessed at* $100,000. A partition suit is necessary to liquidate the contiguous property *because one*

owner does not agree to sell the property. The lien on the property is in the 3 owners' names, so the 3 owners are subject to the lien. The property does not produce any income to the applicant.

Assessed value of *whole* property = $100,000
Assessed value of homesite (the excluded house, homesite, buildings, etc.) = $40,000
Contiguous property assessed value = $60,000
Balance due on entire property's mortgage = *$12,000*

Example #3, Step 2:

Shared partition costs = $2,000
Applicant's attorney's fees = $1,000

Example #3, Step 3:

$ 40,000	Assessed value of homesite
+ 5,000	Exclusion
45,000	Excluded property value

Example #3, Step 4:

$100,000	*Whole* property assessed value
- 2,000	Shared partition costs
98,000	Countable assessed value
- 45,000	Excluded property value
53,000	Contiguous property *assessed* value

Example #3, Step 5:

$ 53,000	Contiguous property *assessed* value
÷ 100,000	*Whole* property assessed value
.53	Portion of *whole* property value represented by the contiguous property
x *12,000*	Balance due on the lien(s)
$ 6,360	*C*ontiguous property lien amount
÷ *3*	*Number of owners subject to lien*
2,120	*Applicant's share of contiguous property lien amount*

Example #3, Step 6:

$53,000.00	Contiguous property *assessed* value
÷ *1/3*	*Applicant's ownership share*
17,666.67	*Applicant's share of contiguous property assessed value*
- *2,120.00*	*Applicant's share of contiguous property lien amount*
15,546.67	*Applicant's share contiguous property equity value*
- 1,000.00	Applicant's attorney fees
14,546.67	Contiguous property countable value

$14,546.67 causes the applicant to have excess resources, so the homesite is re-evaluated for actual use *using the 1972 definition of homesite*.

Example #3, Step 7:

The applicant says that of the contiguous 10 acres, 1 is used for a garden to grow produce used by the household, 1 acre is used for the livestock raised for home consumption, ½ acre is used for the family cemetery, and 1 acre is used for the septic system; a total of 3.5 additional acres are used as the homesite. *The property does not produce any income.*

Assessed value of *whole* property = $100,000
Assessed value of homesite (the excluded house, homesite, buildings, etc.) = $40,000
Assessed value 10 contiguous acres = $60,000 ÷ 10 = 6,000 per acre
$6,000 value per acre x 3.5 acres = $21,000 additional property value excluded *as homesite*

Example #3, Step 8:

$ 40,000 Assessed value of homesite
+ 21,000 Value of additional property excluded as homesite
$ 61,000 Excluded property value

Example #3, Step 9:

$100,000 *Whole* property assessed value
- 2,000 Shared partition costs
98,000 Countable assessed value
- 61,000 Excluded property value
37,000 Contiguous property *assessed* value

Example #3, Step 10:

$ 37,000.00 Contiguous property *assessed* value
÷ 100,000.00 *Whole* property assessed value
.37 Portion of property value represented by the contiguous property
x *12,000.00* Balance due on the lien(s)
$ *4,440.00* Contiguous property lien amount
÷ *3* *Number of owners subject to lien*
1,480.00 *Applicant's share of contiguous property lien amount*

Example #3, Step 11:

$ 37,000.00 Contiguous property *assessed* value
÷ *1/3* *Applicant's ownership share*
12,333.33 *Applicant's share of contiguous property assessed value*
- *1,480.00* *Applicant's share of contiguous property lien amount*
10,853.33 *Applicant's share contiguous property equity value*
- 1,000.00 Applicant's attorney fees
9,853.33 *Re-evaluated* contiguous property countable value

Because *the $9,853.33 re-evaluated value* is less than *the $14,546.67 value first determined,* the countable value of the applicant's contiguous property is *$9,853.33.* The applicant has excess resources and is not eligible for ABD Medicaid.

D. Procedure #4: One Owner (Remainderman), One Life Interest Owner, Lien

Step 1 – When the Medicaid applicant is a remainderman and lives on the property in which he owns a remainder interest, determine the age of the life interest owner, determine the whole property's assessed value, the assessed value of the excluded house and homesite, and determine the balance due on all liens against the property if the Medicaid applicant is subject to the lien(s). No estimated costs of selling the remainder interest are deducted from the countable value.

Step 2 – Calculate the assessed value of the contiguous property:

Assessed value of excluded house and homesite
+ $5,000 Exclusion
Excluded property value

Whole property assessed value
- Excluded property value
Contiguous property assessed value

Step 3 – The applicant is the remainderman on this property – determine the value of the remainder interest in the contiguous property which will be countable EVEN IF the life interest holder does NOT agree to sell the life interest.

Contiguous property assessed value
X Remainder interest factor based on life interest owner's age (from table in M1140.120)
Remainder interest value

Step 4 – Calculate the contiguous property lien amount – the portion of the lien that is against the contiguous property:

Contiguous property assessed value
÷ Whole property assessed value
Portion of whole property value represented by the contiguous property
x Balance due on the lien(s) to which applicant is subject
Contiguous property lien amount

Step 5 – Calculate the countable value of the remainder interest in contiguous property:

Remainder interest value
- Contiguous property lien amount
Countable value of remainder interest in contiguous property

Step 6 - If the contiguous property's countable value causes excess resources, determine if the contiguous property can be excluded for another reason, such as income-producing. Re-evaluate the home property applying the definition of the home used in the State Plan for Medical Assistance in Virginia in effect on January 1, 1972. At that time, a "home" meant the house and lot used as the principal residence and all contiguous property ***essential to the operation of the home regardless of value****.*

Example #4 - One Owner (Remainderman), One Life Estate Owner, Lien:

Example #4, Step 1:

Whole property assessed value = $81,500
Assessed value of homesite (the excluded house, homesite, buildings, etc.) = $64,000
Balance due on property's lien (applicant is the only owner subject to the lien) = $10,000
Life interest owner is 71 years old

Example #4, Step 2:

$64,000 Assessed value of excluded house and homesite
+ 5,000 Exclusion
$69,000 Excluded property value

$81,500 Whole property assessed value
- 69,000 Excluded property value
$12,500 Contiguous property assessed value

Example #4, Step 3:

The life interest owner is 71 years old.

$ 12,500.00 Contiguous property assessed value
X .41086 Remainder interest factor based on life interest owner's age (from table in M1140.120)
$ 5,135.75 Remainder interest value

Example #4, Step 4:

$ 12,500 Contiguous property assessed value
÷ 81,500 Whole property assessed value
.1534 Portion of whole property value represented by the contiguous property
X 10,000 Balance due on the lien(s)
$ 1,534 Contiguous property lien amount

Example #4, Step 5:

$5,135.75 Remainder interest value
- 1,534.00 Contiguous property lien amount
$3,601.75 Countable value of remainder interest in contiguous property

Example #4, Step 6:

The contiguous property's countable value of $3,601.75 causes excess resources. The contiguous property does not produce any income. The home property is re-evaluated for actual use using the 1972 definition of home property.

The applicant says that of the contiguous 5 acres, 1 acre is used for a garden to grow produce used by the household and 1 acre is used for the septic system; a total of 2 additional acres are used as the homesite.

Assessed value of whole property = $81,500
Assessed value of homesite (the excluded house, homesite, buildings, etc.) = $64,000
Assessed value 5 contiguous acres = $17,500 ÷ 5 = $3,500 per acre
$3,500 value per acre x 2 acres = $7,000 additional property value excluded as essential to homesite

$64,000 Assessed value of home & homesite
+ 7,000 Value of additional property excluded as homesite
$ 71,000 Excluded home property value

$81,500 Assessed value of whole property
-71,000 Excluded home property value
10,500 Contiguous property assessed value

The life interest owner is 71 years old.

$ 10,500.00 Contiguous property assessed value
X .41086 Remainder Interest Factor Based on Life Interest Owner's Age (from table in M1140.120)
$4,314.03 Remainder interest value

$ 10,500 Contiguous property assessed value
÷ 81,500 Whole property assessed value
.1288 Portion of whole property value represented by the contiguous property
X 10,000 Balance due on the lien(s)
$ 1,288 Contiguous property lien amount

$4,314.03 Remainder interest value
-1,288.00 Contiguous property lien amount
$3,026.03 Re-evaluated countable value of remainder interest in contiguous property

Because $3,026.03 is less than $3,601.75, the re-evaluated countable value of the applicant's remainder interest in the contiguous property is used for the contiguous property countable value, and is added to all other resources to determine eligibility.

$3,026.03 contiguous property countable value.

E. Procedure #5: Joint Owners (Remaindermen), One Life Estate Owner, Lien

This is home and contiguous real property that is owned jointly (undivided estate) and is subject to a life interest owner; the Medicaid applicant is one of the owners (remaindermen). The Medicaid applicant lives on the property in which he owns a remainder interest. Because there is a life interest owner of this property and life estate property cannot be divided, ***no*** *estimated partition costs & attorney's fees are deducted from the value of the Medicaid applicant's remainder share.*

Step 1 - Determine the total property assessed value, the assessed value of the excluded house and homesite, the balance due on all liens against the property if the applicant is subject to the lien, and the age of the life interest owner.

Step 2 – Calculate the assessed value of the contiguous property:

Assessed value of excluded house and homesite
+ $5,000 Exclusion
Excluded property value

Whole property assessed value
- Excluded property value
Contiguous property assessed value

Step 3 – The applicant is one of the remaindermen owners of this property – determine the value of the remainder interest in the contiguous property which will be countable EVEN IF the life interest holder does NOT agree to sell the life interest.

Contiguous property assessed value
X Remainder interest factor based on life interest owner's age (from table in M1140.120)
Remainder interest value

Step 4 – Calculate the contiguous property lien amount – the portion of the lien that is against the contiguous property:

Contiguous property assessed value
÷ Whole property assessed value
Portion of whole property value represented by the contiguous property
x Balance due on the lien(s) to which the applicant is subject
Contiguous property lien amount

Step 5: Calculate the equity value of applicant's share of the remainder interest in contiguous property:

Remainder interest value
÷Number of remaindermen (joint owners of property)
Applicant's share of remainder interest
- Contiguous property lien amount
Equity value of applicant's remainder interest = Countable value of contiguous property

Step 6 - If the countable value of the contiguous property causes excess resources, determine if the contiguous property can be excluded for another reason, such as income-producing. Re-evaluate the home property applying the definition of the home used in the State Plan for Medical Assistance in Virginia in effect on January 1, 1972. At that time, a "home" meant the house and lot used as the principal residence and all contiguous property ***essential to the operation of the home regardless of value****.*

Example #5 Joint Owners (Remaindermen), One Life Estate Owner, Lien

An applicant owns ½ remainder interest (2 owners) in non-home, non-business real property; there is one life interest owner, age 80. There is a lien on this property and the applicant is the only remainderman owner subject to the lien. The lien balance due is $10,000. The assessed value of the property is $181,500. The life interest owner agrees to sell, but the other remainderman owner does not agree to sell. No estimated costs of partitioning or selling the property are deducted.

Example #5, Step 1:

Whole property assessed value = $181,500
Assessed value of homesite (the excluded house, homesite, buildings, etc.) = $64,000
Balance due on property's lien (applicant is the only owner subject to the lien) = $10,000

***Example #5, Step 2**: – Calculate the assessed value of the contiguous property:*

$64,000 Assessed value of excluded house and homesite
+ 5,000 Exclusion
$69,000 Excluded property value

$181,500 Whole property assessed value
- 69,000 Excluded property value
$112,500 Contiguous property assessed value

***Example #5, Step 3** –Determine the value of the remainder interest in the contiguous property; life interest owner is 80 years old.*

$112,500.00 Contiguous property assessed value
X .56341 Remainder interest factor based on life interest owner's age (from table in M1140.120)
$63,383.63 Remainder interest value

***Example #5, Step 4** – Calculate the contiguous property lien amount – the portion of the lien that is against the contiguous property:*

$112,500 Contiguous property assessed value
÷181,500 Whole property assessed value
.6198 Portion of whole property value represented by the contiguous property
x 10,000 Balance due on the lien(s)
$ 6,198 Contiguous property lien amount

***Example #5, Step 5:** Calculate the equity value of applicant's share of the remainder interest in contiguous property:*

$63,383.63 Remainder interest value
÷ 2 Number of remaindermen (joint owners of property)
$31,691.82 Applicant's share in remainder interest in contiguous property
- 6,198.00 Contiguous property lien amount
$25,493.82 Equity value of applicant's remainder interest

$25,493.82 countable value of contiguous property

Example #5, Step 6:

The $25,493.82 countable value of the contiguous property causes excess resources. The contiguous property cannot be excluded because it does not produce income. The home property must be re-evaluated for actual use using the 1972 home property definition.

The applicant says that of the contiguous 5 acres, 1 acre is used for a garden to grow produce used by the household and 1 acre is used for the septic system; a total of 2 additional acres are used as the homesite. The property does not produce any income.

Assessed value of whole property = $181,500
Assessed value of homesite (the excluded house, homesite, buildings, etc.) = $64,000
Assessed value 5 contiguous acres = $117,500 ÷ 5 = $23,500 per acre
$23,500 value per acre x 2 acres = $47,000 additional property value excluded as essential to homesite

$ 64,000 Assessed value of home & homesite
+ 47,000 Value of additional property excluded as homesite
$111,000 Excluded home property value

$181,500 Assessed value of whole property
-111,000 Excluded home property value
$ 70,500 Contiguous property assessed value

The life interest owner is 80 years old.

$ 70,500.00 Contiguous property assessed value
X .56341 Remainder interest factor based on life interest owner's age (from table in M1140.120)
$39,720.41 Remainder interest value

$ 70,500 Contiguous property assessed value
÷ 181,500 Whole property assessed value
.3884 Portion of whole property value represented by the contiguous property
X 10,000 Balance due on the lien(s)
$ 3,884 Contiguous property lien amount

$39,720.41 Remainder interest value
- 3,884.00 Contiguous property lien amount
$35,836.41 Re-evaluated countable value of remainder interest in contiguous property

Because the $35,836.41 re-evaluated countable value is less than $39,720.41, the re-evaluated value of the applicant's remainder interest in the contiguous property, $35,836.41, is used for the contiguous property countable value of the property and is added to all other resources to determine eligibility.

$35,836.41 contiguous property countable value

ABD Home Property Evaluation Worksheet

I. $5,000 Exclusion

1. **Assessed Value (AV)**
   (1a) *House & homesite* _____
   (1b) Contiguous +_____
   (1c) Total AV =_____

2. **Enter Lien *Balance Due*** _____

3. AV *house & homesite (*1a) _____
4. Exclusion +$5,000
5. Excluded Property =_____

6. Total AV (1c) _____
7. *Partition Costs -_____
8. Countable AV =_____

9. Excluded Property (5) -_____

10. Contiguous Property *AV*=_____

11. Total AV (1c) ÷_____
12. % Contiguous Property =_____

13. Lien *Balance* (2) X_____

14. Lien on ***Contiguous*** Property =_____

15. Contiguous Property *AV* (10) _____

16. Lien on Contiguous Property (14) -_____

17. Equity in Contiguous Property =_____

18. Applicant's Share ÷_____

19. Countable Equity Contiguous Property =_____

20. *Applicant's Attorney Fees -_____

21. Countable Equity *in* Contiguous Property =_____

If countable equity + all other countable resources exceed resource limit, go to Section II.

Use if jointly owned, undivided or unprobated estate *and partition is required

II. *January 1972* Use of Land *Home* Exclusion

22. #Acres Used/Essential to Home _____
23. Assessed Value Per Acre X_____
24. *Additional* Exclusion =_____

25. AV House *& homesite (1a)* _____

26. *Additional* Exclusion (24) +_____

27. Excluded Property =_____

29. Total AV (1c) _____

30. *Partition Costs -_____

31. Countable AV =_____

32. Excluded Property (27) -_____

33. Contiguous Property *AV*=_____

34. Total AV (1c) ÷_____

35. % Contiguous Property =_____

36. Lien *Balance* (2) X_____

37. Lien on ***Contiguous*** Property =_____

38. Contiguous Property *AV* (33) _____

39. Lien *on* Contiguous Property (37) -_____

40. Equity in Contiguous Property =_____

41. Applicant's Share ÷_____

42. Countable Equity Contiguous Property =_____

43. *Applicant's Attorney Fees -_____

43. Countable Equity/Contiguous Property =_____

Compare line 21 to line 43. Countable resource is the lesser of the two.

Burial Fund Designation

CASE NAME
CASE NUMBER

I hereby designate the funds described below for burial.

RESOURCE DESIGNATED		OWNER	
Description (Include name of financial institution, insurance company, location, account number or policy number, etc.)	**Designated for Whom**	**Date First Considered Designated**	**Value**

RESOURCE DESIGNATED		OWNER	
Description (Include name of financial institution, insurance company, location, account number or policy number, etc.)	**Designated for Whom**	**Date First Considered Designated**	**Value**

RESOURCE DESIGNATED		OWNER	
Description (Include name of financial institution, insurance company, location, account number or policy number, etc.)	**Designated for Whom**	**Date First Considered Designated**	**Value**

SIGNATURE	DATE

DETERMINING THE COUNTABLE VALUE OF NON-HOME REAL PROPERTY

Definitions

1. "Assessed value" means the tax assessed value that the tax assessor's office places on the real property for tax purposes; the tax assessed value is the current fair market value (FMV) of the real property. In Virginia, all real property is assessed at 100% of its current FMV, so the assessed value of the real property is the current FMV of the property.

2. "Equity value" means the property's assessed value minus the balance due on the lien (a mortgage or a court-ordered judgment) against the property, **when the lien is in the Medicaid applicant's name, when the Medicaid applicant is one of the individuals listed on the lien, or when the Medicaid applicant is one of the owners subject to the lien, meaning responsible for paying the lien. If the Medicaid applicant is not subject to the lien, the balance due on the lien is not subtracted from the value of the property. If the Medicaid applicant is one of two or more individuals subject to the lien, then ONLY the Medicaid applicant's fractional share of the lien balance is deducted from the applicant's share of the property's value.**

3. "Life estate interest" is a limited type of ownership in real property. A life estate conveys to the individual to whom it is given certain property rights for the duration of his or her life, or someone else's life. In some cases, it may be conditional: e.g., for life or until remarriage. The owner of a life estate can sell the life estate interest but does not have title to the property and normally cannot sell the property or pass it on as an inheritance.

4. "Remainderman" is the term used when an individual has an ownership interest in the real property, but does not have the right to possess and use the property until termination of the life estate interest.

A. Procedure A: Non-business Real Property Owned by One Owner, Not Producing Income

Step 1 - Determine the total property assessed value and the balance due on all liens against the property that are in the applicant's name.

Step 2 - Property assessed value
- Lien amount balance (when Medicaid applicant is subject to the lien)
Equity value

Example A1 (one-owner non-business, non-income-producing property):

Example #A1, Step 1:

Total property assessed value = $81,500
Balance due on property's mortgage (applicant is subject to the lien) = $72,000

Example #A1, Step 2:

$81,500 Total property assessed value
- 72,000 Lien balance
$ 9,500 Equity value

$9,500 is countable value

B. Procedure B: Non-business Real Property Owned by One Owner, producing income

Step 1 - Determine the total property assessed value and the balance due on all liens against the property to which the Medicaid applicant is subject.

Step 2 - Property assessed value
- Lien amount balance (the applicant is subject to the lien)
Equity value of property

Step 3 - The real property is not business property, so determine if the $6,000 disregard applies to the property because the property is essential to self-support (S1130.502 and S1130.503):

Ask: Does property produce goods/services essential to the individual's daily activities?

If yes, subtract the $6,000 disregard from the equity value, regardless of how much income the property produces – no rate of return is calculated.

If no, does the property produce net annual income (after all expenses are subtracted from the gross annual income produced by the property) that equals or exceeds 6% of the property's **excluded equity** value?

If yes, subtract the $6,000 disregard from the equity value.

If no, do not subtract the $6,000 disregard.

Example B1 (one-owner non-business, income-producing property, essential to daily living - M1130.502):

Example #B1, Step 1:

Total property assessed value = $81,500
Balance due on property's mortgage (applicant is subject to the lien) = $72,000

Example #B1, Step 2:

$81,500 Total property assessed value
- 72,000 Lien balance
$ 9,500 Equity value

Example #B1, Step 3:

Does property produce goods/services essential to the individual's daily activities?

Yes – property is used as a garden for the individual's household's consumption – only any excess not used by the household is sold, and the individual receives only $100 a year from selling the excess. Rate of return is not calculated because the property is used to produce goods essential to the individual's daily activities.

$ 9,500 Equity value
- 6,000 Disregard
$ 3,500 Countable value of property

Example #B2 (one-owner non-business, income-producing property, NOT essential to daily living – M1130.503):

Example #B2, Step 1:

Total property assessed value = $90,500
Balance due on property's mortgage (applicant is subject to the lien) = $70,000

Example #B2, Step 2:

$90,500 Total property assessed value
- 70,000 Lien balance
$20,500 Equity value

Example #B2, Step 3:

Does property produce goods/services essential to the individual's daily activities? No.

Does the property produce net annual income (after all expenses are subtracted from the gross annual income produced by the property) that equals or exceeds 6% of the excluded equity value? Because the equity value is over $6,000, the excluded equity value cannot exceed $6,000; the rate of return is calculated on the maximum $6,000 excluded equity value.

Calculate rate of return:

$10,000 Gross annual income from property
- 2,000 Annual expenses to produce income
$ 8,000 Net annual income from property

$6,000 Excluded equity value of property
X .06 6%
$ 360 6% of equity

Because $8,000 net annual income from the property exceeds $360 (6% of the excluded equity value), the property produces the required rate of return and the $6,000 disregard is subtracted from the equity value to determine the countable value of the property:

$ 20,500 Equity value
- 6,000 Disregard
$ 14,500 Countable value of property

Example #B3 (one-owner non-business, income-producing, NOT essential, equity < $6,000 – M1130.503):

Example #B3, Step 1:

Total property assessed value = $12,500
Balance due on property's mortgage (applicant is subject to the lien) = $7,000

Example #B3, Step 2:

$12,500 Total property assessed value
- 7,000 Lien balance
$ 5,500 Equity value

Example #B3, Step 3:

Does property produce goods/services essential to the individual's daily activities? No.

Does the property produce net annual income (after all expenses are subtracted from the gross annual income produced by the property) that equals or exceeds 6% of the excluded equity value? Yes.

Calculate rate of return:

$2,000 Gross annual income from property
- 100 Annual expenses to produce income
$1,900 Net annual income from property

$5,500 Equity value of property
X .06 6%
$ 330 6% equity

Because the $1,900 net annual income from the property exceeds $330 (6% of the excluded equity value of $5,500), the property produces the required rate of return and the $6,000 disregard is applicable. Because the equity value of the property is less than $6,000, the entire equity value is subtracted from the equity value to determine the countable value of the property:

$ 5,500 Equity value
-5,500 Disregard
$ 0 Countable value of property

C. Procedure C: Real Property Owned by One Owner (Remainderman) and One Life Interest Owner

Step 1 - Determine the age of the life interest owner, the property's assessed value and the balance due on the lien against the property when the applicant is subject to the lien. If there is more than one owner subject to the lien, determine the number of owners subject to the lien.

Step 2 - The applicant is the remainderman on this property – determine the value of the remainder interest in the property which will be countable EVEN IF the life interest holder does NOT agree to sell the life interest. No estimated costs of selling the remainder interest are deducted:

Assessed value of property
X Remainder interest factor based on life interest owner's age (from table in M1140.120)
Remainder interest value
- Lien balance (or portion) if applicant is subject to the lien
Countable value of remainder interest in property

Example #C1 - Real Property Owned by One Owner (Remainderman) and One Life Interest Owner:

Example #C1, Step 1:

Total property assessed value = $81,500
Balance due on property's mortgage; applicant is NOT subject to the lien = $72,000

Example #C1, Step 2:

The life interest owner's age is 60 years old.

$81,500.00 Assessed value
X .25509 Factor from table for life interest owner 60 years old
$20,789.84 Remainder interest value
- 0 Lien balance (applicant is not subject to the lien)
$20,789.84 Equity value of remainder interest

$20,789.84 countable value of real property

D. Procedure D: Joint Ownership - Undivided Estate or Unprobated Estate

This is non-home real property that is owned jointly (undivided estate).

Step 1 - Determine the total property assessed value and the balance due on all liens against the property to which the applicant is subject. If there is more than one owner subject to the lien, determine the number of owners subject to the lien.

Step 2 - **When a partition suit is necessary to liquidate the property:** Determine the shared partition costs for liquidating the property. Use the average cost of partitioning in the locality where the property is located, based on the **assessed** (not equity) value of the TOTAL property.

If a partition suit is NOT necessary to liquidate the property (all the owners agree to sell it), do not subtract any partition costs or attorneys' fees; insert zeros in the formula in place of partition costs and attorneys fees.

Step 3 - Assessed value of property
- Shared partition costs
Assessed value less shared partition costs

Step 4 - Assessed value less shared partition costs
÷ Applicant's ownership share of property
Applicant's share
- Balance due on the lien(s) (or portion) when applicant is subject to the lien
- Applicant's attorney fees
Applicant's equity value

Step 5 – When the property produces income to the applicant, determine if the $6,000 disregard can be subtracted from the Applicant's Equity Value (S1130.502 and S1130.503):

Ask: Does property produce goods/services essential to the individual's daily activities?

If yes, subtract the $6,000 from the Applicant's Equity Value, regardless of how much income the property produces to the applicant – no rate of return is calculated.

If no, does the property produce net annual income (after all expenses are subtracted from the gross annual income produced by the property) that equals or exceeds 6% of the property's **excluded equity** value (the excluded equity value cannot exceed $6,000)? If yes, subtract the $6,000 disregard from the Applicant's Equity Value. If no, do not subtract the $6,000 disregard.

Example #D1 (undivided joint ownership, producing income):

Example #D1 - An applicant owns a 1/3 interest in non-home, non-business real property. There is a lien on this property; the applicant and another owner are subject to the lien that has a balance due of $10,000. The assessed value of the property is $100,000. A co-owner does not agree to sell, so a partition suit is required to sell the property. The estimated shared cost of partitioning is $2,000 and the applicant's attorney's fees will be $1,000. The property produces $200 per year gross income to the applicant; there are no expenses to produce the income.

Example #D1, Step 1:

Assessed value of total property = $100,000
Balance due on entire property's mortgage = $10,000
Applicant's one-half share of lien balance = $5,000

Example #D1, Step 2:

Shared partition costs = $2,000
Applicant's attorney's fees = $1,000

Example #D1, Step 3:

$100,000 Total property assessed value
- 2,000 Shared partition costs
98,000 Assessed value less shared partition costs

Example #D1, Step 4:

$98,000 Assessed value less shared partition costs
÷ 3 Applicant's ownership share of property owners
$32,666.67 Applicant's share
- 5,000.00 Applicant's share of balance due on the lien
- 1,000.00 Applicant's attorney fees
$26,666.67 Applicant's equity value

Example #D1, Step 5:

Does property produce goods/services essential to the individual's daily activities? No

Does the property produce net annual income (after all expenses are subtracted from the gross annual income produced by the property) to the applicant that equals or exceeds 6% of the excluded equity value ($6,000)? If yes, subtract the $6,000 disregard from the Applicant's Equity Value. If no, do not subtract the $6,000 disregard.

Calculate rate of return:

$6,000 Excluded equity value of property
X .06 6%
$ 360 6% Rate of Return

Since the annual net income received from the property is $200, which is **less than** the required rate of return of $360, the $6,000 disregard **is not** subtracted when determining the countable value of the property:

$26,666.67 Applicant's equity value
- 0 Disregard
$26,666.67 Countable value of real property

E. Procedure E: Joint Owners (Remaindermen), One Life Interest Owner, produces income

This is non-home real property that is owned jointly (undivided estate), has one life interest owner, and the property produces income to the applicant who is one of the owners (remaindermen). No $6,000 disregard is applicable to remainder interests in real property. No estimated partition costs & attorney's fees are deducted because the property is subject to a life estate interest.

Step 1 - Determine the total property assessed value and the balance due on all liens against the property to which the applicant is subject. When there is more than one owner subject to the lien, determine the number of owners subject to the lien to determine the Medicaid applicant's share of the lien balance. No estimated partition costs & attorney's fees are deducted.

Step 2 - Determine value of the remainder interest in the property (M1140.120) regardless of whether the life interest owner agrees to sell the life interest, using the age of the life interest owner:

Assessed value of property
X Remainder interest factor based on life interest owner's age (from table in M1140.120)
Remainder interest value

Step 3: Remainder interest value
÷Applicant's ownership share of remaindermen (joint owners of property)
Applicant's share of remainder interest
- Lien balance (or portion) when applicant is subject to lien
Countable value of property

Example #E1 - Joint Owners (Remaindermen),1 Life Interest Owner, produces income:

An applicant owns ½ remainder interest in non-home, non-business real property; there is one life interest owner, aged 80 years. There is a lien on this property; the applicant is the only owner who is subject to the lien. The balance due on the lien is $10,000. The assessed value of the property is $81,500. The life interest owner agrees to sell, but the other remainder owner does not agree to sell. No estimated costs of partitioning or selling the property are deducted. No $6,000 disregard for income-producing property is allowed on a remainder interest.

Example #E1, Step 1:

Total property assessed value = $81,500
Balance due on property's mortgage (applicant is only owner subject to lien) = $10,000

Example #E1, Step 2:

The life interest owner's age is 80 years old.

$81,500.00 Total property assessed value
X .56341 Factor from table for life interest owner's Age (80 years old)
$45,917.92 Value of remainder interest

Example #E1, Step 3:

$45,917.92 Value of remainder interest
÷ 1/2 Applicant's ownership share of remainder interest (joint owners of property)
$22,958.96 Applicant's share of remainder interest
- 10,000.00 Lien balance (applicant is the only owner subject to lien)
$12,958.96 Countable value of property

$12,958.96 countable value of property

CHAPTER 011
RESOURCES
SUBCHAPTER 40
TYPES OF COUNTABLE RESOURCES

S1140 Changes

Updated With	Effective Date	Pages Changed
TN #96	10/1/11	Table of Contents pages 12-12a, 24
TN #93	1/1/10	pages 13-15 pages 24, 25
TN #91	5/15/09	pages 11-12a

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TYPES OF COUNTABLE RESOURCES

S1140.001 PURPOSE OF SUBCHAPTER

Introduction

This subchapter contains instructions for the development of resources whose value ordinarily will count toward the resource limit. Use these instructions only after you have made certain that the property at issue:

- is a resource, based on instructions in the S1110 and S1120 subchapters; and
- is not an excluded resource, based on instructions in the S1130 subchapter.

M1140.010 GENERAL VERIFICATION REQUIREMENTS -- INITIAL APPLICATIONS

A. Development and Documentation-- Any Resources

1. General Rule: Verify

Except as indicated in 2. and B. below, always verify the value of resources for any month for which you must determine eligibility.

If an applicant appeals a denial related to a particular resource, the evidence in the file must clearly establish the value of that resource. It must do so even if the issue under appeal is not the value itself (e.g., when the issue under appeal is ownership). This requirement ensures that at each level in the appeals process, the file contains complete documentation of the resource in question.

2. Exceptions to the General Rule

You do not have to verify the value of resources for a given month if:

- the resource is **totally** excluded, regardless of its value; or
- the individual is ineligible for that month for a nonfinancial reason.

3. Values That Apply to Resources

See S1140.042 and M1110.400 for detailed instructions on "current market value (CMV) and "equity value" (EV).

Develop the EV of a resource whenever:

- the CMV of all countable resources exceeds the applicable limit; and
- the individual alleges a debt against the resource.

You do **not** have to develop the EV for a resource if the CMV of all countable resources does not exceed the applicable limit.

See S1110.510 for developing the value of a resource when there is a **shared ownership**.

B. Development and Documentation- Exceptions for Liquid Resources Only

Cash on Hand

Accept an allegation of cash on hand, regardless of amount. Never ask to see or count cash.

C. Development and Documentation-- Photocopying Restrictions

U.S. Government Securities and Obligations

It is legal to photocopy checks issued by the Federal Government, U.S. Savings Bonds, Treasury notes, and other securities and obligations of the U.S. Government **only if** the photocopies are:

- in black and white; and
- of a size less than three-fourths or more than one and one-half, in linear dimension, of each part of the item illustrated.

Photocopying Not Legal

If equipment limitations or restrictions imposed by State or Federal law do not permit legal photocopying of a document, make a certification from the original document involved. If the document appears to have been altered in some way, certify it "as is" with a notation as to the apparent alteration.

S1140.020 GENERAL VERIFICATION REQUIREMENTS -- POSTELIGIBILITY

A. Development and Documentation-- Any Resources

Evaluation of continued eligibility is required for redetermination and changes. Different types of Medicaid coverage may require additional months to be evaluated, i.e., QMB and SLMB reevaluation may require retroactive and ongoing medically needy evaluation. The following instructions apply to any period of review.

1. Value During Past Months

a. **Ineligibility for Entire Period**
You do not have to verify the value of resources for a period of review, **if** for the **entire** period, the individual is ineligible because of a nonfinancial reason.

b. **Eligibility for One or More Months**
Verify the value of resources for any month being reviewed for which the individual is not ineligible based on a. above.

2. Value in Current Month

As at initial application, always verify the value of resources for any month for which you must determine eligibility.

You do not have to verify the current value of resources if the individual is ineligible for a nonfinancial reason.

3. Developing Value When An Appeal is Filed

See S1140.010A.1. if an individual appeals a termination of Medicaid coverage due to the value of particular resource.

B. Development and Documentation-- Non-Liquid Resources

1. General Rule- Apply Current Value

Use the current value of a nonliquid resource in determining resources for any months evaluated due to redetermination or change unless:

- the specific instructions for developing that resource say not to; or
- evidence indicates that it would be inappropriate to do so, as may be the case with a resource that continually appreciates in value.

2. Exception Chart

If the resource is...	then see...	regarding
real property	M1140.100 D.2.	use of the tax-assessed value.
foreign property	M1140.100 F.4.	the retroactive application of current foreign exchange rates
an automobile	M1130.200 A.2	use of the current N.A.D.A Guide.

C. Development and Documentation-Liquid Resources

1. General Rule--Verify Verify the value of liquid resources for each month covered by an application unless 2 below applies.

2. Exception--Cash As in initial, accept the individual's allegation.

D. Related Policy

1. Photo-copying Restrictions See M1140.010 C. for photocopying restrictions imposed by Federal or State law.

2. Current Market Value/Equity Value See M1110.400 for detailed instructions on CMV and EV.

See M1140.010 A.3. for what values to apply to resources.

3. Shared Ownership See S1110.510 for developing the value of a resource when there is shared ownership.

4. Determining Equity Value See S1140.042.

S1140.030 OWNERSHIP

A. Operating Policy--Liquid Resources

1. Assumption For presumably liquid resources (S1110.305), assume that the person whose name is shown as owner owns the entire resource. If more than one owner is shown, assume that each has equal ownership interest.

2. Exceptions: Checking/ Savings Accounts and Time Deposits See S1140.200 and S1140.205 for checking and savings accounts. See S1140.210 for time deposits.

B. Operating Policy-Nonliquid Resources For presumably nonliquid resources (S1110.310), assume, absent some indication to the contrary, that an individual's allegation of sole ownership is correct.

S1140.042 DETERMINING EQUITY VALUE

A. Operating Policy

Develop the equity value of a resource (liquid or nonliquid) when an individual alleges a debt against it and the difference between equity and CMV could mean the difference between eligibility and ineligibility.

B. Development and Documentation

1. Statement

If an individual alleges a debt against the resource in question, obtain his or her signed description of the debt.

2. Verification

a. **Verify,** at a minimum:

- the outstanding principal balance of any month for which a determination must be made; and
- **Obtain** a copy of the agreement or note that establishes the debt. If this does not provide all the information needed, you may use other records of the individual, the creditor, or both.

3. Determining the Countable Value of Real Property

The procedures for determining the countable value of real property are found in Appendix 1 to subchapter S1130.

C. Example-Equity Value Permits Eligibility for Limited Time

The Rounds, an aged couple, file for Medicaid in January 1994. Their countable liquid resources total $1,500. They also own nonhome real property with a CMV of $2,000, which would cause their total resources to exceed the $3,00 limit.

However, there is a mortgage on the land with an outstanding principal balance of $800. Thus, the property's equity value ($1,200) currently permits eligibility.

Payments on the mortgage reduce the outstanding principal balance by $80 a month. At that rate, the property's equity value will reach $1,520 in May 1994, and resources will exceed the limit.

S1140.044 RESOURCES WITH ZERO VALUE

A. Policy Principal

Property that meets the definition of a resource (S1110.100 B.1.) is a resource even if it has no value to count; i.e., has a CMV of zero (S1110.100 B.2.).

B. Operating Policy

An unsuccessful attempt to sell property at its estimated CMV may suggest that the property has a lesser CMV than estimated, but does not necessarily mean that the property has no CMV at all.

C. Related Policies

1. Reasonable Efforts to Sell

For the effect of reasonable but unsuccessful efforts to sell real property see M1130.140.

2. Conversion of a Resource

Should property that has been determined to have no CMV be sold, the proceeds of the sale represent the conversion of a resource, not income (S1110.600 B.4.).

REAL PROPERTY

S1140.100 NON-HOME REAL PROPERTY

A. Definition

Non-home real property consists of land and buildings or immovable objects (including some mobile homes) that are attached permanently to the land and that do not meet the definition of a home (M1130.100).

B. Operating Policy--Assumptions

1. Sole Ownership

Absent evidence to the contrary, accept an individual's allegation of sole ownership of property.

2. Marketability

Absent evidence to the contrary, assume that an individual can sell the property at its estimated CMV.

C. Development and Documentation Shared Ownership

Document an allegation of shared ownership with any of the following evidence:

- a tax assessment notice or bill;
- a current mortgage statement;
- a deed;
- a report of title search;
- wills, court records, or other documentation of inheritance.

If the individual alleges owning other than an equal share of the property (e.g., alleges having a 25 percent ownership interest where there are only two owners), the evidence must support that allegation, as well.

D. Development and Documentation Current Market Value

1. Tax Assessment Notice

a. **When to Use**
Obtain a copy of the most recently issued tax assessment notice for the property . Base the CMV on this assessment.

b. **How to Use**
To determine CMV based on a tax assessment notice, divide the assessed value by the assessment ratio. For example, an assessed value of $2,000 divided by an assessment ratio of 50 percent equals a CMV of $4,000.

2. Knowledge-able Source Estimate

a. **When to Use**
If an individual owns property which does not have a tax assessment, in order to establish CMV, have the individual obtain an estimate of the property's CMV from a knowledgeable source.

b. What The Estimate Must Show
The estimate must show, in addition to the estimate itself:

- the name of the person providing the estimate;
- the name, address and telephone number of the business or agency for whom the person providing the estimate works;
- the basis for the estimate, to include such things as a description of the property and its condition and, where appropriate, the value of similar property in the same area; and
- the period to which the estimate applies (which should correspond to the period for which it is being request).

c. Knowledgeable Sources Knowledgeable sources include but **are** not limited to:

- real estate brokers;
- the local office of the Farmer's Home Administration (for rural land);
- banks, savings and loan associations, mortgage companies, and similar lending institutions;
- an official of the local property tax jurisdiction (be sure to obtain the individual's estimate rather than the office's assessment); and
- the County Agricultural Extension Service.

d. **Assisting The Individual**
If the individual is incapable of obtaining an estimate, lend assistance. If you obtain an estimate by phone, be sure to record all pertinent facts in file.

If you cannot obtain an estimate by phone, you can contact a knowledgeable source for an estimate by mail.

e. **Obtaining More Than One Estimate**
If you doubt the validity of an estimate furnished by the individual, obtain an estimate from an additional knowledgeable source.

E. Development and Documentation Equity Value

1. When to Develop

See S1140.042

2. Evidence

a. The allegation of an encumbrance (any legal debt, such as a mortgage, lien, loan, purchase contract, security interest, etc.) must be supported with evidence of:

- the original amount owed;
- the outstanding principal balance; and
- the schedule and amount of payments due on the principal balance.

b. Have the individual submit a copy of the **note or agreement** establishing the encumbrance.

c. Verify with the creditor (by phone, if possible) any required information that the note or agreement does not show (normally, this will be the outstanding principal balance).

3. Special Review

If, because of scheduled payments on the debt, the equity value of the property may cause the individual's resources to exceed the resource limit before the next scheduled redetermination, establish a special review.

4. Exempt and Nonexempt Property with Single Encumbrance

If there is an encumbrance on the property only the prorated share of the encumbrance on the countable assessed value will be used to determine the countable equity value.

Example: An applicant owns a home, lot and four acres of contiguous property. The contiguous property is assessed at $15,000, but the equity is only $3,000. $5,000 of the assessed value of $15,000, would be exempt as home property. The portion of the equity value of $3,000 relating to the countable $10,000 portion of the land would then be included as a countable resource.

The portion of the equity value, $10,000 divided by $15,000 is .666. Therefore, .666 of $3,000 equity or $1,998 is countable**.**

5. Determine the Countable Value

The procedures and an example for determining the countable value of real property with an encumbrance are found in Appendix 1 to subchapter S1130.

F. Development and Documentation Foreign Property

1. General

Foreign property is subject to the same rules as domestic property.

2. Obtaining Evidence of Legal Bars

a. **General**
Evidence of a legal bar to the sale of property, or to removing the proceeds of a sale from the country, makes CMV development unnecessary. If the individual alleges such a bar, try to verify it by phone before going through the development in 3. below. Document the information you obtain.

b. **Acceptable Source of Information**
Acceptable sources of information are a consulate, mission, or embassy of the country, or our own Department of State. The number of the General Information Desk at State is (202) 647-4000. Contact your regional office if you need help.

3. Obtaining Evidence General

If an individual does not have the documents necessary to support a determination of ownership and CMV or equity value, he or she may be able to write for them, directly or with the aid of a local nationality organization.

- a detailed description of the property, its location, and any other background information the individual can provide;
- the specific information needed, e.g., CMV, the details of any restrictions on removing the proceeds of a sale from the country, etc., and
- the source(s) of the necessary documents or information, to the extent known.

4. CMV Estimate in Foreign Currency

If the CMV estimate is in foreign currency, contact a local bank for the current exchange rate. Apply the current rate retroactively and prospectively unless the individual provides reliable evidence of a different rate.

5. Effect of Partial Restrictions

a. If a legal restriction limits the **amount** an individual can remove from the country, that limit is the maximum value the property can have as a resource.

b. If a legal restriction affects **when** the proceeds of a sale can be removed from the country (e.g., once a year), such proceeds are income when they can be removed, and are not resources before then.

c. If the individual has already sold property and can remove a portion of the proceeds before the next scheduled redetermination:

- document the appropriate amount as unearned income for the expected month of receipt; and
- if, in your judgement, the amount to be received is likely to affect eligibility based on resources for the month after receipt, set a special review for the month after receipt to make a resource determination.

M1140.110 OTHER PROPERTY RIGHTS

A. Introduction

1. Mineral Rights Mineral rights represent ownership interest in natural resources such as coal, oil, or natural gas, which normally are extracted from the ground.

2. Timber Rights Timber rights permit one party to cut and remove free standing trees from the property of another property.

3. Easements An easement gives one party the right to use the land of another party for a special purpose.

4. Leaseholds A leasehold gives one party control over certain property of another party for a specified period. In some States, a "lease for life" can create a life estate under common law. See M1140.110A.6 for life estates.

5. Water Rights Water rights usually confer upon the owner for riverfront or storefront property the right to access and use the adjacent water.

6. Life Estates

a. General

A life estate conveys to the individual to whom it is given certain property rights for the duration of his or her life, or someone else's life. In some cases, it may be conditional: e.g., for life or until remarriage.

The owner of a life estate can sell the life estate but does not have title to the property and thus normally cannot sell it or pass it on as an inheritance.

b. Life Estate Created Prior to August 28, 2008

The value of a life estate created prior to August 28, 2008 is not counted as a resource. Exception: The value of a life estate owned by a QDWI enrollee is countable, regardless of the date on which it was created.

c. Life Estate Created On or After August 28, 2008 *but Before February 24, 2009*

The value of a life estate created on or after August 28, 2008 *but before February 24, 2009* is a countable resource to the owner of the life estate unless the life estate is excluded under one of the real property exclusions contained in Chapter S1l. Exception: The value of a life estate owned by a QDWI enrollee is countable, regardless of the date on which it was created.

The value of a life estate in real property on which the individual resides and considers to be his home is excluded. If the individual leaves the property but retains a life estate, and the property is not occupied by a spouse or dependent child, the value of the life estate becomes a countable resource unless it is excluded under one of the real property exclusions contained in Chapter S11.

d. Life Estate Created on or after February 24, 2009

The value of a life estate created on or after February 24, 2009 is not counted as a resource. Exception: The value of a life estate owned by a QDWI enrollee is countable, regardless of the date on which it was created.

7. Remainder Interests

When the owner of property gives it to one party in the form of a life estate, and designates a second party to inherit it upon the death of the life estate holder, the second party has a remainder interest in the property.

B. Development and Documentation

1. General

Treat the items in A. above as real property and develop ownership and value per S1140.100. See 4. below for additional instructions regarding life estates and remainder interests.

2. Mineral Rights

a. Ownership of Land and Mineral Rights

If the individual owns the land to which the mineral rights pertain, the CMV of the land can be assumed to include the value of the mineral rights. Additional development is unnecessary.

b. Ownership of Mineral Rights Only

If the individual does not own the land to which the mineral rights pertain, obtain a CMV estimate from a knowledgeable source. Such sources include, in addition to those listed in S1140.100 D.2.c.:

- the Bureau of Land Management;
- the U.S. Geological Survey;
- any mining company that holds leases.

3. Lease for Life

Refer any "lease for life" agreement and related information to the regional coordinator for a determination of whether it creates a life estate under State law.

4. Value of Life Estate

a. General

The value of a life estate created on or after August 28, 2008 but before February 24, 2009 is a countable resource to the owner of the life estate unless the life estate is excluded under one of the real property exclusions contained in Chapter S1l.

b. Calculate Value of Life Estate

To determine the countable value of a life estate, use the table in S1140.120, *Life Estate and Remainder Interest Tables.* Multiply the CMV of the property by the “life estate” decimal that corresponds to the *applicant’s or enrollee’s* age. Record the result *in the case record*.

If there is more than one life estate owner, divide the *CMV* of the real property by the number of people *owning* a life estate interest. Multiply the prorated *CMV* of the property by the life estate decimal that corresponds to the *applicant's or enrollee's* age. Record the result *in the case record*.

c. Life Estate *Interest Owned by Another Person* Affects Property Value

Any countable equity value of real property *is* affected if it is:

- subject to someone else having life estate interest, or
- the applicant/recipient transfers real property *and retains* a life estate interest, thus affecting the *real property* value *used to calculate the uncompensated value of the* asset transfer.

See S1140.120, Life Estate and Remainder Interest Tables to determine *the value* of *the life estate interest*.

5. Value of Remainder Interest

a. General

A "remainder" interest in real property is the term used when an individual has an ownership interest in the real property, but usually does not have the right to possess and use the property until termination of the life estate interest. The individual who owns a remainder interest in real property is called the "remainderman." An individual's ownership of a remainder interest in real property must be evaluated to determine the real property's countable value.

b. Calculate Value of Remainder Interest – One Remainderman

To determine the countable value of a remainder interest when only one individual owns the remainder interest, use the table in S1140.120, Life Estate and Remainder Interest Tables. Multiply the CMV of the real property by the "Remainder" decimal that corresponds to the ***life estate owner's age.*** *The result is the value of the remainder interest. Record the result in the case record.*

c. Calculate Value of Remainder Interest – Two or More Remaindermen

*To determine the countable value of a remainder interest when more than one individual owns a remainder interest in the property, divide the CMV of the real property by the number of remainder interests owned. Multiply the prorated CMV of the property by the "****Remainder"*** *decimal that corresponds to the* ***life estate owner's age****. If a remainderman is subject to a lien against the property, subtract the remaining balance or portion of the balance from the CMV value. The result is the countable value of the remainder interest. Record the countable value calculation and result in the case record.*

6. Examples in S1130 Appendix 1 and Appendix 4

See Appendix 1 and Appendix 4 to subchapter S1130 for instructions for, and examples of, determining the countable value of life estate and remainder interests in real property.

S1140.120 LIFE ESTATE AND REMAINDER INTEREST TABLES

EXHIBIT--TABLE -UNISEX LIFE ESTATE OR REMAINDER TABLE

AGE	LIFE ESTATE	REMAINDER
0	*.97188*	*.02812*
1	*.98988*	*.01012*
2	*.99017*	*.00983*
3	*.99008*	*.00992*
4	*.98981*	*.01019*
5	*.98938*	*.01062*
6	*.98884*	*.01116*
7	*.98822*	*.01178*
8	*.98748*	*.01252*
9	*.98663*	*.01337*
10	*.98565*	*.01435*
11	*.98453*	*.01547*
12	*.98329*	*.01671*
13	*.98198*	*.01802*
14	*.98066*	*.01934*
15	*.97937*	*.02063*
16	*.97815*	*.02185*
17	*.97700*	*.02300*
18	*.97590*	*.02410*
19	*.97480*	*.02520*
20	*.97365*	*.02635*
21	*.97245*	*.02755*
22	*.97120*	*.02880*
23	*.96986*	*.03014*
24	*.96841*	*.03159*
25	*.96678*	*.03322*
26	*.96495*	*.03505*
27	*.96290*	*.03710*
28	*.96062*	*.03938*
29	*.95813*	*.04187*
30	*.95543*	*.04457*
31	*.95254*	*.04746*
32	*.94942*	*.05058*
33	*.94608*	*.05392*
34	*.94250*	*.05750*
35	*.93868*	*.06132*

EXHIBIT--TABLE -UNISEX LIFE ESTATE OR REMAINDER TABLE

AGE	LIFE ESTATE	REMAINDER
36	*.93460*	*.06540*
37	*.93026*	*.06974*
38	*.92567*	*.07433*
39	*.92083*	*.07917*
40	*.91571*	*.08429*
41	*.91030*	*.08970*
42	*.90457*	*.09543*
43	*.89855*	*.10145*
44	*.89221*	*.10779*
45	*.88558*	*.11442*
46	*.87863*	*.12137*
47	*.87137*	*.12863*
48	*.86374*	*.13626*
49	*.85578*	*.14422*
50	*.84743*	*.15257*
51	*.83674*	*.16126*
52	*.82969*	*.17031*
53	*.82028*	*.17972*
54	*.81054*	*.18946*
55	*.80046*	*.19954*
56	*.79006*	*.20994*
57	*.77931*	*.22069*
58	*.76822*	*.23178*
59	*.75675*	*.24325*
60	*.74491*	*.25509*
61	*.73267*	*.26733*
62	*.72002*	*.27998*
63	*.70696*	*.29304*
64	*.69352*	*.30648*
65	*.67970*	*.32030*
66	*.66551*	*.33449*
67	*.65098*	*.34902*
68	*.63610*	*.36390*
69	*.62086*	*.37914*
70	*.60522*	*.39478*

EXHIBIT--TABLE -UNISEX LIFE ESTATE OR REMAINDER TABLE

AGE	LIFE ESTATE	REMAINDER
71	*.58914*	*.41086*
72	*.57261*	*.42739*
73	*.55571*	*.44429*
74	*.53862*	*.46138*
75	*.52149*	*.47851*
76	*.50441*	*.49559*
77	*.48742*	*.51258*
78	*.47049*	*.52951*
79	*.45357*	*.54643*
80	*.43659*	*.56341*
81	*.41967*	*.58033*
82	*.40295*	*.59705*
83	*.38642*	*.61358*
84	*.36998*	*.63002*
85	*.35359*	*.64641*
86	*.33764*	*.66236*
87	*.32262*	*.67738*
88	*.30859*	*.69141*
89	*.29526*	*.70474*
90	*.28221*	*.71779*
91	*.26955*	*.73045*
92	*.25771*	*.74229*
93	*.24692*	*.75308*
94	*.23728*	*.76272*
95	*.22887*	*.77113*
96	*.22181*	*.77819*
97	*.21550*	*.78450*
98	*.21000*	*.79000*
99	*.20486*	*.79514*
100	*.19975*	*.80025*
101	*.19532*	*.80468*
102	*.19054*	*.80946*
103	*.18437*	*.81563*
104	*.17856*	*.82144*
105	*.16962*	*.83038*
106	*.15488*	*.84512*
107	*.13409*	*.86591*
108	*.10068*	*.89932*
109	*.04545*	*.95455*

FINANCIAL INSTITUTION ACCOUNTS

*M*1140.200 CHECKING AND SAVINGS ACCOUNTS

A. Operating Policies

1. Ownership

Assume that the person designated as owner in the account title owns all the funds in the account (see S1140.205 regarding joint accounts).

2. Right to Withdraw Funds

Absent evidence to the contrary, assume that the person shown as owner in the account title has the legal right to withdraw funds from the account.

3. Fiduciaries

A fiduciary's right to withdraw funds is the same as the owner's right to withdraw them.

4. Examples of Evidence to the Contrary

a. **Right to Withdraw Funds Restricted to a Specified Account Holder**
An account is titled, "In trust for John Jones and Mary Smith, subject to sole order of John Jones, balance at death of either to belong to survivor." Since John alone has unrestricted access, none of the funds in the account could be considered Mary's resources unless John were her fiduciary or his resources were deemed available to her.

b. **Withdrawals Require Authorization of Third Party**
An account is title, "George Dahey, restricted Individual Indian Money Account." Mr. Dahey cannot withdraw funds from the account without Bureau of Indian Affairs (BIA) authorization. Therefore, the account is not his resource.

c. **"Blocked" Accounts**
If State law specifically requires the funds be made available for the care and maintenance of an individual, assume, absent evidence to the contrary, that they are that individual's resource. This is true despite the fact that the individual or his/her agent is required to petition the court to withdraw funds for the individual's care. Refer to regional coordinator any questions regarding State law on "blocked accounts."

5. Right to Use for Support and Maintenance

Absent evidence to the contrary, assume that an individual who owns and has the legal right to withdraw funds from a bank account also has the legal right to use them for his or her own support and maintenance.

6. Examples of Evidence to the Contrary

a. **Use Restricted by Court Order**
Even with ownership interest and the legal ability to access property, a legal restriction against the property's use for the owner's own support and maintenance means the property is not the owner's resources (S1110.100).

EXAMPLE: An account is titled, "Aristotle Iris by Hester Pry, Representative Payee," where Ms. Pry is an officer of the institution in which Mr. Iris lives. A statewide court order prohibits such officers from using the funds of an institutionalized person for support and maintenance provided by the State. Therefore, the funds in the account are not a resource while Mr. Iris is in the institution.

b. **Special Purpose Accounts**
An account is titled, "Thomas Green, Kiwanis Club Fund for Heart Surgery." While Mr. Green has unrestricted access to funds, development shows that their use is restricted to the expenses of his surgery. Therefore, they are not a resource.

B. Development and Documentation Initial Applications and Post-eligibility

1. Informing the Individual of Reporting Responsibilities

Be sure the individual understands that:

- he must report any bank account on which his or her name appears, regardless of any special purpose for which the account may have been established or whose money is in it;
- DSS may use other statements or forms to obtain information from any bank account or financial institution to verify the allegations.

2. Curtailing Development

Do not verify account balances under any of the following circumstances:

a. the individual alleges that his name does not appear on any accounts, and there is no evidence to the contrary;

b. the individual is ineligible for a non-financial reason.

3. Minimum Documentation -Account Balances Must Be Verified

Document, in addition to the balances themselves;

- the name and address of the financial institution;
- the account number(s); and
- the exact account designation.

4. *Electronic Verifications*

Electronic verifications, such as on-line bank statements and automated teller machine (ATM) receipts, are acceptable verifications provided that they include:

- *the name of the financial institution,*
- *the individual's name,*
- *the individual's account number, and*
- *date of the receipt or online statement.*

5. *Determining the Value of a Bank Account*

There is no single method for determining the countable value of a bank account. The countable value is the lower of:

- *the balance before income is added, or*
- *the ending balance minus any income added during the month.*

Funds cannot be both income and a resource in the same month. Income that has been added to a bank account during the month must be subtracted from the ending balance to ensure that the income is not also counted as a resource.

6. Requesting Information from Financial Institutions

a. When it is necessary to request account information from a financial institution, have the individual sign an authorization for release of the information.

b. Balance Information

The financial institution may show the opening balance for the first day of a given month or the closing balance for the last business day of the previous month. Accept either, the amount will be the same. See M1110.001 for Monthly Determinations of Resource Eligibility.

c. Financial Institution Does Not Cooperate

If a financial institution refuses to provide the information needed for a determination, try to obtain its cooperation by explaining why assistance is required.

If the institution still refuses to provide the information, inform the individual and ask him or her to try to get the information from the institution.

C. Development and Documentation -- Posteligibility Only

If you discover a previously undeveloped checking or savings account after eligibility has been established, develop account balances and interest for the period that a determination can cover.

S1140.205 JOINT CHECKING AND SAVINGS ACCOUNTS

A. Introduction

The instructions in S1140.200, except for A.1. (ownership), apply to all checking and savings accounts. The instructions in this section, which apply to joint accounts only, supplement those in S1140.200.

B. Operating Policy-- Rebuttable Ownership Assumptions

1. Account Holders Include One Or More Applicants or Recipients and No Deemors

Assume that all the funds in the account belong to the applicant(s) /recipient(s), in equal shares if there is more than one applicant or recipient.

2. Account Holders Include One or More Deemors

Provided that none of the account holders is an applicant or recipient (in which case the assumption in 1. above would apply), assume that all the funds in the account belong to the deemor(s), in equal shares if there is more than one deemor.

C. Development and Documentation-- Initial Applications and Posteligibility

1. Informing the Individual

Inform the individual:

- of the applicable ownership assumption;
- of the corresponding income implications (S0810.130); and
- of his or her right to provide evidence rebutting the ownership assumption, if he or she disagrees with it.

2. Individual Wishes to Rebut

a. Rebuttal Statement

If an individual wishes to rebut the applicable ownership assumption, obtain his or her statement, regarding:

- who owns the funds;
- why there is a joint account;
- who has made deposits to and withdrawals from the account; and
- how withdrawals have been spent.

b. Required Evidence

In addition, inform the individual that he or she must submit the following evidence:

- a corroborating statement from each other account holder (if the only other account holder is incompetent or a minor, have the individual submit a corroborating statement from anyone aware of the circumstances surrounding establishment of the account);

- account records showing deposits, withdrawals and interest in the months for which ownership is at issue;

- if the individual owns *none* of the funds, evidence showing that he or she can no longer withdraw funds from the account;

- if the individual owns only a portion of the funds, evidence showing removal from the account of such funds, or removal of the funds owned by the other account holder(s), and redesignation of the account.

c. Determination

Any funds that the evidence establishes were owned by the other account holder(s), and that the individual can no longer withdraw from the account, were not and are not the individual's resources. However, such funds can be deemed available to the individual if the account holder to whom they belong is a deemor. Document the determination in file.

NOTE: You must verify joint account balances if an individual rebuts ownership of any of the funds in an account.

S1140.210 TIME DEPOSITS

A. Introduction

1. Time Deposits

A time deposit is a contract between an individual and a financial institution whereby the individual agrees to leave funds on deposit for a specified period (six months, two years, five years, etc.) and the financial institution agrees to pay interest at a specified rate for that period. Certificates of deposit (C.D.s) and savings certificates are common forms of time deposits.

2. Penalties for Early Withdrawal

Withdrawal of a time deposit before the specified period expires incurs a penalty, which usually is imposed against the principal. This penalty does not prevent the time deposit from being a resource, but does reduce its value as a resource.

3. Early Withdrawal Prohibited

On rare occasions, the terms of a time deposit will prohibit early withdrawal altogether.

B. Operating Policy

1. Ownership

The assumptions regarding ownership of bank accounts (S1140.200 and S1140.205) apply to time deposits.

2. Early Withdrawal Prohibited

a. **Principal**
If the owner of a time deposit cannot under any circumstances withdraw it before it matures, it is not a resource. It becomes a resource (not income) on the date it matures, and may affect countable resources for the following month.

b. **Interest**
If the owner has no access to the interest before the deposit matures, accrued interest is not a resource and is income in the month the deposit matures (not before then).

3. Value as a Resource

The resource value of a time deposit at any given time is the amount the owner would receive upon withdrawing it at that time, excluding interest paid that month. Generally, this is:

- the amount originally deposited;
- plus accrued interest for all but the current month;
- minus any penalty specified on the certificate for early withdrawal.

C. Related Policy--Interest

See S0830.425 regarding the treatment of interest for income purposes.

D. Development and Documentation

Verify the original amount deposited, interest accrued, and what penalty applies for early withdrawal. If the individual alleges that the deposit cannot be withdrawn prior to maturity under any circumstances, verify that. Obtain this information from the individual's copies of account records to the extent possible. Contact the financial institution only to obtain information the individual's records do not provide.

S1140.215 CONSERVATORSHIP ACCOUNTS

A. Definitions

1. Conservator-ship Account

The term "conservatorship account" refers to a financial account in which a person or institution has been appointed by a court to manage and preserve the assets of an individual which are held in the account.

2. "Individual"

For Medicaid purposes the "individual" for whom a conservatorship account is held may be a applicant, recipient, or other person whose resources are deemable to the applicant or recipient.

B. Policy

The following policy does not apply to trusts, which are discussed in S1120.200.

1. Assumption of Availability for Support and Maintenance

If State law requires that funds in a conservatorship account be made available for the care and maintenance of an individual, we assume, absent evidence to the contrary, that funds in such an account are available for the individual's support and maintenance and are, therefore, that individual's resource.

A State statute may not specifically address the issue of whether funds in a conservatorship account must be made available for the care and maintenance of the individual. Other State statutes or case law may specifically prohibit the use of funds held in the conservatorship account for general support of the individual in certain circumstances. Eligibility Workers (EW) should follow regional instructions regarding availability presumptions that apply in those States.

2. Examples of "Evidence to the Contrary"

Examples of evidence of the contrary include (but are not limited to):

- restrictive language in the court order that established the account or in a subsequent court order;
- State or local procedural rules for the withdrawal of funds from the account; and
- local court practices regarding withdrawal of funds.

3. Requirement to Petition Court for Release of Funds

The fact that an individual or his/her agent must petition the court for withdrawal of funds does not mean that the funds may be assumed to be unavailable for the individual's support and maintenance (and, therefore, not a resource for Medicaid purposes).

Denial by the court of a request for withdrawal of funds does not necessarily mean that funds in the account are unavailable for the individual's support and maintenance. If the court approves requests to withdraw funds in order to provide support and maintenance, and only disapproves requests for non-essential items, the funds are considered available and a resource for Medicaid purposes. The EW should review the

history of petitions for (and approvals and denials of) withdrawal of funds. If a denial by the court appears to be an exception rather than the rule, the funds may be determined to be a resource for Medicaid purposes.

C. Procedure

1. Follow Regional Instructions

Refer to regional instructions regarding State law, State or local rules, or local court practices regarding the conditions under which funds held in conservatorship accounts may be withdrawn.

2. Obtain the Individual's Allegation

Obtain over the individual's signature an allegation regarding:

- who can withdrawn the funds;
- the method for withdrawing funds (e.g., petition the court or unlimited ability to withdraw by the individual or his/her agent);
- uses to which funds may or must be put; and
- any restrictions on availability or use of funds.

If the court has restricted use of funds in the account **at the individual's or his/her agent's request**, obtain the individual's allegation as to whether the restriction(s) can be removed by request or petition.

3. Obtain Evidence as Necessary

If you must verify the value of the funds (see S1140.010 or S1140.020 for general verification requirements) or if the individual's allegations suggest that funds in the conservatorship account are not a resource for Medicaid purposes, ask the individual to submit evidence regarding the account. Obtain evidence to document the issues which must be addressed. This evidence may include:

- the court order establishing the conservatorship and the account;
- any account records showing withdrawals, deposits, and balances;
- prior applications or petitions for withdrawal of funds (if applicable), including any correspondence or notices from the court responding to the applications or petitions; and
- any other documents or evidence in the individual's possession pertaining to the conservatorship account.

4. Make Resource Determination

Document in the case record your determination as to whether the funds in the account are a resource for Medicaid purposes. Refer to regional instructions, as applicable.

If the court has restricted use of funds in the account at the individual's or his/her agent's request and the registration(s) can be removed at the individual's or agent's request or petition, determine that the funds are a resource for Medicaid purposes.

If due to the complexity of the conservatorship account or the history of petitions for funds, you are unable to determine the status of the account for Medicaid resource purposes, refer to the case to the Regional Specialist.

D. Examples

The following examples illustrate policy and procedures for conservatorship accounts.

1. Funds Assumed to Be Available for Support and Maintenance

The claimant, a disabled 28-year-old individual, received a $20,000 court-ordered personal injury award as a result of an accident on a city bus. The court order stipulates that the claimant's legal guardian must petition the court for withdrawal of funds as needed. The order does not place any restrictions on how the funds may be used on behalf of the claimant.

The EW consults the regional specialist on conservatorship or "blocked" accounts and determines that, under State law, the funds in an account such as this may be assumed to be available for the individual's support and maintenance. Therefore, the EW determines that the funds in the account are a resource for Medicaid purposes.

2. Funds Not Available for Support and Maintenance

Same situation as above. However, regional instructions indicate that State law restricts the use of personal injury funds held in conservatorship accounts to medical expenses only. Since the funds are not available for food, clothing, or shelter, the EW determines the funds are not a resource.

3. Petition for Withdrawal of Funds Denied

The Medicaid recipient, a 2-year-old child, has received a $100,000 medical malpractice award. The court order requires that the child's parents petition the court for withdrawal of funds. The parent/payee alleged that a recent petition for withdrawal of funds was denied.

The EW asks the payee to submit evidence of the petition in question and all prior petitions. Examining the evidence, the EW concludes that all but one petition for withdrawal of funds were approved for the general support and maintenance of the child. The court denied one petition, citing the intended use of the funds. The court characterized the intended use as "nonessential for the child's care."

Since the one denied petition does not negate the presumption that the funds are available for the child's support and maintenance, the EW concluded that the funds are a resource for Medicaid purposes.

OTHER COMMON INVESTMENT VEHICLES

S1140.220 STOCKS

A. Introduction

Shares of stock represent ownership in a business corporation. Their value shifts with demand and may fluctuate widely. The following guidelines apply to all stocks, including preferred stocks, warrants and rights, and options to purchase stocks.

B. Operating Policy

1. Co-Ownership

Absent evidence to the contrary, assume that each owner owns an equal share of the value of the stock.

2. Salability

Absent evidence to the contrary, assume that the owner of shares of stock can sell them at will at current value.

3. Broker Fees

Broker fees do not reduce the value that stocks have as resources.

D. Development and Documentation

1. Ownership

Ask the individual to submit the stock certificate or most recent statement of account (including dividend account) from the firm that issued or is holding the stock. Document the file with a photocopy. If the individual does not have this documentation, have him or her obtain a statement from the firm. Provide assistance as needed.

2. Value--Publicly Traded Stocks

a. **Which Value to Use**

The CMV of a stock is its closing price on the previous business day. The values of over-the-counter stocks are shown on a "bid" and "asked" basis. For example, "18 bid, 19 asked." Use the bid price as the CMV.

The "par value" or "stated value" shown on some stock certificates is not the market value of the stock.

b. **Sources of Information**

The closing price of a stock on a given day can usually be found in the next day's regular or financial **newspaper.**

As a last resort, contact a local **securities firm.** Record the appropriate closing price and the source of the information.

3. Value--Stock That Is Not Publicly Traded

a. **Traded**
The stock of some corporations is held within close groups and traded very infrequently. The sale of such stock is often handled privately and subject to restrictions. As a rule, it cannot be converted to cash within 20 working days.

b. **Evidence**
The burden of proof for establishing the value of this kind of stock is on the individual. The preferred evidence is a letter or other written statement from the firm's accountants giving their best estimate of the stock's value and the basis for the estimate, e.g.:

- most recent sale,
- most recent offer from outsiders,
- CMV of assets less debts on them,
- cessation of activity and sale of assets,
- bankruptcy, etc.

Keep the statement or a photocopy of it in the file.

S1140.230 MUTUAL FUND SHARES

A. Introduction

A mutual fund is a company whose primary business is buying and selling securities and other investments. Shares in a mutual fund represent ownership in the investments held by the fund.

B. Development and Documentation

The development guidelines for stocks in S1140.220, apply to mutual funds shares. Many newspapers contain a separate table showing the values of funds not traded on an exchange.

S1140.240 U.S. SAVINGS BONDS

A. Introduction

U.S. Savings Bonds are obligations of the Federal Government. Unlike other government bonds, they are not transferable; they can only be sold back to the Federal Government. U.S. Savings Bonds have a mandatory retention period:

- 6 months for Series E, EE and I bonds issued prior to 2/1/03,
- 12 months for Series EE and Series I bonds issued on or after 2/1/03, and
- 6 months for Series H and HH bonds.

U.S. Savings Bonds are resources the first month following the mandatory retention period.

NOTE: The mandatory retention period is the same for both paper and electronic Series EE and I bonds. Series E bonds have not been issued since June 1980.

B. Operating Policy

1. Sole Ownership

The individual in whose name a U.S. Savings Bond is registered owns it (the Social Security Number shown on the bond is not proof of ownership).

2. Co-Ownership

The co-owners own equal shares of the value of the bond.

3. Status as Resources

a. General

U.S. Savings Bonds are not resources during a mandatory retention period. They are resources (not income) as of the first day of the month following the mandatory retention period.

b. Co-ownership Without Access

A U.S. Savings Bond is not a resource to a co-owner if another co-owner has and will not relinquish physical possession of it.

C. Development and Documentation

1. Ownership

a. Paper Bonds

Have the individual submit any bonds that he or she has an ownership interest in. Use the name(s) shown on the bond to determine ownership per B.1. or B.2. above.

b. Electronic Bonds

When an individual alleges ownership of electronic savings bonds, document bond ownership by asking the individual to download a record of his bond holdings from the Treasury Department. (see C.3.b below).

2. Status as Resources

If the individual alleges that he or she cannot submit a bond because a co-owner has and will not relinquish physical possession of it, obtain from the co-owner a signed statement verifying that the co-owner:

- has physical possession of the bond;
- will not allow the individual to cash the bond; and
- will not cash the bond and give the individual his or her share of its value.

3. Value

a. Series E, EE, and I paper bonds

- **On-line Verification** at: http://www.publicdebt.treas.gov/sav/savcalc.htm
- Current copy of the Table of Redemption Values for US Savings Bonds
- **Bank Verification** As a last alternative, obtain the value by telephone from a local bank and record it. The bank will need the series, denomination, date of purchase and/or date.

b. Series E, EE, and I electronic bonds

- Ask individual to obtain his "Current Holdings" list from the Treasury web site at: http://www.savingsbonds.gov/
- Use Current Holding Summary to verify number of bonds, face value, issue dates, confirmation numbers and value.

c. Series H and HH Bond After Maturity

After maturity, the redemption value of a series H or HH bond is its face value. Verification of value per a. or b. above is unnecessary.

4. Photocopy

Document the file with a photocopy or certification of the bond(s). See **S1140.010 C**. on photocopying U.S. Government obligations.

5. Follow-up, if Appropriate

If an individual owns a U.S. Savings Bond which, upon maturity, may cause countable resources to exceed the limit, recontact the recipient shortly before the bond matures in order to redevelop the value of countable resources.

S1140.250 MUNICIPAL, CORPORATE, AND GOVERNMENT BONDS

A. Introduction

1. Bond

A bond is a written obligation to pay a sum of money at a specified future date. Bonds are negotiable and transferable.

2. Municipal Bond

A municipal bond is the obligation of a State or a locality (county, city, town, villages or special purpose authority such as a school district).

3. Corporate Bond

A corporate bond is the obligation of a private corporation.

4. Government Bond

A government bond, as distinct from a U.S. Savings Bond (see S1140.240), is a **transferable** obligation issued or backed by the Federal Government.

B. Operating Policy

Municipal corporate, and government bonds are negotiable and transferable. Therefore, their value as a resource is their CMV. Their redemption value, available only at maturity, is immaterial.

C. Documentation

Documentation instructions for stocks (S1140.220) also apply to bonds.

M1140.260 ANNUITIES

A. Introduction

An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer. For Medicaid purposes, an annuity *means* a contract *or an agreement by which one receives fixed, non-variable payments on an investment for a lifetime or a specified number of years. An annuity must be issued by* an insurance company, bank, or other registered or licensed entity *approved to do business in the state in which the annuity was established*.

B. Operating Policy

1. *An annuity that names revocable beneficiaries is considered to be an available resource because it can be surrendered, cashed in, assigned, transferred or have the beneficiary changed. Annuities are presumed to be revocable when the annuity contract does not state that it is irrevocable. The countable value of the revocable annuity is the amount of the funds in the annuity minus any fees required for surrender.*

2. *Annuities purchased with the assets of a third party such as those received through a legal settlement are not considered to be countable resources.*

3. *An annuity issued prior to February 8, 2006, is considered a countable resource if the annuity can be surrendered. The countable value of the annuity is the amount of the funds in the annuity minus any fees required for surrender.*

4. *A non-employment related annuity purchased by or for an individual on or after February 8, 2006, using that individual's assets will be considered an available resource unless it meets all of the following criteria: the annuity*

   (a) is irrevocable;
   (b) is non-assignable;
   (c) is actuarially sound; and
   d) provides for payments in equal amounts during the term of the annuity with no deferral and no balloon payments made.

5. *Prior to receiving long-term care services paid by Medicaid, all annuities purchased by the institutionalized individual or the community spouse on or after February 8, 2006, must name the Commonwealth of Virginia as the primary beneficiary for at least the total amount of medical assistance paid on behalf of the institutionalized individual. If there is a community spouse or minor or disabled child, the Commonwealth must be named as the remainder beneficiary behind the spouse or minor or disabled child.*

6. *For individuals applying for long-term care services, annuities owned by either the applicant or the applicant's spouse must also be evaluated using the policy in M1450.200 to determine whether an uncompensated asset transfer has occurred.*

S1140.300 PROMISSORY NOTES, LOANS, AND PROPERTY AGREEMENTS

A. Introduction

1. General

The context of the instruction in this section is the individual as the creditor (lender of money, seller of property) and, therefore, as the owner of the promissory note, loan, or property agreement.

See S1120.220 for additional information on notes, loans and property agreements.

2. Promissory Note

A promissory note is a written, unconditional agreement whereby one party promises to pay a specified sum of money at a specified time (or on demand) to another party. It may be given in return for goods, money loaned, or services rendered.

3. Loan

A loan is a transaction whereby one party advances money to or on behalf of another party, who promises to repay the lender in full, with or without interest. The loan agreement may be written or oral, and must be enforceable under State law. A written loan agreement is a form of promissory note.

4. Property Agreement

A property agreement is a pledge or security of particular property for the payment of a debt or the performance of some other obligation within a specified period. Property agreements on real estate generally are referred to as mortgages but also may be called land contracts, contracts for deed, deeds of trust, and so on. Personal property agreements—e.g., pledges of crops, fixtures, inventory, etc.—are commonly known as chattel mortgages.

B. Operating Policy

1. Real Estate Contracts Prior to Settlement

When an individual enters into a contract for the sale of real estate, he or she owns two items until the settlement of the sale is completed: the real estate and the contract. The real estate is not a resource because the individual cannot convert it to food or shelter. The contract is a property agreement whose status and value as a resource must be determined in accordance with this section.

2. Value as a Resource Assumption

Assume that the value of a promissory note, loan, or property agreement as a resource is its outstanding principal balance unless the individual furnishes reliable evidence that it has a CMV of less than *the outstanding principal balance* (or no CMV at all).

C. Development and Documentation – Written Agreement

1. Copy of Agreement

Obtain a copy of the agreement for the file. Cease development if including the original balance in countable resources does not cause ineligibility.

2. Principal Balance

If including the original balance in countable resources causes ineligibility and payments have been made, obtain evidence of the outstanding principal balance.

Cease development if including the outstanding principal balance in countab resources does not cause ineligibility.

3. Rebuttal Rights

If including the outstanding principal balance in countable resources causes ineligibility, **inform the individual** that we will use the outstanding principal balance in determining resources unless he or she submits:

- evidence of a legal bar to the sale of the agreement ; or
- an estimate from a knowledgeable source, showing that the CMV of the agreement is less than its outstanding principal balance.

4. Knowledgeable Sources

Knowledgeable sources include anyone regularly engaged in the business of making such evaluations: e.g., banks or other financial institutions, private investors or real estate brokers. The estimate must show the name, title, and address of the source.

D. Related Policy

1. Loans and the Borrower

See S1120.220 on how to determine whether the proceeds of a loan are income or a resource to the borrower.

2. Home Replacement Funds Exclusion

See S1130.110 when a contract is from the sale of an excluded home.

3. Individuals Requesting Long-term Care

For individuals requesting Medicaid payment for long-term care who have purchased promissory notes, loans, or mortgages on or after February 8, 2006, see M1450.540.

M1140.305 CONTINUING-CARE RETIREMENT COMMUNITY ENTRANCE FEES

A. Introduction

Continuing-care or life-care retirement communities generally provide guaranteed care for the life of the individual in return for a set entrance fee as well as monthly maintenance fees. If the applicant has entered into a continuing-care contract or agreement with a retirement community, the entrance fee paid by the individual to the retirement community must be evaluated.

B. Operating Policy

An individual's entrance fee paid to a continuing-care retirement or life-care retirement community that collects an entrance fee upon admission shall be considered an available resource if:

- *the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care;*
- *the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the continuing-care or life-care contract and leaves the retirement community; and*
- *the entrance fee does not confer an ownership interest in the continuing-care retirement community or life-care community.*

C. Development and Documentation

1. Copy of Contract/ Agreement

Obtain a copy of the contract or agreement. If one or more of the conditions in B. above is not met in the terms of the contract, do not develop the contract further as a resource..

2. Countable Value of Entrance Fee

If all of the conditions in B. above are met in the terms of the contract or agreement, determine the countable value of the entrance fee. Contact the retirement community to determine:

- *the amount of the entrance fee actually paid if the contract or agreement stipulates installment payments, and*
- *whether any amount has been refunded to the applicant.*

Subtract any amount that the retirement community has refunded from the amount paid. Document the resulting balance in the case record as a countable resource.

M1140.310 LIFE INSURANCE

A. Introduction

This section provides broad policy principles concerning the treatment of life insurance policies for Medicaid purposes. Detailed instructions on the development and, where applicable, the exclusion of life insurance are contained in M1130.300.

B. Policy Principles

1. Countability Based on Total Face Value

If the combined face values of all the life insurance policies an individual, owns on a given insured age 21 or older, exceed $1,500, the cash surrender value of any such policy is a resource to the individual.

2. Policies Whose Face Values Are Not Taken into Account

For purposes of determining whether the combined face values of all the life insurance policies an individual owns on a given insured age 21 or older, exceed $1,500, the face values of the following are not taken into account:

- term insurance that does not have a cash surrender value; and
- burial insurance; i.e., insurance whose terms preclude the use of policy proceeds (proceeds include any cash surrender value) for any purpose other than payment of the insured's burial expenses.

TRUSTS

M1140.400 TRUSTS ESTABLISHED BY A WILL

A. Policy

If a Medicaid applicant or recipient is the named beneficiary in a trust established by a will, determine from the terms of the trusts, what income or principal is available to the applicant or recipient. If the trust is "discretionary" determine what part of the corpus or income the trustee is making available to the applicant or recipient. Any corpus or income which the trustee does not make available cannot be counted in determining Medicaid eligibility.

M1140.401 TRUSTS WHICH WERE NOT CREATED BY A WILL

A. Policy

This section deals with the countable value of trusts or similar legal devices which were not established by a will. The trust may be revocable or irrevocable. The date the trust was established will affect how the trust is evaluated for Medicaid eligibility.

For detailed instruction on Trust Property, see:

- M1120.200, Trust Property
- M1120.201, Trust Established on or After August 11, 1993
- M1120.202, Trust Established for Disabled Individual on or After August 11, 1993
- M1130.520, Trust Established Between July 1, 1993 and August 10, 1993
- M1140.402, Medicaid Qualifying Trust (Created Prior to August 11, 1993)
- M1140.403, Trust(s) Created After July 1, 1993 and Before August 11, 1993 With Corpus in Excess of $25,000

M1140.402 MEDICAID QUALIFYING TRUSTS (CREATED PRIOR TO AUGUST 11, 1993)

A. Introduction

A "Medicaid qualifying trust" is a trust, or similar legal device, established (other than by a will) by an individual or an individual's spouse prior to August 11, 1993. Under this trust the individual may be beneficiary to all or part of the payments from the trust and the distribution of such payments is determined by one or more trustees who are permitted to exercise any discretion with respect to the distribution to the individual.

EXCEPTION: A trust or initial trust decree established **prior** to April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded is not "Medicaid Qualifying Trust."

B. Trust Restrictions Not Recognized

The requirements of this section shall apply without regard to:

- whether or not the Medicaid qualifying trust is irrevocable or
- is established for purposes other than to enable a grantor to qualify for Medicaid; or
- whether or not the trustee(s) exercises his discretion to distribute any payments to the individual.

C. Development

1. Countable Value

The **maximum** amount of payments permitted under the terms of a "Medicaid Qualifying Trust" to be distributed to the grantor, **if** the trustee exercised his discretion to the **fullest** extent possible, shall be considered available in determining the grantor's eligibility for Medicaid.

D. Exception

A trust or initial trust decree established prior to April 7, 1986, solely for the benefit of a mentally retarded individual who resides in an intermediate care facility for the mentally retarded is not a "Medicaid Qualifying Trust."

E. References

M1120.200, Trust Property
M1120.201, Trusts Established on or after August 11, 1993.

M1140.403 TRUST(S) CREATED AFTER JULY 1, 1993 AND BEFORE AUGUST 11, 1993 WITH CORPUS IN EXCESS OF $25,000

A. Policy

Single or multiple trusts created after July 1, 1993 and before August 11, 1993, with corpus or corpora in excess of $25,000, will have the excess over $25,000 evaluated for countable resources for Medicaid eligibility.

B. Trust Restrictions Not Recognized

The following will not affect the evaluation of the countable value, regardless of whether or not the trust:

- is irrevocable; or
- established for purposes other than to make the individual eligible for Medicaid; or
- the trustee exercises his discretion to distribute trust payments to the applicant/recipient.

C. Development/ Documentation

1. Countable Value

a. Verify the current value of the corpus or corpora of the trust(s).

b. Prorate $25,000 by the number of trusts.

c. Subtract the amount in b. above from the corpus or corpora of the trust(s).

d. The remainder of the corpus or corpora of the trust(s)

- that may be paid under the terms of the trust,
- without any limits imposed by any void restrictive clauses within the trust

is counted as an available resource.

e. The maximum amount of income payable from the trust according to its terms is considered available income whether or not it is actually paid to the applicant/recipient.

D. References

Trusts Established Between July 1, 1993 and August 11, 1993, M1130.520

M1140.404 TRUSTS ESTABLISHED ON OR AFTER AUGUST 11, 1993

A. Introduction

The enactment of OBRA 93 affects the treatment of trusts. For purposes of determining the countable value of a trust for an individual's eligibility for Medicaid, the rules specified in this section shall apply to a trust established by such individual on or after August 11, 1993.

For the purposes of determining an individual's eligibility for Medicaid, the rules specified below shall apply to a trust established by such individual.

EXCEPTION: Certain trusts established for disabled individuals
See M1120.202.

B. Policy

1. Who Establishes Trust

a. Individual Establishes Trust

An individual shall be considered to have established a trust if assets of the individual were used to form all or part of the corpus of the trust and if any of the following individuals established such trust other than by will:

- the individual,
- the individual's spouse,
- a person, including a court or administrative body (i.e., Power of Attorney, etc.), acting at the direction or upon the request of the individual or the individual's spouse.

b. Funeral Director Establishes Trust

A funeral home director who operates his business in Virginia can legally establish an irrevocable trust for an individual for the purpose of paying for funeral and burial expenses. Under a "two-step" process, funds transferred from the individual to the funeral home are deemed a compensated transfer for value when the amount of the funds transferred does not exceed the value of the goods and services purchased. The entire amount of the trust is exempt when placed in an irrevocable trust by the funeral director.

The "two step" process occurs when:

1) the individual signs a preneed contract with a funeral home director promising prepayment in return for specific funeral merchandise and services and pays the agreed upon amount in the form of a direct cash payment or purchase of a life insurance policy or annuity to the

funeral director;

2) then, the funeral home director in turn places the money, life insurance policy or annuity into a trust, *established by a person other than the individual.*

2. Treatment of Assets in Trust

In the case of a trust, the corpus of which includes assets of an individual and assets of any other person or persons, the provisions of this section shall apply to the portion of the trust attributable to the assets of the individual.

This section shall apply without regard to:

- the purpose for which a trust is established,
- **whether the trustee has or exercises any discretion under the trust,**
- any restrictions on when or whether distributions may be made from the trust, or
- any restriction on the use of distributions from the trust.

3. Revocable Trust

In the case of a revocable trust:

a. the corpus of the trust shall be considered resources available to the individual.

b. Payments from the trust to or for the benefit of the individual shall be considered income of the individual.

c. Any other payments from the trust shall be considered assets disposed of by the individual.

4. Irrevocable Trust

a. Payment Can Be Made To Individual

When there are any circumstances under which payment from the trust corpus or income could be made to or for the benefit of the individual, the following rules apply:

- payments from the trust corpus or income which are made to or for the benefit of the individual shall be considered **income** to the individual;

- income from the trust corpus that could be paid to the individual is considered a **resource** to the individual;

- the portion of the trust corpus that could be paid to the individual is considered a **resource** to the individual;

- a payment from the trust that is NOT made to or for the benefit of the individual shall be considered a transfer of assets by the individual.

NOTE: An irrevocable trust for burial is a trust from which payment will be made for the benefit of the individual.

b. Payment CANNOT Be Made To Individual

1) When all or any portion of the corpus of the trust cannot be paid under any circumstances to the individual, all (or any such portion) of the trust corpus shall be considered a transfer of assets. The effective date of the transfer of assets is the date the trust was established.

2) Any income earned by the corpus of the trust, from which no payment could be made (under any circumstances) to the individual, shall be considered a transfer of income.

c. Under the provisions of Section 55-19.5 of the Code of Virginia, clauses in a trust which foreclose or prohibit payments to an individual if he requires nursing home or medical care, or if he applies for Medicaid, are void. However, if a trust has been written in another state in which such clauses are legally enforceable, the date payment is foreclosed by such a clause is a transfer of assets that occurs on the date the payment is foreclosed.

d. In determining the value of the trust assets transferred, include all payments made from the trust after the date the trust was established or, if later, the date payment to the individual was foreclosed.

If the individual adds funds to the trust after these dates, the addition of those funds is considered to be a new transfer and effective on the date the funds are added.

M1140.500 WORKERS' COMPENSATION MEDICARE SET-ASIDE ARRANGEMENT ACCOUNTS

A. Introduction

A Workers' Compensation Medicare Set-aside Arrangement (WCMSA) is an arrangement which allocates a portion of a Workers' Compensation settlement for future medical expenses. The initial amounts of any set asides are determined on a case-by-case basis and are reviewed by the Centers for Medicare and Medicaid Services (CMS). Most WCMSAs will be placed in interest bearing accounts and are self-administered by applicants/enrollees, or by a competent administrator.

Funds authorized by a WCMSA are unearned income in the month of receipt, and any amount retained following the month of receipt is a countable resource. Section S0830.235 contains information on Workers' Compensation payments.

B. Operating Policy

1. Ownership

Assume that the person designated as owner in the account title owns all the funds in the account.

2. Right to Withdraw Funds

Absent evidence to the contrary, assume that the person shown as owner in the account title has the legal right to withdraw funds from the account.

3. Fiduciaries

A fiduciary's right to withdraw funds is the same as the owner's right to withdraw them.

4. Right to Use for Support and Maintenance

Although funds are intended for specific medical expenses, there are no legal restrictions as to how an individual uses the funds. Assume that an individual who owns and has the legal right to withdraw funds from a WCMSA also has the legal right to use them for his own support and maintenance.

C. Development and Documentation

The development and documentation instructions for checking and savings accounts contained in section S1140.200 apply to WCMSA accounts.

S1140.990 RESOURCES GUIDE -- OPTIONAL DESK AID

A. Introduction

This section provides:

- general information about various investment vehicles encountered; and
- serves as a guide to appropriate instructions which follow this table.

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Term	See	Cross Reference
Balanced Fund	E.4.	See Mutual Fund below.
Bond	C.	Interest, Capital Gains, Security Trades
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CD (Certificate of Deposit)	B.4.	Disqualified Interest, Forfeit Interest, Interest
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Corporate Bond	C.1.	Interest, Capital gains, Security Trades
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FREDDIE MAC	D.4.	See U.S. Government Security below.
GINNIE MAE	D.4.	See U.S. Government Security below.
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Income Fund	E.3.	See Mutual Fund below.
IRA (Individual Retirement Account)	H.	Varies with type of investment
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Money Market Fund	E.6.	See Mutual Fund below.
Municipal Bond	C.2.	Interest, Capital Gains, Security Trades

Term	See	Cross Reference
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UIT (Unit Investment Trust)	C.3.	Interest, Security Trades
U.S. Government Security	D.	Interest, Security Trades, Capital Gains
U.S. Savings Bond	D.5.	Interest
Zero Coupon Bond	C.4.	Interest, Capital Gains, Security Trades

B. Description of Checking and Savings Accounts

1. Savings Accounts

Savings accounts pay interest unless the financial institution has a minimum balance requirement and the account does not meet this requirement. Account owners can make deposits and withdrawals at any time in any amount. Develop per S1140.200 - .205.

2. Now and Super Now Accounts

NOW (Negotiable Order of Withdrawal) accounts are interest-bearing checking accounts. Super NOW accounts are money market checking accounts. They have higher interest rates than NOW accounts. Develop per S1140.200 -.205.

3. MMDA (Money Market Deposit Accounts)

MMDA's allow banks to compete with mutual fund money markets. They are interest-bearing checking accounts. Develop per S1140.200 -.205.

4. CD (Certificate of Deposit)

A CD is a bank deposit that cannot be withdrawn for a certain period of time or that can be withdrawn early only with a penalty. Develop per S1140.210.

C. Description of Bonds

1. Corporate Bonds

Develop corporate bonds in accordance with the instructions in S1140.250.

a. General Type
Corporations sell corporate bonds to raise capital. There are two types:

- **debentures**, which are backed by the issuer's full faith and credit and
- **mortgage backed bonds**, which are backed by a lien on the company's assets.

b. Two Forms of Each Type
Corporate bonds are issued in two forms:

- **registered,** which pay interest to their registered owner; and
- **bearer** or **coupon** bonds, which pay it to whomever holds the bond.

c. Convertible Bonds
Convertible bonds are debentures that can be exchanged for a specified number of shares of a company's common stock.

d. Junk Bonds
High risk bonds are called junk bonds.

e. Interest
Corporate bonds usually pay a fixed rate of interest for a fixed period of time--annually, semi-annually, or quarterly.

2. Municipal or Tax Exempt Bonds

Municipal bonds are to city, county and State governments and authorities what corporate bonds are to corporations. They are exempt from Federal taxes and often are exempt from State and local taxes as well. Most municipal bonds are one of two general types:

- general obligation bonds, which are backed by the full faith and credit of the issuing municipality and supported by the taxing power; and
- revenue bonds, which are backed by the project being financed and the revenue or user fees it generates.

Other types of municipals are: limited-tax bonds, anticipation notes, industrial development bonds, and life-care bonds.

Develop municipal bonds in accordance with the instructions in S1140.250.

3. UIT (Unit Investment Trust)

A UIT is a package of bonds in a portfolio. One can buy share of the package for $1 to $1,000 per share with a minimum investment of $750 to $5,000, depending on the trust. The interest rate usually is fixed at purchase and does not change. Units usually are sold or redeemed through the trust sponsor.

4. Zero Coupon Bonds

Zero coupon bonds usually are issued by corporations. They do not pay current interest; accrued interest is paid at maturity. The U.S. Government does not issue zero coupon bonds directly. However, see TIGER and CATS.

5. Buying and Selling Bonds

Bonds usually are bought and sold through brokers, securities dealers, or other investors. They may sell for more or less than their face value or purchase price, depending on a variety of factors.

6. Reading Bond Quotations

The following is a typical bond quotation, showing from left to right:

- the name and the issuer (AT&T);
- the bond's nominal or coupon rate (3 7/8 percent);
- the last two digits of the year in which the bond matures (1990);
- the current yield (5.6 percent);
- the number of bonds traded during the year (54,000);
- the highest, lowest, and last price of the bond for the period covered by the quotation (bond prices are quoted on a par of 100, so the last price of 69 1/4 equals $692.50).
- the net change in the bond price.

	CURRENT	SALES				
ISSUE	YIELD	1000's	HIGH	LOW	CLOSE	CHANGE
AT&T 3 7/8	5.6	54	69 3/4	69 1/4	69 1/4	-3/8

D. Description of U.S. Government Securities

1. Treasury Bills (T-Bills)

T-Bills are short-term obligations that require a minimum investment of $10,000. Certificates are not issued for T-Bills; they are registered in book form at the Treasury Department and receipts are provided as proof of purchase. T-Bills can be sold before maturity. Develop in accordance with S1140.250.

2. Treasury Notes and Bonds

Treasury notes and bonds are similar to T-Bills but have longer maturities and a lower minimum investment requirement. They have been registered in book entry form since July 1986 but were sometimes issued as bearer bonds before then. Develop per S1140.250.

3. Tiger and Cats

These are Government securities issued with a zero coupon concept. The broker removes the interest coupons from the security and sells it at a big discount with a long maturity. Accrued interest is then paid at maturity. These bonds can be sold before maturity. Develop in accordance with S1140.250.

4. Federal Agency Securities

Some of the Federal agencies with charters to issue securities are:

- the Federal Home Loan Bank Board;
- the Federal Home Loan Mortgage Corporation (FREDDIE MAC);
- the Export-Import Bank; and
- the Government National Mortgage Association (GINNIE MAE).

Minimum investment requirements range from $1,000 to $25,000. Develop per S1140.250.

5. U.S. Savings Bonds

U.S. Savings Bonds are registered, nontransferable Treasury securities Develop per S1140.240.

E. Description of Mutual Funds

1. General

"Mutual fund" is a term that encompasses a wide range of investments. Basically, it is a pool of assets (stocks, bonds, etc.) managed by an investment company. A mutual fund share represents ownership interest in this pool as opposed to a particular stock or bond. Develop mutual funds per S1140.230.

2. Growth Funds

The primary objective of these funds, also known as performance funds and hedge funds, is aggressive long term growth of investment rather than current income. Dividends typically are low.

3. Income Funds

The objective is current income through high dividends and interest, as opposed to capital gains.

4. Balanced Funds

The objective is a balance of growth and income.

5. Municipal Bond (Tax Exempt Fund)

The fund invests in tax-exempt bonds and the interest is passed along to holders on a tax-exempt basis.

6. Money Market Funds

The fund invests in conservative vehicles such as T-Bills and bank certificates. The minimum investment usually is $1,000, but may be less. Income may fluctuate daily based on interest rates. Money market funds often have a check-writing feature.

7. Buying and Selling Mutual Funds

"Load" funds are sold through a broker who collects a commission. "Noload" funds usually are purchased directly from the fund (no commission) and often are advertised in newspapers and magazines.

8. Reading Mutual Fund Quotations

The format of the following table is typical of those shown in newspapers and financial publications, showing from left to right:

- the names of the funds available for each management group (in this case, four funds managed by the Fund Founders Group);
- the high and low values for the preceding 52-week period;
- the most recent closing price;
- the change over the previous week; and
- the fund's income and capital gains totals for the previous 12 months.

Fund Founders Group	52 Weeks H	L	Close	Week's Change	Income*	Capital Gains
Growth n.	8.77	6.28	6.37	-0.08	0.157	2.505
Income n.	15.18	13.72	13.87	+ 0.01	1.273	0.232
Mutual	11.56	9.74	9.98	- 0.07	0.426	0.706
Special n.	37.11	22.88	23.54	- 0.13	1.900	1.395

n = no-load
*= last 12 months

F. Description of Stocks

1. Common Stocks

Common stock usually is held in the form of a certificate registered in the owner's name. Dividends usually are paid quarterly and may vary with company earnings.

- "Listed" stocks are those listed on the NYSE, AMEX, or on one of the regional exchanges such as Boston, Philadelphia, or Chicago.
- Over-the-counter (OTC) stocks, which include "penny" stocks, are not listed on the major exchanges. They usually are reported in the National Association of Security Dealers Automated Quotations (NASDAQ) system.

2. Preferred Stock

Preferred stock receives preference with respect to dividends and, in case of bankruptcy, the distribution of assets. Preferred stock dividends:

- are paid at a fixed rate;
- must be paid before common stock dividends can be paid; and
- must be made up later, when not paid timely, whereas common stock dividends may be skipped.

3. Reading Stock Quotations

Stock tables vary little from publication to publication. The following quote is typical, showing from left to right:

- the standard abbreviations of the name of the company (Philadelphia Electric in this case), followed by "pf" for preferred stock on the second line;
- the dividend amount;
- the price-to-earnings ratio;
- sales volume, in thousands;
- the day's high, low, and closing prices (22 3/4 = $22.75); and
- the change in price from the previous day.

NAME	DIV	PE	SALES	HIGH	LOW	LAST	CHG
Phi El	2.20	9	4323	22 7/8	22 5/8	22 3/4	- 1/8
Phil E pf	4.30	-	50	42 3/4	42 3/4	42 3/4	-

G. Description of Options

An option is the right to sell or buy something at a specified price by a specified date. The "something" is usually stock, but there are options on interest rates, stock market indexes, commodity futures, and other items as well. An option to sell is called a "put." An option to buy is a "call." The value of an option depends on:

1. General

- the length of the contract (3, 6, or 9 months);
- the difference between the CMV of the item and the price at which the put permits it to be sold or the call permits it to be bought; and
- the volatility of the item (how much its CMV is expected to fluctuate).

2. Buying and Selling Options

Options can be sold through a broker. If the CMV of an item goes up in relation to a call price, the value of the option increases. If it goes down, the value of the option decreases. The reverse is true for a put.

3. Reading Option Quotations

There are several exchanges across the country that list option prices for about 300 stocks: the Chicago Board of options Exchanges (CBOE), AMEX, the Philadelphia Stock Exchange, and the Pacific Stock Exchange. Transactions on these exchanges are listed in financial publications and many newspapers.

Although a stock option contract controls 100 shares of stock, options are quoted on the price per share. If a contract sells for $300, the cost per share is $3. Options come due and are quoted for each January, April, July and October.

The following example is a typical options quotation and shows, from left to right:

- the name of the stock (Tandy), the expiration month (April) and per-share price of the option ($30 for put option on line 2);
- the number of contracts sold (996 on line 2);
- the high, low, and closing prices for a contract ($56.25, $25, and $37.50, respectively, on line 2); and
- the net change in the value of the contract ($6.25).

Name, Expiration Date, and Price	Sales	High	Week's Low	Last	Net Change
Tandy Apr.30	1317	4 3/4	2 3/4	3 1/8	- 1/8
Apr. 30p	996	9/16	1/4	3/8	-1/16

H. Description of IRA (Individual Retirement Account) and Keogh Account

The terms IRA and Keogh account refer to retirement plans. They do not identify the underlying investment vehicle, which can be a bank account, CD, mutual fund, etc. Develop IRA's and Keogh accounts in accordance with the section(s) that deal with the underlying investment vehicle.

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QDWI *(*QUALIFIED DISABLED AND WORKING INDIVIDUALS*)*

A. Introduction

This appendix contains the policy regarding resources that are treated differently for the QDWI covered group. The resource policy for QDWI individuals is identical to SSI resource policy. The policy in this appendix applies to QDWI evaluations only.

B. QDWI Resource Evaluation

Resource treatment and evaluations used in QDWI evaluations are listed in:

- S1110 Resources, General;
- S1120 Identifying Resources;
- S1130 Resource Exclusions; and
- S1140 Countable Resources.

C. Resources Treated Differently

The following types of resources are treated differently for QDWI individuals. The differences are:

- automobiles*
- burial fund exclusions - maximum amount of $1,500
- burial plots - only one space per individual and immediate family members
- home property*
- household goods and personal effects*
- inheritances and unprobated estates*
- life estates*
- real property whose sale would cause undue hardship, due to loss of housing, to a co-owner*
- real property following reasonable but unsuccessful efforts to sell

The policy for counting resources marked with *an asterisk is contained* in this appendix.

D. References

Information on how to treat other types of resources of a QDWI individual is found within each of the following sections:

M1130.400 Burial Spaces
S1130.410 Burial Fund Exclusions
M1140.110 Countable Life Estate Interest

DETERMINING *QDWI* ELIGIBILITY BASED ON RESOURCES

S1110.600 FIRST-OF-THE-MONTH (FOM) RULE FOR MAKING DETERMINATIONS

A. Policy Principle -- the FOM Rule

We make all resources determinations as of the first moment of a calendar month.

B. Policy Principle -- Significance of the FOM Rule

1. Increase in Value of Resources

We consider any increase in the value of an individual's resources in the resources determination as of the first moment of the month following the month in which:

- the value of an existing resource increases (e.g., the value of a share of stock goes up or installment payments increase a property's equity value);
- an individual acquires an additional resource (e.g., inherits property); or
- an individual replaces an excluded resource with one that is not excluded (e.g., sells an excluded automobile for nonexcluded cash).

2. Decrease in Value of Resources

We consider any decrease in the value of an individual's resources in the resources determination as of the first moment of the month following the month in which:

- the value of an existing resource decreases (e.g., the value of a share of stock goes down);
- an individual spends a resource (e.g., withdraws $150 from a savings account to pay bills); or
- an individual replaces a countable resource with one that is not countable (e.g., trades a countable piece of real property for an excluded automobile).

3. Treatment of Assets Under Income and Resources Counting Rules

When an individual receives something in cash or in kind during a month, we evaluate it under the appropriate income-counting rules in that month. If the individual retains the item into the month following that of receipt, we evaluate it under the resource-counting rules. Thus, we do not evaluate the same asset under two sets of counting rules for the same month.

4. Receipts from the Sale, Exchange, or Replacement of a Resource

If an individual sells, exchanges, or replaces a resource, what he/she receives in return is not income. It is a different form of resource. This includes assets which have never been subject to resources counting because the owner sold, exchanged, or replaced them in the same month in which he/she received them.

The concept of such transactions not producing income does not apply to receipts from the sale of timber, minerals, or other like items which are part

of the land.

C. Example--Receipt of a Resource Considered as Income and Exchanged in Same Month

Miss Laramie, a disabled individual, received a $350 unemployment insurance benefit on January 10 at which time it was unearned income. On January 18, she used the $350 to purchase several shares of stock; i.e., she exchanged one resource (cash) for another resource (stock). We never counted the $350 cash payment as a resource because Miss Laramie exchanged it for stock in the month of receipt. The stock is not income; it is a different form of resource. Since a resource is not countable until the first moment of the month following the receipt, we first count the stock in the resources determination made as of February 1.

S1120.215 INHERITANCES AND UNPROBATED ESTATES

A. Introduction

An ownership interest in an unprobated estate may be a resource if an individual:

- *is an heir or relative of the deceased; or*
- *receives any income from the property; or*
- *under State intestacy laws, has acquired rights in the property due to the death of the deceased.*

B. Operating Policy

1. When to Develop

We develop for this type of resource only if:

- *the property in question is not excludable under any of the provisions in S1110.210 B.; and*
- *counting the property's value would result in excess resources.*

2. Ownership Interest

There is an ownership interest in an unprobated estate if:

- *documents (e.g., a will or court records) indicate an individual is an heir to property of a deceased; or*
- *an individual has use of a deceased's property or receives income from it; or*
- *documents establish, or the individual alleges, a relationship between himself and the deceased which, under State intestacy laws, awards the individual a share in the distribution of the deceased's property; and*
- *the inheritance, use of income, and distribution are uncontested.*

3. When Unprobated Estate Can Be a Resource

We do not consider that an inheritance is a resource until the month following the month in which it meets the definition of income. See S0830.550 for the income rules on inheritances. Thereafter, if retained, we evaluate the property as a resource.

C. Development and Documentation

1. Ownership Interest

Document the file, as applicable, with a copy of:

- *an inheritance or relationship document (or a signed statement alleging a relationship);*
- *evidence of income from the property;*
- *individual's signed statement concerning his/her use of the property and whether there is contest of any factor; or*
- *other evidence showing that the situation meets the criteria in B.*

2. *Sole vs. Shared Ownership*

Follow S1110.510 and S1140.030 to determine and document whether there are other owners and, if so, whether the individual needs their consent to sell his/her share of the property.

3. *Status as a Resource*

- *If the individual is the sole owner or if other owners give needed consent to sell, the property is the individual's resource. Some States do not require the consent of other heirs in order for a co-owner to sell property.*

- *If other owners withhold consent and that consent is necessary to sell, the property is not a resource until the estate has been through probate. It is subject to the resource counting rules the month following the month it meets the definition of income.*

4. *Value of Resource*

a. *CMV - Develop the property's CMV (and EV, if appropriate) following guidelines in S1140 for the particular type of property involved.*

b. *Shared Ownership*

- *For real property, and most personal property, see S1140.030 B.*
- *For checking/savings accounts and time deposits, see S1140.205 and S1140.210.*

REAL PROPERTY

S1130.100 THE HOME

A. Policy Principles

1. *Exclusion of the Home*

An individual's home, regardless of value, is an excluded resource.

2. *Definition of the Home*

An individual's home is property in which he or she has an ownership interest and that serves as his or her principal place of residence. It can include:

- *the shelter in which he or she lives;*
- *the land on which the shelter is located; and*
- *related buildings on such land.*

3. *Principal Place of Residence*

An individual's principal place of residence is the dwelling the individual considers his or her established or principal home and to which, if absent, he or she intends to return. It can be real or personal property, fixed or mobile, and located on land or water.

4. Individual Owns The Land

For purposes of excluding "the land on which the shelter is located" (A.2. above), it is not necessary that the individual own the shelter itself.

EXAMPLE: *If an individual lives on his or her own land in someone else's trailer, the land meets the definition of home and is excluded.*

5. Extent of Property To Which The Exclusion Applies

a. Land

The home exclusion applies not only to the plot of land on which the home is located, but to any land that adjoins it.

Land adjoins the home plot if not completely separated from it by land in which neither the individual nor his or her spouse has an ownership interest.

Easements and public rights of way (utility lines, roads, etc.) do not separate other land from the home plot.

b. Buildings

The home exclusion applies to all buildings on land excluded per a. above.

6. Property That No Longer Serves As The Principal Place of Residence

a. General Rule

Property ceases to be the principal place of residence - and, therefore, to be excludable as the home - as of the date that the individual, having left it, does not intend to return to it.

Such property, if not excluded under another provision, will be included in determining countable resources as of the first moment of the first day of the following month.

b. Exceptions to General Rule

Even if the individual leaves the home without the intent to return, the property remains an excluded resource for as long as:

- *a spouse or dependent relative of the individual continues to live there while the individual is institutionalized; or*
- *its sale would cause undue hardship, due to loss of housing, to a co-owner of the property.*

7. Dependent Relative Defined

a. ***Dependency*** *may be of any kind (financial, medical, etc.).*

b. ***Relative*** *means:*

- *child, stepchild, or grandchild;*
- *parent, stepparent, or grandparent;*
- *aunt, uncle, niece, or nephew;*
- *brother or sister, stepbrother or stepsister, half brother or half sister;*
- *cousin; or*
- *in-law.*

B. Development and Documentation - Initial Claims

1. Ownership

a. Use of Allegation

Accept an individual's allegation of home ownership unless the file raises a question about it (e.g., a life estate is involved, the individual is under age 18, does not live with a parent, and does not live with someone else). If there is a question, have the individual submit one of the items of evidence listed in b. - d., below.

b. Evidence of Real Property Ownership

- tax assessment notice;
- recent tax bill;
- current mortgage statement;
- deed;
- report of title search;
- evidence of heirship in an unprobated estate (e.g., receipt of income from the property, a will, or evidence of relationship recognizable under State intestate laws in cases where the home is unprobated property).

c. Evidence of Personal Property Ownership (e.q., a Mobile Home)

- **title;**
- **current registration.**

d. Evidence of Life Estate or Similar Property Rights

- deed;
- will;
- other legal document**.**

e. Equitable Ownership

If an individual alleges equitable ownership (e.g., an unwritten ownership interest or right of use for life) obtain any pertinent documents and a signed statement from each of the parties involved regarding any arrangement that has been agreed to. Forward the document to a medical assistance program consultant for an opinion from legal counsel.

2. *Principal Place of Residence -- Operating Assumption*

*Absent ownership in more than one residence or evidence that raises a question about the matter, **assume** that the alleged home is the individual's principal place of residence.*

3. *Indication of More than One Residence*

*If an individual alleges or other evidence indicates ownership of more than one residence, **obtain** his or her signed statement concerning such points as:*

- *how much time is spent at each residence;*
- *where he or she is registered to vote;*
- *which address he or she uses as a mailing address or for tax purposes.*

***Determine** the principal place of residence accordingly and document the determination in file.*

4. *Evidence Indicates Nonadjoining Property*

a. Individual Agrees With Evidence

If evidence indicates that land the individual owns does not adjoin the home plot, and the individual agrees that it does not:

- ***obtain** his or her statement to that effect; and*
- ***develop** the nonadjoining portion per S1140.100 (Nonhome Real Property) or S1130.500 (Property Essential to Self-Support), as applicable.*

b. Individual Disagrees With Evidence

If the individual maintains that all the land adjoins the home plot, document the file with:

- *a sketch of the land showing the boundaries of the various plots and the location of the shelter used as the home; and*
- *evidence of how the land is treated for tax assessment purposes.*

The sketch may be by the individual, from public records, or by the Eligibility Worker (from direct observation).

The tax assessment information may be in the form of a tax assessment notice or obtained from the appropriate tax jurisdiction and recorded in case record

c. Combined or Single Holding for Tax Assessment

Assume that the land is a single piece of property in which all the land adjoins the home plot if:

- *it is recorded and treated as a single holding for tax assessment purposes; or*
- *the original holding has been subdivided, but still is treated as a single holding for tax assessment purposes.*

d. More Than Single Holding for Tax Assessment

If the land is recorded and treated as two or more holdings for tax assessment purposes, use the sketch to determine whether other holdings adjoin the home plot.

5. Absences From The Home

a. Summary of Development

If the individual is in an institution, determine whether a spouse or dependent relative is living in the home (see b. below).

If no spouse or dependent relative is living the home, or if the absence is for a reason other than institutionalization, determine:

- *whether the individual intends to return to the home (see c. below); and*
- *if not, whether the sale of the home would cause undue hardship, due to loss of housing, to a co-owner (see D.1. below).*

NOTE: *If a previously undeveloped absence from the home has ended, assume that the individual always intend to return. The absence, regardless of duration, will not affect the home exclusion.*

b. Spouse or Dependent Relative Development

Obtain a signed statement from the individual as to:

- *whether anyone is living in the home while the individual is in the institution;*
- *if so, how that person is related to the individual, if at all; and*
- *if related (except for the individual's spouse), how that person is dependent on the individual, if at all.*

Absent evidence to the contrary, accept the allegations.

c. "Intent to Return" Development

If the individual has left his or her home but intends to return to it, see D. below for the necessary development.

NOTE: *"Intent to return" development applies only to the* ***continued*** *exclusion of property which met the definition of the individual's* ***home*** *prior to the time the individual left the property. See A.2. above for the definition of "home."*

C. Procedure -- Posteligibility

If, after Medicaid eligibility is established, an individual receives real property - for example, as an inheritance or gift - which may be excludable as his/her home, apply the policy and procedures in A. and B. above to determine whether the home exclusion applies.

Redevelop the exclusion from resources of an individual's home only if something raises a question about the correctness of the original determination or indicates that the exclusion may no longer apply (e.g., a change of address).

If the individual has left his or her home but intends to return to it, see D. below.

D. Procedure -- "Intent to Return Home" Development

1. Obtain Statement

Obtain a signed statement from the individual as to:

- *when and why he or she left the home;*
- *whether he or she intends to return; and*
- *if he or she does not intend to return, when that decision was made.*

NOTE: *If the individual has a representative payee, obtain the "intent" statement from the payee.*

This statement governs the "intent to return" determination unless the statement is self-contradictory (see 2. through 4. below).

2. Self-Contradictory Statement

Consider a statement to be self-contradictory if it contains conflicting or unclear expressions of intent.

Examples of self-contradictory statements:

"Sometimes I want to go home and sometimes I don't."

"I intend to go home but I also want to stay here."

"Yes, I want to go home, but I really don't know if I should."

3. Factors Not to Consider

Do not consider other factors, such as the individual's age, physical condition, or other circumstances when determining intent to return home. Assuming the individual is mentally competent, age, mental capacity, and physical condition are ***not*** *factors in evaluating the individual's statement of intent.*

Example: *The recipient is 93 years old and in the intensive care unit of a hospital. She tells the Eligibility Worker that her doctor believes she may not be able to leave the hospital and return home. However, she states that she intends to return to her former residence as soon as she is well enough to leave the hospital. Based on her statement, "intent to return home" is established.*

Example: *The recipient's home was partially destroyed by fire. He does not know when the necessary repairs will be completed. In the meantime, he is living with his sister. He states he intends to return to the former residence as soon as possible. Based on his statement, "intent to return home" is established.*

4. Obtaining More Information If Needed

If the individual's statement of intent is self-contradictory, contact someone who knows the situation, such as a physician, family member, or close friend or relative, to clarify the situation.

S1130.130 REAL PROPERTY WHOSE SALE WOULD CAUSE UNDUE HARDSHIP, DUE TO LOSS OF HOUSING, TO A CO-OWNER

A. Policy Principles

1. *Exclusion*

*The value of an individual's ownership interest in jointly owned real property is an excluded resource **for as long as** sale of the property would cause undue hardship, due to loss of housing, to a co-owner.*

2. *Undue Hardship*

Undue hardship would result if such co-owner:

- *uses the property as his or her principal place of residence;*
- *would have to move if the property were sold; and*
- *has no other readily available housing.*

B. Development and Documentation-- Initial Applications and Post-Eligibility

1. *Allegations of Loss of Housing for Co-Owner*

If someone alleges that the sale of certain real property would force a co-owner living on it to move, obtain:

- *the individual's signed statement to that effect, and*
- *evidence of joint ownership (see S1130.100 E.1.b.-d.).*

If co-ownership is not proven, skip to 3. below. Otherwise, obtain the statement in 2. below.

2. *Required Statement from Resident Co-Owner*

Obtain a statement from the co-owner regarding whether he or she:

- *uses the property as his or her principal place of residence;*
- *would have to move if the property were sold; and*
- *has other living quarters readily available.*

Apply the policy principle in A. above to determine whether, on the basis of the statements of the individual and the co-owner, the sale of the property would cause undue hardship to the co-owner.

Accept any reasonable allegation from the co-owner that there is no readily available housing (e.g., no other affordable housing available or no other housing with necessary physical modifications for a handicapped individual).

3. *Determination-Not Undue Hardship*

If the property cannot be excluded on the basis of undue hardship:

- *document the file to that effect;*
- *issue appropriate notice.*

4. *Determination-Undue Hardship*

If the property can be excluded on the basis of undue hardship:

- *document the file to that effect;*
- *issue appropriate notice.*

S1130.140 REAL PROPERTY FOLLOWING REASONABLE BUT UNSUCCESSFUL EFFORTS TO SELL

A. Policy Principles

Real property that an individual has made reasonable but unsuccessful efforts to sell will be excluded from resource evaluation for as long as:

- the individual continues to make reasonable efforts to sell it; and
- including the property as a countable resource would result in a determination of excess resources.

B. Policy Reasonable Efforts to Sell/Buy

1. Reasonable Efforts to Sell - General

The individual must make reasonable efforts to sell excess nonliquid property by taking all necessary steps to sell it through media serving the geographic area in which the person lives or, if different, where the property is located.

2. Reasonable Efforts to Sell Real Property

a. The individual/couple agrees in writing to:

- sell excess nonliquid resources at their current market value (CMV); and

b. Within 30 days of signing an agreement, the owner must:

- list the property with an agent; or
- begin to advertise in at least one of the appropriate media; place a "For Sale" sign on the property (if permitted); begin to conduct open houses or otherwise show the property to interested parties on a continuing basis; or attempt any other appropriate methods of sale such as posting notices on community bulletin boards, distributing fliers, etc.

NOTE: Reasonable efforts must be evaluated in consideration of the individual's circumstances and must not be restricted to "traditional" sales methods such as employing a real estate agent.

c. Except for gaps of no more than 1 week, the owner must maintain efforts of the type listed in a. above; and

d. The owner must not reject any reasonable offer to buy the property and must accept the burden of demonstrating to DSS's satisfaction that he rejected an offer because it was not reasonable.

3. Reasonable Offer to Buy Real Property

We assume that an offer to buy real property is reasonable if it is at least two-thirds of the estimated CMV unless the owner proves otherwise.

a. Definition

Good cause exists when circumstances beyond an individual's control prevent his/her taking the required actions to accomplish reasonable efforts to sell.

b. Significance of Good Cause

- Without good cause, failure to meet the criteria outlined in 1. or 2. above, as applicable, means that the individual is not making reasonable efforts to sell the property. Therefore, his/her countable resources include the value of the excess property.

- With good cause, failure to meet the criteria in 1. or 2. above means that the exclusion continues.

C. Examples - Good Cause

1. No Offer to Buy	The individual makes good faith efforts to sell excess nonliquid resources (or is prevented from doing so by circumstances beyond his/her control) but receives no offer to buy them.
2. Reliance on an Offer That Does Not Result in a Sale	A legitimate or apparently legitimate offer to buy an excess nonliquid resource halts further efforts to sell it for a prolonged period of time, and the prospective buyer subsequently cannot or will not complete the purchase.
3. Escrow Begins But Closing Does Not Take Place Within Disposal Period	The individual accepts an offer to buy real property, and escrow begins, which precludes acceptance of another offer. Closing (at which full or partial payment and transfer of title are exchanged) does not take place within the disposal period.
4. Incapacitating Illness Or Injury	The individual becomes homebound or hospitalized for a prolonged period, due to illness or injury, and cannot take the steps necessary to sell the resource or to arrange for someone to sell it on his/her behalf.
5. Part-Owner Dies	A part-owner of a resource dies, and administration or probate of the estate delays efforts to sell the resource (assuming that the property continues to be a resource.)

PERSONAL PROPERTY

S1130.200 AUTOMOBILES

A. Policy Principles

1. Automobile Defined	For Medicaid purposes, "automobiles" means any vehicle used for transportation. It thus can include, in addition to cars and trucks: boats, snowmobiles, animal-drawn vehicles, and even animals.

2. Current Market Value Defined

The CMV of an automobile is the average price an automobile of that particular year, make, model and condition will sell for on the open market (to a private individual) in the particular geographic area involved.

3. Exclusion Regardless of Value

One automobile is excluded regardless of value if, for the individual or a member of the individual's household, it is:

- necessary for employment;
- necessary for the treatment of a specific or regular medical problem;
- modified for operation by, or the transportation of, a handicapped person; or
- necessary, because of climate, terrain, distance or similar factors, for the performance of **essential** daily activities.

4. Alternate Exclusion--Up to $4,500 Of CMV

If **no** automobile is excluded per 3. above, up to $4,500 of the **CMV** of **one** automobile is excluded. If the CMV exceeds $4,500, the excess counts as a resource unless the automobile can be excluded under some other provision. Equity value is not a consideration for purposes of this exclusion.

5. Other Automobiles

Any automobile an individual owns in addition to the one wholly or partly excluded per 3. or 4., and which cannot be excluded under another provision is a resource in the amount of its equity value.

B. Operating Policy--More Than One Automobile Owned

1. General Rule

The exclusion applies in the manner most advantageous to the individual.

2. Example--One of Two Cars is Totally Excluded

If one of two cars can be excluded as necessary for medical treatment, and the other will be a countable resource, the exclusion applies to the car with the greater equity value regardless of which car is used to obtain medical treatment.

3. Example--Neither of Two Cars is Totally Excluded, One Is Excluded to $4,500 of CMV

Mr. Smith owns two cars. One has a CMV of $8,000 and an equity value of $500. The other, which has been paid off, has a CMV and equity value of $2,500. Neither can be excluded based on use.

Applying the $4,500 exclusion to the car with the $8,000 CMV would leave $3,500 of the CMV of that car as a countable resource. It also would leave the $2,500 equity value of the other car as a countable resource.

Applying the $4,500 exclusion to the car with the $2,500 CMV excludes that car entirely, leaving only the $500 equity value of the other car to be included among countable resources. Therefore, the exclusion applies to the car with the $2,500 CMV.

C. Development and Documentation-- Initial Applications

1. Status as Automobile

a. Use of Allegation

For the purpose of determining whether a vehicle is used for transportation (i.e., whether it is an automobile for Medicaid purposes), accept the individual's account of its use unless a question arises. If a vehicle is not being used for transportation, find out why.

b. Vehicle Not Used for Transportation

- A temporarily broken down vehicle normally used for transportation still qualifies as an automobile. One that has been junked or that is used only as a recreational vehicle (such as a boat used weekends on the lake) does not.

Vehicles that do not meet the definition of an automobile are personal property. The value they have as a resource is their equity value, and the personal effects exclusion does not apply to them.

2. Ownership

Absent evidence to the contrary, accept the individual's allegation as to sole or joint ownership and his or her proportionate share of joint ownership. Resolve any questions by examining the title, the current year's registration, or the bill of sale. Place in file a photocopy of the document examined or record the relevant facts in case record.

3. Exclusion Regardless of Value

Absent evidence to the contrary, accept the individual's allegation as to the presence of a factor that would qualify the automobile for exclusion regardless of value.

4. CMV Based On N.A.D.A. Guides

a. Description of Vehicle

When the value of an automobile must be developed, get a description complete enough to enable you to find it in one of the N.A.D.A. guides discussed below, e.g.: 1982 Chevrolet Caprice, V-6, 2-door.

b. N.A.D.A. Official Used Car Guide

This publication gives values for popular foreign and domestic cars and light trucks up to 8 years old. Use as the automobile's CMV the average **trade-in** value shown for it in the most recently published of these two issues, regardless of the period of time covered by the determination.

c. N.A.D.A. Older Car Guide

This publication gives values for popular cars and trucks from 8 to 18 years old. Use the average trade-in value shown in the most recently published January-April issue.

If the automobile is more than 18 but less than 25 years old, use the value shown for it at 18 years old.

d. Other N.A.D.A. Guides
N.A.D.A. also publishes guides on mobile homes, recreational vehicles, boats, motorcycles, and mopeds.

5. Rebuttal of N.A.D.A. Value

a. When Rebuttal Applies
If the N.A.D.A. guide value affects eligibility and the individual disagrees with it, give him or her the opportunity to rebut it.

b. Rebuttal Evidence
Rebuttal evidence can consist of N.A.D.A. guides and/or of a written appraisal of the automobile's CMV obtained by the individual at his or her own cost from a disinterested knowledgeable source, such as a used car of truck dealer or an automobile insurance company.

c. Determination
Document a rebuttal determination in case record.

6. Exceptions To Use of N.A.D.A. Guide Values

The following circumstances preclude use of the N.A.D.A. guides:

- The guides do not list the make and/or model of the vehicle.
- The guides list but do not show a value for the make and/or model of the vehicle.
- The vehicle is a car or truck 25 or more years old.
- The vehicle is any motorized vehicle other than a car or truck, or is a nonmotorized vehicle (e.g., an animal or animal-drawn vehicle).

7. Knowledgeable Source Estimate

When one of the exceptions in 6. above applies, or other circumstances make use of the N.A.D.A. guides inappropriate, get a CMV estimate from a disinterested knowledgeable source.

Provide the contact with a complete description of the vehicle, including year, make, model, number of doors, equipment, etc. Absent evidence to the contrary, such as that the vehicle is damaged or is in "mint" condition, assume it to be in average condition.

Inform the contact that the estimate should show what the vehicle would sell for on the open market in the geographic area covered by local media. If the estimate is obtained by telephone, document the file with all the pertinent facts.

D. Development and Documentation-Posteligibility

1. Exclusion Regardless Of Value

If an automobile has been excluded regardless of value, it is not necessary to redevelop the exclusion or the value.

2. Exclusion To $4,500 of CMV

a. General
It is not necessary to redevelop the CMV of a vehicle that has been excluded to $4,500 of its CMV unless the CMV in excess of $4,500 affects eligibility.

b. Exception
Always redevelop the collector value of an antique or other collectible vehicle.

E. Related Policy

If a vehicle cannot be excluded under this provision, consider the possibility of its exclusion as property essential to self-support (S1130.500), or as part of a plan for achieving self-support.

S1130.430 HOUSEHOLD GOODS AND PERSONAL EFFECTS

A. Policy Principles

1. Items Excluded Regardless Of Value

a. One wedding ring and one engagement ring per individual are excluded regardless of value.

b. Prosthetic devices, wheelchairs, hospital beds, dialysis machines and **other items required by a person's physical condition** are excluded regardless of value **if** they are not used extensively and primarily by other members of the household.

2. Exclusion Of Up To $2,000 Equity Of Other Items

A general exclusion of up to $2,000 applies to the total equity value of household goods and personal effects other than those excluded regardless of value. Any portion of the total equity in excess of $2,000 is not excluded under this provision.

B. Definitions

1. Household Goods

Household goods are items of personal property customarily found in the home and used in connection with the maintenance, use, and occupancy of the premises as a home. They include, but are not limited to: furniture, appliances, televisions sets, carpets, cooking and eating utensils, dishes, etc.

2. Personal Effects

Personal effects are items of personal property that are worn or carried by an individual or that have an intimate relation to him or her. They include, but are not limited to: clothing, jewelry, personal care items, prosthetic devices, and educational or recreational items such as books, musical instruments, or hobby materials.

3. Items Of Unusual Value

An item of unusual value is one whose CMV exceeds $500.

4. Durable Items

Durable household goods and personal effects include furniture, major appliances, expensive carpets and jewelry, and other items that retain a significant resale value over time.

Durable items do **not** include:

- anything treated as an item of unusual value;
- ordinary cooking and eating utensils;
- small appliances;
- linens;

- clothing; or
- household furnishings of little value.

C. Development and Documentation--Initial Claims

1. Wedding And Engagement Rings

If only one wedding and/or engagement ring per individual is alleged, exclude it without further development. Treat additional such rings in accordance with the instructions below.

2. Allegation Of No Items Of Unusual Value, Or Of Only One Such Item With A CMV of $1,000 Or Less

Absent evidence to the contrary, accept the allegation. Assume that the total equity value of all household goods and personal effects is $2,000 or less. No further development is required.

3. Allegation Of Items Of Unusual Value Whose Total CMV Exceeds $1,000

a. Ask if the individual's physical condition requires any of the items. If the answer is "No," record it in the *case record* and skip to c. below for the additional development required.

If the answer is "Yes," record it in the case record with the following information:

- what the condition is;
- why the item is required for that condition (unless the reason is obvious);
- the extent to which the individual uses the item; and
- the extent to which any other member of the household uses the item.

b. **Determine,** based on the allegations, whether any of these items is excluded per A.1.b. above.

If, after exclusion of appropriate items per A.1.b., the alleged total CMV of the remaining items of unusual value does not exceed $1,000, **discontinue development.** Otherwise, proceed according to c. below.

c. Have the individual list all durable items and the estimated value of each. If the sum of their alleged value and the alleged value of the nonexcluded items of unusual value does not exceed $2,000, **cease development.** If it does exceed $2,000, proceed according to d. below.

d. **Verify** the CMV of any item of unusual value not excluded per A.1.b. Use any reliable evidence of CMV the individual can submit, such as a recent sales slip or appraisal, or insurance coverage, or obtain an estimate from a knowledgeable source, such as a local merchant.

NOTE: Insurance appraisals and amounts of insurance coverage often reflect replacement value (the amount it would cost to purchase a

similar item new) rather than CMV. Do not use replacement value in lieu of CMV.

If the verified CMV of all nonexcluded items of unusual value and the alleged CMV of all durable items totals $2,000 or less, **cease development.** Otherwise, proceed according to e. below.

e. **Determine** whether any of the durable items (i.e., that are not items of unusual value) can be excluded per A.1.b. above. If they can, and if the verified CMV of all nonexcluded items of unusual value and the alleged CMV of the remaining durable items then totals $2,000 or less, **cease development.** Otherwise, proceed according to f. below.

f. **Verify** the CMV of the nonexcluded durable items. If the verified total CMV of all nonexcluded items of unusual value and nonexcluded durable items is $2,000 or less, **cease development.** Otherwise, proceed according to g. below.

g. If the portion of the total CMV that exceeds $2,000 affects eligibility, **determine** the equity value of any item on which the individual alleges there is an encumbrance. If total equity value then exceeds $2,000, that portion of the equity in excess of $2,000 cannot be excluded under this provision.

S1140.110 OTHER PROPERTY RIGHTS

A. Introduction

For resources other than a life estate, apply development and documentation located in S1140.110 to QDWI evaluations.

B. Life Estate

A life estate conveys to the individual to whom it is given certain property rights for the duration of his or her life, or someone else's life. In some cases, it may be conditional: e.g., for life or until remarriage. The owner of a life estate can sell the life estate but does not have title to the property and thus, normally cannot sell it or pass it on as an inheritance.

For QDWI evaluations, a life estate in real property, other than the home property, is counted as a resource ***regardless of when the life estate was established.*** *Follow the policy in M1140.110 for determining the countable value of a life estate.*

A life estate in home property does not need to be developed as the home is an excluded resource.

QMB, SLMB, QI AND ABD 80% FPL

A. Introduction

This section contains information regarding the resources that are treated differently for *QMB, SLMB, QI and ABD 80% FPL covered groups. The differences are:*

- home property,
- inheritances and unprobated estates, and
- real property whose sale would cause undue hardship, due to loss of housing, to a co-owner.

B. Resource Evaluation

Resource treatment and evaluation used *for QMB, SLMB, QI and ABD 80% FPL determinations are listed in:*

- S1110 Resources, General,
- S1120 Identifying Resources,
- S1130 Resource Exclusions and
- S1140 Countable Resources

C. Resource Policy Exceptions

Sections of policy that apply only to QMB, SLMB, QI and ABD 80% FPL evaluations are:

- S1120.215 Inheritances and Unprobated Estates
- S1130.100 The Home
- S1130.130 Real Property Whose Sale Would Cause Undue Hardship, Due to Loss of Housing to a Co-owner

The detailed information on these resources is below.

S1120.215 INHERITANCES AND UNPROBATED ESTATES

A. Introduction

An ownership interest in an unprobated estate may be a resource if an individual:

- is an heir or relative of the deceased; or
- receives any income from the property; or
- under State intestacy laws, has acquired rights in the property due to the death of the deceased.

B. Operating Policy

1. When to Develop

We develop for this type of resource only if:

- the property in question is not excludable under any of the provisions in S1110.210 B.; and
- counting the property's value would result in excess resources.

2. Ownership Interest

There is an ownership interest in an unprobated estate if:

- documents (e.g., a will or court records) indicate an individual is an heir to property of a deceased; or

- an individual has use of a deceased's property or receives income from it; or
- documents establish, or the individual alleges, a relationship between himself and the deceased which, under State intestacy laws, awards the individual a share in the distribution of the deceased's property; and
- the inheritance, use of income, and distribution are uncontested.

3. When Unprobated Estate Can Be a Resource

We do not consider that an inheritance is a resource until the month following the month in which it meets the definition of income. See *S0830.550* for the income rules on inheritances. Thereafter, if retained, we evaluate the property as a resource.

C. Development and Documentation

1. Ownership Interest

Document the file, as applicable, with a copy of:

- an inheritance or relationship document (or a signed statement alleging a relationship);
- evidence of income from the property;
- individual's signed statement concerning his/her use of the property and whether there is contest of any factor; or
- other evidence showing that the situation meets the criteria in B.

2. Sole vs. Shared Ownership

Follow S1110.510 and S1140.030 to determine and document whether there are other owners and, if so, whether the individual needs their consent to sell his/her share of the property.

3. Status as a Resource

- If the individual is the sole owner or if other owners give needed consent to sell, the property is the individual's resource. Some States do not require the consent of other heirs in order for a co-owner to sell property.

- If other owners withhold consent and that consent is necessary to sell, the property is not a resource until the estate has been through probate. It is subject to the resource counting rules the month following the month it meets the definition of income.

4. Value of Resource

a. CMV - Develop the property's CMV (and EV, if appropriate) following guidelines in S1140 for the particular type of property involved.

b. Shared Ownership

- For real property, and most personal property, see S1140.030 B.
- For checking/savings accounts and time deposits, see S1140.205 and S1140.210.

REAL PROPERTY

S1130.100 THE HOME

A. Policy Principles

1. Exclusion of the Home

An individual's home, regardless of value, is an excluded resource.

2. Definition of the Home

An individual's home is property in which he or she has an ownership interest and that serves as his or her principal place of residence. It can include:

- the shelter in which he or she lives;
- the land on which the shelter is located; and
- related buildings on such land.

3. Principal Place of Residence

An individual's principal place of residence is the dwelling the individual considers his or her established or principal home and to which, if absent, he or she intends to return. It can be real or personal property, fixed or mobile, and located on land or water.

4. Individual Owns The Land But Not The Shelter

For purposes of excluding "the land on which the shelter is located" (A.2. above), it is not necessary that the individual own the shelter itself.

EXAMPLE: If an individual lives on his or her own land in someone else's trailer, the land meets the definition of home and is excluded.

5. Extent of Property To Which The Exclusion Applies

a. Land

The home exclusion applies not only to the plot of land on which the home is located, but to any land that adjoins it.

Land adjoins the home plot if not completely separated from it by land in which neither the individual nor his or her spouse has an ownership interest.

Easements and public rights of way (utility lines, roads, etc.) do not separate other land from the home plot.

b. Buildings

The home exclusion applies to all buildings on land excluded per a. above.

6. Property That No Longer Serves As The Principal Place of Residence

a. General Rule

Property ceases to be the principal place of residence - and, therefore, to be excludable as the home - as of the date that the individual, having left it, does not intend to return to it.

Such property, if not excluded under another provision, will be included in determining countable resources as of the first moment of the first day of the following month..

b. Exceptions to General Rule
Even if the individual leaves the home without the intent to return, the property remains an excluded resource for as long as:

- a spouse or dependent relative of the individual continues to live there while the individual is institutionalized; or
- its sale would cause undue hardship, due to loss of housing, to a co-owner of the property

7. Dependent Relative Defined

a. Dependency may be of any kind (financial, medical, etc.).

b. Relative means:

- child, stepchild, or grandchild;
- parent, stepparent, or grandparent;
- aunt, uncle, niece, or nephew;
- brother or sister, stepbrother or stepsister, half brother or half sister;
- cousin; or
- in-law.

B. Development and Documentation-- Initial Claims

1. Ownership

a. Use of Allegation
Accept an individual's allegation of home ownership unless the file raises a question about it (e.g., a life estate is involved, the individual is under age 18, does not live with a parent, and does live with someone else). If there is a question, have the individual submit one of the items of evidence listed in b. - d. below.

b. Evidence of Real Property Ownership:

- tax assessment notice;
- recent tax bill;
- current mortgage statement;
- deed;
- report of title search;

evidence of heirship in an unprobated estate (e.g., receipt of income from the property, a will, or evidence of relationship recognizable under State intestate distribution laws in cases where the home is unprobated property).

c. Evidence of Personal Property Ownership (e.g., a Mobile Home):

- title;
- current registration.

d. Evidence of Life Estate or Similar Property Rights

- deed;
- will

- other legal document**.**

e. Equitable Ownership

If an individual alleges equitable ownership (e.g., an unwritten ownership interest or right of use for life) obtain any pertinent documents and a signed statement from each of the parties involved regarding any arrangement that has been agreed to. Forward the document to a medical assistance program consultant for an opinion from legal counsel.

2. Principal Place of Residence -- Operating Assumption

Absent ownership in more than one residence or evidence that raises a question about the matter, **assume** that the alleged home is the individual's principal place of residence.

3. Indication of More than One Residence

If an individual alleges or other evidence indicates ownership of more than one residence, **obtain** his or her signed statement concerning such points as:

- how much time is spent at each residence;
- where he or she is registered to vote;
- which address he or she uses as a mailing address or for tax purposes.

Determine the principal place of residence accordingly and document the determination in file.

4. Evidence Indicates Nonadjoining Property

a. Individuals Agrees With Evidence
If evidence indicates that land the individual owns does not adjoin the home plot, and the individual agrees that it does not;

- **obtain** his or her statement to that effect and
- **develop** the nonadjoining portion per S1140.100 (Nonhome Real Property) or S1130.500 (Property Essential to Self-Support), as applicable.

b. Individual Disagrees With Evidence
If the individual maintains that all the land adjoins the home plot, document the file with:

- a sketch of the land showing the boundaries of the various plots and the location of the shelter used as the home; and
- evidence of how the land is treated for tax assessment purposes.

The sketch may be by the individual, from public records, or by the Eligibility Worker (from direct observation).

The tax assessment information may be in the form of a tax assessment notice or obtained from the appropriate tax jurisdiction and recorded in the case record.

c. Combined or Single Holding for Tax Assessment

Assume that the land is a single piece of property in which all the land adjoins the home plot if:

- it is recorded and treated as a single holding for tax assessment purposes; or
- the original holding has been subdivided, but still is treated as a single holding for tax assessment purposes.

d. More Than Single Holding for Tax Assessment

If the land is recorded and treated as two or more holdings for tax assessment purposes, use the sketch to determine whether other holdings adjoin the home plot.

5. Absences From The Home

a. Summary of Development

If the individual is in an institution, determine whether a spouse or dependent relative is living in the home (see b. below).

If no spouse or dependent relative is living in the home, determine:

- whether the individual intends to return to the home (see c. below); and
- if not, whether the sale of the home would cause undue hardship, due to loss of housing, to a co-owner (see D.1. below).

NOTE: If a previously undeveloped absence from the home has ended, assume that the individual always intend to return. The absence, regardless of duration, will not affect the home exclusion.

b. Spouse or Dependent Relative Development

Obtain a signed statement from the individual as to:

- whether anyone is living in the home while the individual is in the institution;
- if so, how that person is related to the individual, if at all; and
- if related (except for the individual's spouse), how that person is dependent on the individual, if at all.

Absent evidence to the contrary, accept the allegations.

c. "Intent to Return" Development

If the individual has left his or her home but intends to return to it, see D. below for the necessary development.

NOTE: "Intent to return" development applies only to the **continued** exclusion of property which met the definition of the individual's **home** prior to the time the individual left the property. See A.2. above for the definition of "home."

C. Procedure -- Posteligibility

If, after Medicaid eligibility is established, an individual receives real property - for example, as an inheritance or gift - which may be excludable as his/her home, apply the policy and procedures in A. and B. above to determine whether the home exclusion applies.

Redevelop the exclusion from resources of an individual's home only if something raises a question about the correctness of the original determination or indicates that the exclusion may no longer apply (e.g., a change of address).

If the individual has left his or her home but intends to return to it, see D. below.

D. Procedure -- "Intent to Return Home" Development

1. Obtain Statement

Obtain a signed statement from the individual as to:

- when and why he or she left the home;
- whether he or she intends to return; and
- if he or she does not intend to return, when that decision was made.

NOTE: If the individual has a representative payee, obtain the "intent" statement from the payee.

This statement governs the "intent to return" determination unless the statement is self-contradictory (see 2. through 4. below).

2. Self-Contradictory Statement

Consider a statement to be self-contradictory if it contains conflicting or unclear expressions of intent.

Examples of self-contradictory statements:

"Sometimes I want to go home and sometimes I don't."

"I intend to go home but I also want to stay here."

"Yes, I want to go home, but I really don't know if I should."

3. Factors Not to Consider

Do not consider other factors, such as the individual's ages, physical condition, or other circumstances when determining intent to return home. Assuming the individual is mentally competent, age, mental capacity, and physical condition are **not** factors in evaluating the individual's statement of intent.

Example: The recipient is 93 years old and in the intensive care unit of a hospital. She tells the Eligibility Worker that her doctor believes she may not be able to leave the hospital and return home. However, she states that she intends to return to her former residence as soon as she is well enough to leave the hospital. Based on her statement, "intent to return home" is established.

Example: The recipient's home was partially destroyed by fire. He does not know when the necessary repairs will be completed. In the meantime, he is living with his sister. He states he intends to return to the former residence as soon as possible. Based on his statement, "intent to return home" is established.

4. Obtaining More Information If Needed

If the individual's statement of intent is self-contradictory, contact someone who knows the situation, such as a physician, family member, or close friend or relative, to clarify the situation.

S1130.130 REAL PROPERTY WHOSE SALE WOULD CAUSE UNDUE HARDSHIP, DUE TO LOSS OF HOUSING, TO A CO-OWNER

A. Policy Principles

1. Exclusion

The value of an individual's ownership interest in jointly owned real property is an excluded resource **for as long as** sale of the property would cause undue hardship, due to loss of housing, to a co-owner.

2. Undue Hardship

Undue hardship would result if such co-owner:

- uses the property as his or her principal place of residence;
- would have to move if the property were sold; and
- has no other readily available housing.

B. Development and Documentation--Initial Applications and Post-Eligibility

1. Allegations of Loss of Housing for Co-Owner

If someone alleges that the sale of certain real property would force a co-owner living on it to move, obtain:

- the individual's signed statement to that effect, and
- evidence of joint ownership (see S1130.100 E.1.b.-d.).

If co-ownership is not proven, skip to 3. below. Otherwise, obtain the Statement in 2. below.

2. Required Statement from Resident Co-Owner

Obtain a statement from the co-owner regarding whether he or she:

- uses the property as his or her principal place of residence;
- would have to move if the property were sold; and
- has other living quarters readily available.

Apply the policy principle in A. above to determine whether, on the basis of the statements of the individual and the co-owner, the sale of the property would cause undue hardship to the co-owner.

Accept any reasonable allegation from the co-owner that there is no readily available housing (e.g., no other affordable housing available or no other housing with necessary physical modifications for a handicapped individual).

3. Determination-Not Undue Hardship

If the property cannot be excluded on the basis of undue hardship:

- document the file to that effect;
- issue appropriate notice.

4. Determination-Undue Hardship

If the property can be excluded on the basis of undue hardship:

- document the file to that effect;
- issue appropriate notice.

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SPENDDOWN GENERAL PRINCIPLES AND DEFINITIONS

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M1310.000 SPENDDOWN GENERAL PRINCIPLES AND DEFINITIONS

M1310.100 GENERAL PRINCIPLES OF MEDICAID SPENDDOWN

A. Introduction

Individuals and families who otherwise meet the medically needy non-financial and resource eligibility requirements, but whose countable income exceeds the medically needy income limits, are not eligible for Medicaid unless:

- the excess income is insufficient to meet the cost of needed medical care, and
- the cost of incurred medical or remedial care recognized under state law has been deducted from excess income.

This section contains the policy and procedures for determining a family's or a non-institutionalized individual's medically needy income eligibility when their income exceeds the medically needy income limit.

Contact your Regional Medicaid Consultant for the policy and procedures for Medicaid spenddowns established prior to July 1, 1999.

B. Applicability

Spenddown applies only to medically needy (MN) covered groups. Individuals and families must meet the MN nonfinancial and resource requirements in order to be placed on a spenddown.

An individual or family is income eligible when countable income after deducting specified medical or remedial care expenses is equal to or less than the medically needy income limit (MNIL) for the budget period.

M1310.200 INSTITUTIONALIZED INDIVIDUALS IN MEDICAL FACILITIES OR RECEIVING MEDICAID CBC

A. General Principle

Do not use this subchapter for institutionalized Medically Needy individuals in long-term care [medical facilities or Medicaid Community-based Care (CBC)] who have income over the MNIL.

Go to subchapter M1460 when the individual is institutionalized in a medical facility or when the individual receives Medicaid Community-based Care (CBC) waiver services. Subchapter M1460 contains the policy and procedures for determining the eligibility and spenddown liability for individuals in long-term care.

M1310.300 SPENDDOWN DEFINITIONS

A. Introduction

This section contains the definitions of terms used in the spenddown chapter, Chapter M13.

B. Definitions

1. Applicable Exclusions

Applicable exclusions are the amounts that are deducted from income in determining an individual's income eligibility as identified under the July 16, 1996, AFDC State Plan for Families & Children covered groups, and under the SSI program for aged, blind or disabled individuals.

2. Assistance Unit

The Medicaid assistance unit is the individual or family who applies for Medicaid and whose financial eligibility is determined. The assistance unit for the Families & Children (F&C) covered groups is called the "family unit" or the "budget unit." The assistance unit for an ABD individual is just the individual, unless the individual is married, living with his/her spouse and the spouse is also ABD or the spouse is NABD and has deemable income. In this situation, the assistance unit is the married ABD couple.

3. Available Income

Available income means the earned and unearned income before exclusions used in determining the income eligibility of a medically needy individual.

4. Break in Spenddown Eligibility

A break in spenddown eligibility only occurs after an individual has, at least once, established eligibility by meeting a spenddown in a prior budget period. A break in spenddown eligibility occurs when:

- there is a break between spenddown budget periods;
- the individual establishes Medicaid eligibility as categorically needy (CN), categorically needy non-money payment (CNNMP), in the ABD 80% FPL covered group, or as F&C MI; or
- the individual establishes Medicaid eligibility as medically needy (MN) without a spenddown; or

  NOTE: MN determinations are completed when the individual is not eligible as CN or CNNMP.

- the individual does not meet the spenddown liability in a spenddown budget period.

5. Budget Period

Budget period means a period of time during which an individual's income is calculated to determine Medicaid eligibility.

6. Carry-over Expenses

Carry-over expenses are the balance due on medical, dental, and remedial care expenses incurred in the retroactive or prospective budget periods prior to the current budget period which were not used in establishing eligibility and which may be deducted in consecutive budget periods when there has been no break in spenddown eligibility.

7. Consecutive Budget Period

A consecutive budget period is any spenddown budget period that immediately follows a spenddown budget period in which eligibility was established.

8. Countable Income

Countable income means, for the medically needy, the amount of the individual's gross income after deducting allowable exclusions that is measured against the medically needy income limit (MNIL).

9. Covered Expenses

Covered expenses means expenses for services that are included in the State Plan for Medical Assistance (Medicaid State Plan).

10. Current Payments

Current payments are payments made in the current spenddown budget period on expenses incurred before the current spenddown budget period, which were not used in establishing eligibility in a previous spenddown budget period and when there has been a break in spenddown eligibility. The payment amount allowed is the actual payment amount paid to the provider and is deducted from the spenddown liability on the date the payment is actually made.

11. First Prospective Budget Period

The first prospective budget period is the spenddown budget period that begins:

- the first day of the month the individual first applied for Medicaid and is placed on spenddown, or
- the first day of the month after the cancellation of Medicaid coverage due to excess income, or
- when a new Medicaid application is filed after a break in spenddown eligibility.

12. Incurred Expenses

Incurred expenses means expenses for medical, dental**,** or remedial care services:

- which are recognized under state law;
- which are rendered to an individual, family, or legally responsible relative;
- which the individual is liable for in the current budget period or was liable for in the three-month retroactive period; and
- which are not subject to payment by any liable third party.

An expense for a medical or remedial service is an incurred expense from the date the liability arises until the end of the budget period in which the expense is fully used to meet a spenddown.

13. Initial Application

An initial application is the individual's first Medicaid MN spenddown application. There are two ways an individual can have an initial application:

- this is the individual's first application for Virginia Medicaid, or
- this is the first time the individual has been placed on a spenddown.

14. Legally Responsible Relative

A legally responsible relative is the individual's spouse and/or, when the individual is under age 21, a parent who is responsible by law to support the individual. The legally responsible relative's resources and income may be used in determining the individual's Medicaid eligibility.

15. Liable Third Party

Liable third party means any individual, entity or program that is or may be liable to pay all or part of the cost of medical or remedial treatment for injury, disease or disability of a Medicaid applicant or recipient.

16. Medical Expense Record Form

The "Medical Expense Record-Medicaid" (#032-03-023) is a form provided to the client for keeping a chronological record of his medical expenses. It is used by the eligibility worker to determine if the spenddown has been met.

17. Medically Needy Income Limit (MNIL)

MNIL means the medically needy income limit. This is the income standard established to determine the financial eligibility of medically needy individuals and families.

18. Noncovered Expenses

Noncovered expenses are expenses for necessary medical and remedial services recognized under state law but not covered under the Medicaid State Plan, including those that exceed the Medicaid limitation on amount, duration, or scope of the service covered under the State Plan.

19. Old Bills

Old bills are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid application's retroactive period *or*
- *were incurred during the retroactive period if the individual either did not meet the retroactive spenddown or was not eligible for Medicaid in the retroactive period (for example, due to excess resources), and*
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

Old bills that are based on previous applications do not meet the definition of "old bills" when there has been a break in spenddown eligibility.

EXCEPTION: Bills paid by a state or local program are treated as old bills even though they are not the individual's liability.

20. Prospective Budget Period

A prospective budget period is the prospective period of time during which income is projected for the purpose of determining spenddown eligibility.

21. Re-application

Re-application means any Medicaid medically needy spenddown application which is filed after the initial application.

22. Retroactive Spenddown Budget Period

The retroactive spenddown budget period is the retroactive period in which the individual is on a spenddown. The retroactive spenddown budget period is the 3 months immediately prior to the application month, when none of the months overlap (was included in) a previous MN spenddown budget period in which spenddown eligibility was established.

When some of the months overlap a previous MN spenddown budget period in which spenddown eligibility was established, the retroactive spenddown budget period is shortened (prorated) to include only the month(s) which were not included in the previous MN spenddown budget period in which spenddown eligibility was established.

23. Spenddown

Spenddown is the process through which countable income is compared to the MNIL for the budget period and incurred expenses are deducted from excess countable income.

24. Spenddown Budget Period

A spenddown budget period is the budget period during which the individual's or family's countable income exceeds the MNIL for the budget period and during which the individual or family is placed on a spenddown.

25. Spenddown Eligibility

Spenddown eligibility means the individual established eligibility by meeting a spenddown within a spenddown budget period.

***26.* Spenddown Liability**

The spenddown liability is the amount by which the individual's or family's countable income exceeds the MNIL for the budget period.

***27.* State or Territorial Public Program**

A state or territorial public program is a public health program that is wholly or partially funded and administered by a state or territory, including a political subdivision thereof (i.e., SLH, GR, AG and CSB services).

***28.* State or Territorially-Financed Program**

A state or territorially-financed program is a state or territorial public program whose funding, except for deductibles and coinsurance amounts required from program beneficiaries, is either:

- appropriated by the state or territory directly to the administering agency, or
- transferred from another state or territorial public agency to the administering agency.

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SPENDDOWN

SUBCHAPTER 20

SPENDDOWN INFORMATION

M1320 Changes

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M1320.000 SPENDDOWN INFORMATION

M1320.100 INFORMING THE APPLICANT

A. Introduction

An individual applicant who meets all the medically needy Medicaid eligibility requirements except income, because his countable income exceeds the Medicaid income limits, must be told about spenddown and what he can do to become eligible for Medicaid coverage for a limited time period.

This section lists the items of which the EW must inform the applicant.

B. Allowable Expenses

The worker must inform the applicant about the incurred medical, dental, or remedial care expenses, either paid or unpaid, that can be deducted from the spenddown liability.

1. Covered By State or Local Public Program

Expenses for incurred medical services received on or after December 22, 1987, which were provided, covered, or paid for by a state or local government program can be deducted even though the applicant does not owe anything for the service.

Expenses covered by Medicare and Medicaid (which are federal programs) CANNOT be deducted.

2. Old Bills

Expenses incurred for medical services received prior to the initial application's retroactive period or *during the retroactive period if the individual either did not meet the retroactive spenddown or was not eligible for Medicaid in the retroactive period (for example, due to excess resources)* may be deducted if:

- the applicant is legally liable to pay the expense;
- the applicant still owes a balance to the medical service provider for the service;
- the expense was not deducted from (counted in) any previous spenddown budget period in which the spenddown was met, and
- a claim for the expense was submitted to the liable third party(ies), if any.

3. Third Party Payment

An allowable medical expense cannot be deducted until the individual's insurance or other third party, if applicable, has taken action on the claim and the applicant provides evidence documenting:

- the claim was denied, or
- the amount of the claim paid by the third party.

Only the amount not covered by the third party(ies) and which remains the liability of the individual may be deducted from the spenddown liability.

C. Incur Noncovered Expenses First

The worker must inform the applicant that it is to his advantage to use the spenddown liability (excess income) for medical and dental services not covered by the Medicaid program before he uses the spenddown liability for covered services. Medicaid will not pay for noncovered medical services even after the spenddown is met.

D. Estimate When Spenddown Liability Will Be Met

The worker can help the applicant estimate the approximate time when the spenddown liability will be met if:

- the individual has already spent or owes for medical services received prior to, on, or after the first day of the month of application, and
- the individual anticipates medical expenditures in the near future.

E. Reapplying At The End Of The Spenddown Period

The worker must inform the individual of the spenddown period and the need to file a re-application if additional coverage is needed. If eligible as QMB, SLMB, or QDWI, the *Medicaid Renewal form (#032-03-669) may* be used to establish new spenddown budget periods.

The Eligibility Review Part A (#032-03-729A) and Eligibility Review Part B (#032-03-729B) *forms should only be used for QMB, SLMB, or QDWI enrollees when the forms are required by another program under which the individual is receiving benefits.* For all others, the Application For Benefits (#032-03-824) is required to establish additional spenddown budget periods.

M1320.200 PROCESSING TIME STANDARDS

A. Applications

1. Processing Standards

The time standards for Medicaid eligibility determination must be met when determining spenddown. The processing time standards are:

- 90 days for applicants whose disability must be determined and
- 45 days for all other applicants

from the date the signed Medicaid application is received by the local agency.

2. Third Party Payment Verifications

The standards shall also apply to receipt of third party payment or verification of third party intent to pay in order to determine allowable expenses deductible from the spenddown liability. Efforts to determine the third party liability shall continue through the last day of the processing standard period of time. If information regarding third party liability for an incurred expense is not received by this date, eligibility must be determined without deducting the expense.

B. Changes

The time standard for evaluating a reported change is 30 days from the date the worker receives notice of a change in circumstances or a medical or dental expense submitted by the individual.

Efforts to determine the third party liability shall continue through the last day of the processing time standard. If information regarding third party

liability for an incurred expense is not received by this date, eligibility must be determined without deducting the expense.

M1320.300 ACTION ON APPLICATIONS

A. Case Action

When an applicant meets all the MN eligibility requirements except income, the application is denied and the applicant is placed on a spenddown.

B. Retroactive Period

When an applicant has old bills, the worker will determine the retroactive budget period and retroactive spenddown liability. Determination of the retroactive budget period is necessary in order to correctly deduct the old bills from the spenddown liability in the first prospective and consecutive budget periods. If there is no Medicaid-covered service in the retroactive budget period, do not evaluate retroactive Medicaid eligibility.

C. Notice to Applicant

A "Notice of Action on Medicaid..." (#032-03-008) is sent to the applicant. Check the block in the third section which states "Denied full coverage because income exceeds the income level". Enter the spenddown liability and the spenddown budget period begin and end dates in the appropriate section. Send a copy of the "Medical Expense Record - Medicaid" (#032-03-023) to the applicant for recording his medical expenses. See Appendix 1 to subchapter M1340.

M1320.400 SPENDDOWN CASE REVIEW REQUIREMENTS

A. Introduction

The individual must notify the worker when medical or dental expenses are incurred. The individual does NOT have to formally request a re-evaluation of his spenddown.

The individual should submit the "Medical Expense Record - Medicaid" together with bills or receipts for medical services either paid or incurred. Evidence of third party payment or denial of payment must be provided, if applicable.

B. Individual Submits Expenses

When the individual submits medical expenses for re-evaluating the spenddown, a new application form is NOT completed.

Contact the individual and ask if his living situation, resources or income have changed since he signed the application form. If the individual reports any changes, request verification, evaluate accordingly, and record the changes in the case record.

C. Eligibility Worker Actions

When verification of incurred expenses is received, the worker must record the expenses in the record, determine how much of the spenddown liability remains and notify the applicant of the re-evaluation decision.

1. Complete One Evaluation

If incurred medical expenses are submitted to the worker at various times within a month, the worker may accumulate the expenses and complete one

re-evaluation at the end of the 30-day processing time frame for spenddown re-evaluations. The 30-day processing time frame begins the date the first medical bill for that spenddown is received in the agency.

2. Send Notice of Action

After completing a re-evaluation of the individual's spenddown, send a written "Notice of Action on Medicaid..." with the appropriate block checked. In the section marked "Other", tell the individual that he must complete a review or reapply in order to be evaluated for Medicaid after the spenddown period ends.

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SPENDDOWN BUDGET PERIODS

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M1330.000 SPENDDOWN BUDGET PERIODS

M1330.100 SPENDDOWN BUDGET PERIODS

A. Introduction

An individual's medically needy (MN) spenddown eligibility is determined based on the income received within a specified spenddown budget period. The spenddown budget period is based on the application month.

The spenddown budget periods are the:

- retroactive spenddown budget period,
- first prospective budget period, and
- consecutive budget period.

B. Spenddown Budget Period Rules

1. Every Medicaid application has a retroactive period.

2. Budget periods are based on application months. Applications for non-institutionalized individuals create a 6-month prospective budget period. If another Medicaid application is filed in the month immediately after the end of the first prospective budget period in which spenddown eligibility was established, the new application has no retroactive period and the subsequent spenddown budget period is a consecutive 6 months.

   If another application is not filed in the month immediately after the end of a spenddown budget period in which spenddown eligibility was established, the application has a retroactive budget period and a first prospective budget period. If the retroactive spenddown budget period abuts a prior spenddown budget period in which eligibility was established, the retroactive spenddown budget period is also a consecutive budget period.

3. When there is a 6-month prospective budget period in which spenddown eligibility is not established, part of that spenddown budget period may become a retroactive spenddown budget period based on a subsequent application.

4. Spenddown budget periods do not run consecutively when there is a break in spenddown eligibility.

5. The current budget period is the budget period for which spenddown eligibility is being determined.

6. The retroactive spenddown budget period is prorated when one or two of the months in the retroactive period were included in a medically needy spenddown budget period in which spenddown eligibility was established or in the case of death of the individual in the retroactive period.

7. A retroactive spenddown budget period is always followed by a first prospective budget period.

8. The prospective spenddown budget period is prorated (shortened), when the only MN individual in the assistance unit dies, becomes ineligible for a reason other than income, becomes institutionalized, or becomes eligible in another Medicaid classification.

9. Deduction of old bills in a spenddown budget period depends on whether the expense was fully deducted in a previous spenddown budget period during which spenddown eligibility was established. If the expense was fully deducted in a previous spenddown budget period during which spenddown eligibility was established, it CANNOT be deducted in another spenddown budget period. If the expense was not fully deducted, the remaining balance for which the individual is liable may be carried forward and used as a deduction in a following spenddown budget period(s) if there is no break in spenddown eligibility.

10. **Paid** and unpaid expenses incurred during the retroactive spenddown budget period are deducted in the first prospective budget period, to the extent that they were not used to meet the retroactive spenddown and remain the liability of the individual.

11. A break in spenddown eligibility does not necessarily mean that there is a break between budget periods. A break between spenddown budget periods always means that there is a break in spenddown eligibility.

M1330.200 RETROACTIVE SPENDDOWN BUDGET PERIOD

A. Policy

The retroactive spenddown budget period is the 3 months immediately prior to the application month, if none of the months were included in a previous spenddown budget period in which spenddown eligibility was established.

Eligibility for retroactive Medicaid coverage must be determined in all cases if an individual received a Medicaid covered service during the three-month period prior to the month of application. This includes those applying for Auxiliary Grants or Medicaid. Eligibility for retroactive coverage is determined at the same time ongoing eligibility is determined, using the same application.

If an applicant states that a Medicaid covered service was received in any one of the 3 retroactive months, determine eligibility for all months included in the retroactive spenddown budget period. If the applicant states that a Medicaid covered service was not received in the retroactive months, do not determine retroactive eligibility.

B. Months Included In The Retroactive Spenddown Budget Period

The retroactive spenddown budget period consists of all 3 months in the retroactive period when none of the months was included in a previous Medicaid medically needy spenddown budget period in which spenddown eligibility was established. The retroactive spenddown budget period is prorated when one or two of the months in the retroactive period was included in a medically needy spenddown budget period in which spenddown eligibility was established, or in the case of death. If all 3 retroactive months were included in a medically needy spenddown budget period in which spenddown eligibility was established, there is no retroactive spenddown budget period. If a month in the retroactive period was included in a previous medically needy spenddown budget period in which spenddown eligibility was established, that month(s) CANNOT be included in the retroactive spenddown budget period.

C. Income Counted

Only the actual income, minus income exclusions, received in the retroactive spenddown budget period is counted in determining retroactive eligibility. The countable income is applied to the appropriate Medically Needy Income Limit (MNIL) for the number of months actually included in the retroactive spenddown budget period. When the individual's countable income in the retroactive spenddown budget period exceeds the MNIL for the period, he has a spenddown liability for the retroactive spenddown budget period.

EXAMPLE #1: An individual's spenddown budget period ended April 30. He files an application for Medicaid in July and has a Medicaid-covered service in May and June (the second and third months of the retroactive period). The retroactive spenddown budget period based on his July application is prorated and consists of May and June because April was in a prior spenddown budget period in which spenddown eligibility was established. His countable income received in May and June is compared to the monthly MNIL for one person in the locality, multiplied by 2 months in the retroactive spenddown budget period.

EXAMPLE #2: A legally emancipated child age 17, living alone, applies for Medicaid on June 15. He has never applied for Medicaid before this application. He has a Medicaid covered service expense in the first retroactive month, March. The retroactive period is March, April and May. He meets the MI covered group and income requirements in April only. His income exceeded the MI limit in March and May. The retroactive spenddown budget period is 3 months - March, April and May. His countable income in the 3 months is determined and the MN income limit for 1 person for 3 months is subtracted. The remainder is the spenddown liability for the retroactive spenddown budget period.

M1330.300 FIRST PROSPECTIVE BUDGET PERIOD

A. Policy

A first prospective budget period is 6 months for non-institutionalized individuals; 1 month for institutionalized individuals..

The first prospective budget period is the period that begins:

- the first day of the month the individual first applied for Medicaid and is placed on spenddown, or
- the first day of the month after the date Medicaid was canceled because of excess income, or
- when a new application is filed after a break in spenddown eligibility

B. Income Counted

The gross income, minus applicable income exclusions, anticipated to be received by the applicant's assistance unit in the first prospective budget period is counted and compared to the MNIL. Countable income anticipated to be received in the application month is projected over the entire 6-month period, unless the first prospective budget period must be prorated. When the first prospective budget period is prorated, count the income received in the month(s) included in the prorated first prospective budget period and compare it to the MNIL for the same number of months. The difference is the spenddown liability.

C. Example--Individual's First Application For Medicaid

EXAMPLE #3: An individual first applies for Medicaid in July 1999 and has a Medicaid covered service in the retroactive period. He has never applied for Medicaid before. The retroactive period consists of April, May and June 1999. His countable income received for April 1999 through June 1999 is compared to the 3-months MNIL in the locality for one person. The first prospective budget period consists of July 1999 through December 1999. His countable income for July is projected for 6 months and compared to the semi-annual MNIL in the locality for one person.

D. Example--Medicaid Canceled Due To Excess Income

EXAMPLE #4: A Medicaid recipient's coverage is canceled because of excess income effective July 31, 1999. He is placed on a spenddown for the first prospective budget period of August 1, 1999 through January 31, 2000. His countable income for July is projected for 6 months. The semi-annual MNIL in the locality for one person is subtracted from his total countable income.

E. Example--Break in Spenddown Eligibility

EXAMPLE #5: A recipient's Medicaid spenddown eligibility is canceled because of excess resources effective May 31, 1999. He reapplies for Medicaid on October 13, 1999. He had a Medicaid covered medical expense in the retroactive period.

He is placed on a spenddown for the retroactive period of July – September 1999. His countable income received in July – September 1999 is compared to the 3-months MNIL in the locality for one person. The first prospective budget period is October 1, 1999 through March 31, 2000. His countable income for October is projected for 6 months. The semi-annual MNIL in the locality for one person is subtracted from his total countable income for the 6-month spenddown budget period.

M1330.400 CONSECUTIVE BUDGET PERIODS

A. Policy

Consecutive budget periods are any spenddown budget periods that occur when there is no interruption in spenddown eligibility. Consecutive budget periods can occur after there has been a break in spenddown eligibility IF spenddown eligibility has been re-established. A retroactive or prospective spenddown budget period is a consecutive budget period when it follows a spenddown budget period in which eligibility was established.

B. Income Counted

The gross income, minus applicable income exclusions, anticipated to be received by the applicant's assistance unit in a consecutive budget period is counted and compared to the MNIL. Countable income anticipated to be received in the application month is projected over the entire 6-month period, unless the consecutive budget period is prorated.

EXAMPLE #6: A non-institutionalized individual applies for Medicaid in July 1999 and has a Medicaid covered service in the retroactive period. The retroactive period consists of April, May and June 1999. The first prospective budget period consists of July 1999 through December 1999. He meets both spenddowns. On January 20, 2000, he files an application for Medicaid and is placed on a spenddown for the period January 2000 through June 2000. Because spenddown eligibility was established in the prior spenddown budget period, the January 2000 through June 2000 prospective budget period is a consecutive budget period. His countable income for January is projected and the total is compared to the semi-annual MNIL in the locality for one person. He meets the spenddown for the period January 2000 through June 2000.

He files an application in July 2000 and is placed on a spenddown for the period July 2000 through December 2000, which is considered a consecutive budget period. He does not meet the spenddown for this period. A break in spenddown eligibility has occurred.

He files an application in January 2001 and is placed on a spenddown for the period January 2001 through June 2001, which is not a consecutive budget period. He meets the spenddown on May 2, 2001. He files an application in July 2001 and is placed on a spenddown for the period July 2001 through December 2001, which is a consecutive budget period.

CHAPTER M13
SPENDDOWN
SUBCHAPTER 40

SPENDDOWN DEDUCTIONS

M1340 Changes

Changed With	Effective Date	Pages Changed
TN #95	3/1/11	page 6
TN #94	9/1/10	page 6
TN #93	1/1/10	page 18

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M1340.000 SPENDDOWN DEDUCTIONS

M1340.100 SPENDDOWN DEDUCTIONS

A. Introduction

Medical expenses incurred by the individual, family or a financially responsible relative that are not subject to payment by a third party are deducted from the individual's spenddown liability. An expense is incurred on the date liability for the expense arises. The agency must determine which incurred expenses can be deducted and must deduct those expenses in accordance with section M1340.200 below.

The policy and procedures for deducting old bills and incurred expenses are based on federal regulations which were developed to remove the incentive for individuals to not pay their old bills.

B. Policy

Only those medical, dental, or remedial care expenses incurred by the applicant, budget unit member(s) and the applicant's spouse and/or child in the household who is not included in the applicant's assistance unit, are considered as potential deductions from spenddown.

1. Legal Liability For Expense

Medical expenses, or portions of medical expenses, that are covered by Medicare or other health insurance are not legal obligations of the individual and cannot be deducted from spenddown. If the expense was covered by a state or local public program as defined in section M1340.1100, see that section.

If a legally responsible relative's income is deemed to the assistance unit, the legally responsible relative's incurred expenses are deducted from the unit's spenddown. When the legally responsible relative also has a spenddown liability that has not been met, the legally responsible relative must choose the spenddown from which the incurred expense is deducted. An incurred expense can be deducted from only one spenddown. If not totally used to meet the spenddown, the balance can be applied to another spenddown.

2. Projected Expenses

"Projected" expenses are for services that have not yet been rendered. Projected expenses for medical services cannot be deducted, except for nursing facility care. Expenses included in a prepaid package of services cannot be deducted prior to the date the service(s) is actually rendered. See subchapter M1460 or M1480 for nursing facility patients.

3. Chronological Deduction

Expenses are deducted in chronological order based on the date they are incurred. The date incurred is the date the service was received or, in the case of health insurance premiums *that are withheld from monthly benefit payments, the first day of the month the premium payment is due.*

4. Multiple Spenddown Periods

When an individual has established more than one spenddown period, medical expenses are first deducted from the spenddown period during which they were incurred. If not used to achieve eligibility, the bill can be evaluated for use in succeeding budget periods. Specific instructions for treatment of prior

incurred expenses can be found in sections M1340.600, M1340.700 and M1340.800.

M1340.200 KINDS OF ALLOWABLE DEDUCTIONS

A. Policy

To determine the allowable incurred expenses that will be deducted from income, the agency must identify the kind of service.

B. Kinds of Service

In determining allowable incurred expenses, the medical or remedial care expenses listed below may be deducted from the spenddown liability.

1. Health Insurance Expenses

Medicare and other health insurance premiums are allowable health insurance expenses.

2. Noncovered Services Expenses

Noncovered services expenses are expenses incurred by the individual or family or financially responsible relative for necessary medical or remedial care services which are not covered by the Virginia Medicaid State Plan. Noncovered services include expenses for Medicaid-covered services that exceed the State Plan limits on the amount, duration and scope of services. Medicaid co-payments and deductibles on covered services are "noncovered services." Section M1340.400 lists noncovered services.

3. Covered Services Expenses

Covered services expenses are expenses incurred by the individual or family or financially responsible relative for necessary medical or remedial care services which are covered by the Virginia Medicaid State Plan.

M1340.300 HEALTH INSURANCE PREMIUMS, DEDUCTIBLES, COINSURANCE

A. Policy

Incurred expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, including deductibles and copayments imposed by Medicaid, are deducted from the spenddown liability.

B. Health Insurance Premiums

Health insurance premium payments include:

1. Private Health Insurance

Payments made from the applicant's own income for private medical insurance are allowed deductions. Income protection insurance **(**indemnity) policy premiums are not medical expenses and are not deducted from the spenddown liability.

2. Medicare Premiums

Medicare Part A, Part B and/or *Part D* premium payments are allowed deductions when the premiums are paid from the applicant's own income.

3. Amount Deducted

The amount deducted is the amount of the premium paid.

4. When Deducted

A health insurance premium is deducted from the spenddown liability when the monthly premium is due. The worker cannot deduct a pre-paid premium that is paid before the month the premium is due.

When a health insurance premium is withheld from the individual's monthly benefit check, the premium is deducted on the first day of the month. For example, the individual receives a Social Security benefit from which is deducted the Medicare Part B premium. The Social Security check is dated December 13. The Medicare Part B premium is deducted from the individual's spenddown liability on December 1.

C. Deductibles, Coinsurance, and Copayments

Deductibles, coinsurance and co-payment amounts are those portions of a medical services expense which the health insurance policy designates as the individual's responsibility to pay. The health insurance policy will not pay these amounts.

1. Amount Deducted

The amount deducted is the amount of the deductible, coinsurance or co-payment owed for the service.

2. When Deducted

A deductible, coinsurance or co-payment amount is deducted from the spenddown liability on the date the service was received.

D. Verification

Verification of health insurance premiums, deductibles, coinsurance and copayment amounts include:

- a copy of the insurance premium notice,
- the explanation of benefits paid by health insurance,
- *the statement, or a copy of the statement, from the Medicare Part D prescription drug plan (PDP),*
- Medicaid co-pays and deductibles as listed in chapter M18, or the Virginia Medicaid Handbook**.**

M1340.400 NONCOVERED SERVICES

A. Policy

Noncovered services expenses are incurred expenses for necessary medical or remedial care services which are not covered by the Virginia Medicaid State Plan, including the amounts for covered services that exceed the State Plan limits on amount, duration and scope of services. Noncovered services must be ordered by a physician or dentist in order to be deducted.

Noncovered services expenses are deducted on the date the service was rendered**.** For medical supplies and equipment that are ordered, the date of service is the date the supply or equipment was delivered to the individual. Expenses included in a prepaid package of services cannot be deducted prior to the date the service(s) is actually rendered.

B. Noncovered Services

Noncovered services (not covered by Medicaid) include:

1. routine dental care for individuals age 21 or older.

2. services of other licensed practitioners of the healing arts such as chiropractors, naturopaths or acupuncturists, unless the services are covered by Medicare and the individual has Medicare.

3. professional nursing services in an individual's home when prescribed by the individual's physician and the cost is not part of a home health program or a Medicaid CBC waiver.

4. medical services provided by non-participating providers (providers who do not participate in Virginia Medicaid) unless the services are covered by Medicare and the individual has Medicare.

5. over-the-counter medications and medical supplies when ordered by a physician and the cost is not covered by Medicaid or Medicare, if the individual has Medicare.

C. Not Medical/ Remedial Care Services

The following are examples of services that are NOT medical/remedial care services and CANNOT be deducted from a spenddown liability, even if ordered by a physician:

- air conditioners or humidifiers,
- Adult Care Residence (ACR) room & board and services**,**
- personal comfort items, such as reclining chairs or special pillows,
- health club memberships and costs,
- animal expenses such as for seeing eye dogs,
- cosmetic procedures.

D. Verification

Verification of noncovered services expenses includes:

1. a copy of the provider's bill or the insurance company's explanation of benefits paid, that shows:

   - the amount still owed that is the patient's responsibility, and
   - the service provider's name, address, and profession.

2. a prescription, physician's referral, or statement from the patient's physician or dentist that the service was medically necessary.

M1340.500 COVERED SERVICES

A. Policy

Covered services expenses are incurred expenses for necessary medical or remedial care services which are covered by the Virginia Medicaid State Plan.

Covered services expenses are deducted on the date the service was rendered. For medical supplies and equipment that are ordered, the date of service is the date the supply or equipment was delivered to the individual. Expenses included in a prepaid package of services cannot be deducted prior to the date the service(s) is actually rendered.

B. Covered Services

Some of the medical services covered by Medicaid, and the limits on these services, are described in chapter M18. Medicaid covered services include:

- inpatient and outpatient hospital care
- physicians' services
- prescription drugs
- lab and x-ray services
- nursing facility care
- home health care
- rehabilitative services
- psychiatrists' and psychologists services
- licensed clinical social worker and licensed professional counselor services
- physical therapy services
- medical supplies and equipment
- transportation to secure medical care which is purchased, not provided in the individual's own vehicle.

C. Verification

Medical supplies and drugs must be prescribed or ordered by a physician or dentist.

Covered services expenses verification includes:

1. a copy of the provider's bill or the insurance company's explanation of benefits paid, that shows:
   - the amount still owed that is the patient's responsibility, and
   - the service provider's name, address, and profession.
2. a prescription, physician's referral, or statement from the patient's physician or dentist that the service was medically necessary.

D. Medicare Part D Prescription Drug Expenses

Because enrollment in Medicare Part D is voluntary, not all Medicare beneficiaries will be enrolled in a Medicare PDP. For those enrolled in a PDP, not all drugs will be covered. Each PDP may have a different combination of deductibles, co-pays and coverage gaps.

The PDP must issue a periodic (at least monthly) statement to the beneficiary explaining all benefits paid and denied, and any deductible and/or co-pays incurred by the beneficiary. Use the PDP statement to verify prescription drug costs that remain the beneficiary's responsibility.

To determine if drug costs incurred by Medicare beneficiaries are allowable under spenddown, apply the following rules:

1. Beneficiary NOT In Medicare PDP on Date of Service

If the Medicare beneficiary was not enrolled in a Medicare PDP on the date of the prescription drug service, allow the prescription drug cost that is the responsibility of the beneficiary as a spenddown deduction.

2. Beneficiary in Medicare PDP on Date of Service

If the Medicare beneficiary was enrolled in a Medicare PDP on the date of service, allow the prescription drug cost (deductible, co-pays and/or coverage gap) that is the responsibility of the beneficiary as a spenddown deduction.

3. PDP Denies Drug Coverage

If a Medicare PDP denies coverage of a prescription drug, the beneficiary has the right to request an exception for coverage of the drug. The beneficiary is notified in writing of the decision on any exception requested.

- Do NOT allow the charge if the drug charge appears on the statement as a denial and no exception was requested.
- Allow the charge if the drug charge appears on the statement as a denial, and an exception was requested and denied.

Medicare beneficiaries who are enrolled in a Medicare PDP should be advised to keep their statements and other related documentation for consideration under spenddown.

M1340.600 OLD BILLS

A. Policy

Old bills are any unpaid medical, dental and/or remedial care expenses incurred prior to the retroactive period based on an initial application. Unpaid medical, remedial, and dental care expenses incurred prior to a re-application and its retroactive period may also be deducted as old bills provided that:

- they were not incurred during a prior spenddown budget period, in which spenddown eligibility was established, *or*
- *they were incurred during the retroactive period if the individual either did not meet the retroactive spenddown or was not eligible for Medicaid in the retroactive period (for example, due to excess resources), and*
- they were not fully deducted from any previous spenddown that was met, and
- they remain the liability of the individual.

Old bills may include medical bills that were paid by a state or local program.

An unused portion of an old bill which is still the liability of the individual may be applied to a future consecutive spenddown budget period(s) only if there is no break in spenddown eligibility. If there is a break in spenddown eligibility, only current payments made on old bills based on a prior spenddown application can be deducted in the current budget period. The old bill from a prior application is no longer an “old bill” as defined in section M1310.300. Only the amount of any “current payment” made on that expense in the current budget period can be deducted. Go to section M1340.800 for current payments policy and procedures.

B. Procedures Decide whether an old bill is deducted using the following procedures:

1. Verification Request the following verification from the individual or his representative:

- proof that the bill is still owed,
- if applicable, the amount owed that was not covered by the patient's insurance or liable third party,
- the service provider's name, address, and profession
- proof that the service was medically necessary (prescription, physician's referral, statement from the patient's physician or dentist).

2. Determine Amount of Deduction Upon receipt of the requested documentation, determine the unpaid balance still owed on the old bill minus the amount used to meet a prior spenddown, if any.

3. Subtract The Old Bill Subtract the old bill amount from the spenddown liability on the first day of the spenddown budget period according to policy in subsection A above.

C. Example--Deduct Balance of Old Bill **EXAMPLE #1:** The application month is October 1999. The individual never applied for Medicaid before October 1999. He did not receive a Medicaid-covered service in the retroactive period. The spenddown liability for the first prospective budget period October 1999 through March 2000 is $560. The individual provides verification that he still owes $100 for a medically necessary service received in May 1999 (prior to the retroactive period). The $100 old bill is deducted from the first prospective budget period spenddown liability, leaving him a spenddown balance of $460 on October 1, 1999.

M1340.700 CARRY-OVER EXPENSES

A. Policy

Carry-over expenses are unpaid medical or remedial care expenses that:

- were incurred within a retroactive or prospective budget period in which spenddown eligibility was established,
- remain the liability of the individual, and
- were not fully counted in any previous spenddown that was met.

Note: Old bills never become carry-over expenses because old bills, by definition, are incurred outside a spenddown budget period in which spenddown eligibility was established. Carry-over expenses are incurred during a spenddown budget period in which spenddown eligibility was established.

B. Procedures

Determine if the carry-over expenses are fully or partially deducted by using the following procedures:

1. Verification

Request the following verification from the individual or his representative:

- proof that the amount of the carry-over expense is still owed,
- if applicable, the amount owed that was not covered by the patient's insurance or liable third party;
- the service provider's name, address, and profession,
- proof that the service was medically necessary (prescription, physician's referral, or statement from the patient's physician or dentist).

2. Determine Amount of Deduction

Upon receipt of the requested documentation, determine the amount of the expense that can be deducted from the spenddown liability for the current spenddown budget period. Any amount of the expense that was deducted from a previous spenddown that was met CANNOT be deducted in the current spenddown budget period.

3. Subtract Carry-over Expense

Subtract the carry-over expense amount that was not used to meet a previous spenddown from the spenddown liability on the first day of the current spenddown budget period, after deducting old bills.

C. Remaining Balance

The remaining balance of carry-over expenses is applied to the spenddown liability of the next consecutive budget period. If that spenddown is met and there is still a balance remaining on the carry-over expenses, that remaining balance may be deducted in subsequent consecutive budget periods until there is a break in spenddown eligibility.

When a break in spenddown eligibility occurs, only the amount of "current payments" made on that expense in the current spenddown budget period can be deducted from the spenddown liability. See Current Payments on Expenses in section M1340.800 below.

D. Example--Carry-over Expenses

EXAMPLE #2: An individual has been on spenddowns consecutively during the two previous 6-month periods (April through September and October through March). He met both spenddowns. He reapplies for Medicaid on April 1. The spenddown liability for April through September is $560. The individual provides verification that he still owes $100 for a medically necessary noncovered service he received the prior November. The $100 is a carry-over expense and is deducted from the current spenddown budget period's spenddown liability on the first day of the current spenddown budget period (April through September), leaving him a spenddown balance of $460 on April 1.

M1340.800 CURRENT PAYMENTS ON EXPENSES

A. Policy

Current payments are payments made in the current spenddown budget period on unpaid balances of old bills or carry-over expenses incurred before the current spenddown budget period:

- which were not fully used in establishing eligibility in a previous spenddown budget period, and
- when there has been a break in spenddown eligibility.

B. Procedures

Decide whether a current payment is deducted using the following procedures:

1. Verification

Request the following verification from the individual or his representative:

- proof that the expense is still owed,
- if applicable, the amount owed that was not covered by the patient's insurance or liable third party,
- the service provider's name, address, and profession,
- proof that the service was medically necessary (prescription, physician's referral, or statement from the patient's physician or dentist), and
- the amount, frequency and dates of the payments made.

2. Determine Amount of Current Payment

Upon receipt of the requested documentation, determine if there is any remaining amount of the expense that was not used to meet a previous spenddown. If an amount remains, the amount of the current payment can be deducted.

3. Subtract Current Payment

Subtract the payment(s) made in the current spenddown budget period from the current spenddown liability, effective the date the payment is made to the provider.

C. Examples

1. Current Payment on Unpaid Balance of Old Bill

EXAMPLE #3: A request for Medicaid is filed on July 5, 1999. The individual had a prior spenddown application dated July 1996 for the period July 1996 through December 1996, which was met. She also had an application filed in January 1999, which was approved as CNNMP January 1, 1999 and closed March 31, 1999, due to excess countable resources. No medical, dental, or remedial services were received during the retroactive period based on the July 1999 application (April 1, 1999 through June 30, 1999).

The first prospective budget period based on her July 5, 1999 re-application is July 1, 1999 through December 31, 1999. The individual provides verification that she still owes $100 for a medically necessary dental service she received back in March 1996, which is an old bill based on her July 1996 application and which was not used to meet the July 1996 through December 1996 spenddown. She pays the dentist $10 per month on this old bill. Because there was a break in her spenddown eligibility, only the current payment she makes on the March 1996 dental bill can be deducted from her current spenddown. The $10 current payment is deducted on July 8, 1999, the date she makes the payment.

2. Current Payment on Carry-over Expense

EXAMPLE #4: The individual has been on spenddowns consecutively during the two previous 6-month periods which were July 1, 1998 through December 31, 1998 and January 1, 1999 through June 30, 1999. His spenddown liability for each spenddown budget period was $600. He provided verification of a $1,000 bill for a medically necessary noncovered service he received in February 1998. His first spenddown was met by deducting $600 of the $1,000 old bill from the spenddown liability. The remaining $400 balance of the old bill was deducted from his second spenddown liability but eligibility was not established.

He reapplies for Medicaid in July 1999. Because he did not establish eligibility by meeting a spenddown in the spenddown budget period preceding the current spenddown budget period (July through December) only the current payments made on the February 1998 noncovered service can be deducted from his current spenddown liability. These payments are deducted on the date(s) they are actually made. He makes payments of $10 per month on the expense. On July 5, 1999, he makes a $10 payment. This payment is a current payment and is deducted from the current spenddown budget period's spenddown liability. Subsequent payments made in the current spenddown budget period will be deducted on the date made.

M1340.900 WHEN TO DEDUCT INCURRED EXPENSES

A. Incurred Expenses

When determining allowable incurred expenses, the agency must identify the following:

1. Retroactive Spenddown Budget Period

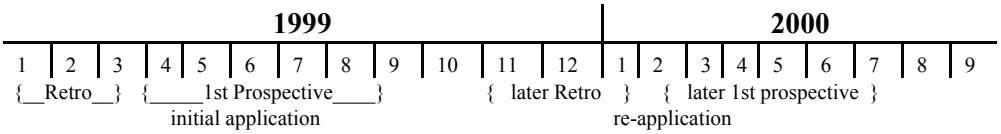
a. The First Retroactive Spenddown Budget Period

The first retroactive spenddown budget period is the retroactive spenddown budget period based on an individual's initial Virginia Medicaid medically needy spenddown application. In the first retroactive spenddown budget period, deduct:

- old bills, and
- paid or unpaid expenses incurred during the retroactive spenddown period.

b. A Later Retroactive Spenddown Budget Period

1) Break in Spenddown Eligibility



a) Policy

In a later retroactive spenddown budget period based on a Virginia Medicaid re-application filed when there is a break in spenddown eligibility, deduct:

- old bills based on the re-application month,
- current payments made on all expenses incurred prior to the first day of the most recent break in spenddown eligibility, and
- paid or unpaid expenses incurred during the retroactive period based on the re-application month,

to the extent that the expenses have not been deducted previously in establishing spenddown eligibility.

In a later retroactive budget period when there has been a break in spenddown eligibility, balances on "old bills" based on previous applications are only deducted as current payments.

b) Procedures

Determine if the expense was incurred in a prior spenddown budget period. If the expense was incurred in a prior spenddown budget period that has already been met and the expense was incurred prior to the date the spenddown was met, recalculate the spenddown eligibility using this expense. If the spenddown is met on an earlier date, re-enroll the individual with an earlier eligibility begin date using "Type 4" eligibility.

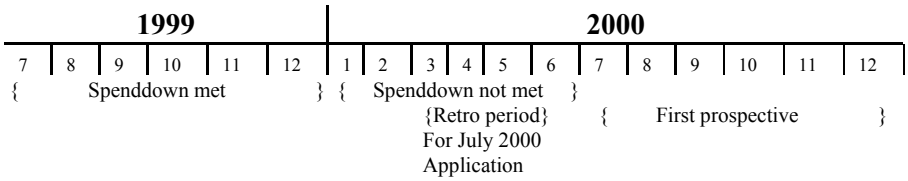
If the expense was incurred in a prior spenddown budget period in which the spenddown was not met, determine if the expense meets the spenddown in that period. If the expense meets the spenddown, the individual establishes spenddown eligibility in that period, effective the date the spenddown is met. If the expense does not meet the spenddown, the expense may be an old bill based on a subsequent re-application.

A re-application's retroactive period may include months that were included in a previous spenddown budget period that was not met. See section M1330.200 for policy regarding the retroactive spenddown budget period.

Re-evaluate whether a break in spenddown eligibility has occurred. If a break in spenddown eligibility has occurred, then all expenses incurred prior to the re-application's retroactive period and subsequent to the last day of the last spenddown budget period that was met and which were not fully used to establish spenddown eligibility in any prior spenddown budget period that was met should be evaluated for deductions as old bills for the new application.

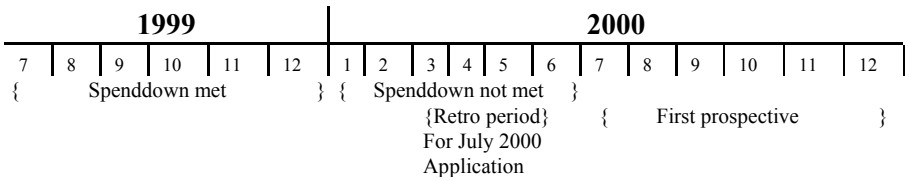
If a break in spenddown eligibility has not occurred, go to section 2. below for procedures to use when no break in spenddown eligibility has occurred.

EXAMPLE #5: Mr. Smith's initial application was filed July 1999. He was placed on a spenddown for the period July 1999 through December 1999. He met the spenddown on August 15, 1999. He reapplied for Medicaid on January 8, 2000. He was placed on a spenddown for the period January 2000 through June 2000. He did not meet the spenddown for that period (January 2000 through June 2000). He reapplies for Medicaid July 19, 2000. The retroactive period for the July 2000 re-application is April 2000 through June 2000. Because he did not establish spenddown eligibility in the January 2000 through June 2000 spenddown budget period, his July 2000 application has a retroactive spenddown budget period consisting of April, May and June 2000.



He presents a bill for a medical expense he incurred on March 3, 2000. The worker determines that the expense was incurred in a previous spenddown budget period that was not met (January 2000 through June 2000). The worker recalculates Mr. Smith's spenddown eligibility for that period by deducting the expense from the January 2000 through June 2000 spenddown liability. He does not meet the spenddown for the period January 2000 through June 2000. The worker next evaluates his eligibility for the retroactive spenddown budget period, April 2000 through June 2000. The March 2000 expense is an old bill based on the July 2000 re-application and is deducted on the first day of the retroactive spenddown budget period, April 2000.

EXAMPLE #6: Ms. Jones' initial application was filed in July 1999. She was placed on a spenddown for the period of July 1999 through December 1999. She met the spenddown on September 2, 1999. She re-applied on January 10, 2000 and was placed on a spenddown for the period of January 2000 through June 2000. She did not meet the spenddown for that period (January 2000 through June 2000). She re-applies for Medicaid on July 5, 2000. The retroactive period for July 2000 re-application is April 2000 through June 2000. Because she did not establish spenddown eligibility in the January 2000 through June 2000 spenddown budget period, her July 2000 re-application has a retroactive spenddown budget period consisting of April, May and June.



The worker calculates the spenddown liability for the retroactive spenddown budget period. The worker re-evaluates the bills in the case record which were submitted during the previous spenddown budget period (January 2000 through June 2000). The expenses incurred January 2000 through March 2000 are old bills if they remain the liability of Ms. Jones. The old bills are deducted on the first day of the retroactive spenddown budget period and the paid and unpaid expenses incurred during the spenddown budget period are deducted chronologically.

2) No Break in Spenddown Liability

A later retroactive spenddown budget period based on a Virginia Medicaid re-application filed when there is no break in spenddown eligibility is also a consecutive budget period. Go to section 3. below for "Consecutive Budget Period".

2. First Prospective Budget Period

a. The First Prospective Budget Period

When the first prospective budget period is the prospective budget period based on an individual's initial Virginia Medicaid medically needy spenddown application and there is a retroactive spenddown budget period, deduct:

1) unpaid balances on old bills carried forward from the retroactive spenddown budget period that were not used to meet the retroactive spenddown. The unpaid balance on an old bill is deducted from the first prospective budget period when:

   - there is no retroactive spenddown budget period, or
   - the individual was eligible without a spenddown in the retroactive period, or
   - the individual does not meet the retroactive spenddown, or
   - the individual meets the retroactive spenddown without using all of the balance of the old bill(s).

2) paid or unpaid expenses incurred during the retroactive spenddown budget period that were not used to meet the retroactive spenddown, including any co-pays, etc., incurred while the individual was eligible for Medicaid in the retroactive period.

3) paid or unpaid expenses incurred during the first prospective budget period.

b. A Later First Prospective Budget Period

A later first prospective budget period is a budget period based on a Virginia Medicaid re-application filed when there **has been** a break in spenddown eligibility. In this budget period, deduct:

- unpaid balances on old bills based on the re-application month **(balances on old bills based on previous applications cannot be deducted as old bills; they may be deducted as current payments),** which are carried forward from the re-application's spenddown retroactive budget period and were not used to meet the re-application's retroactive spenddown.

- current payments made on all expenses (not used previously) incurred prior to the first day of the most recent break in spenddown eligibility;

- paid or unpaid expenses incurred during the retroactive spenddown budget period based on the re-application month, that were not used to meet the retroactive spenddown, including any co-pays, etc., incurred while the individual was eligible for Medicaid; and

- paid or unpaid expenses incurred during the first prospective budget period based on the re-application month,

to the extent that the expenses have not been deducted previously in establishing spenddown eligibility.

EXAMPLE #7: In Example #6 above, Ms. Jones established spenddown eligibility in the retroactive budget period on April 1 by deducting a portion of the old bills incurred in January, February and March 2000. The remaining balance of the old bills from January, February and March 2000 is deducted from her spenddown liability in the first prospective budget period that begins July 1, 2000 and ends December 31, 2000.

She verifies that she started making payments on July 1, 2000, on a noncovered medical expense she incurred in December 1999 which was prior to January 1, 2000, the first day of the most recent break in spenddown eligibility. The payment she made on July 1 is deducted on July 1 as a current payment. She submits a receipt for payment of a dental service she received on May 2, 2000. This expense is deducted from the spenddown liability on the first day of the later first prospective budget period (July 1, 2000). Any medical expenses she incurs during the later first prospective budget period are deducted on the date incurred.

3. Consecutive Budget Period

In a consecutive budget period, deduct:

a. unpaid balances on old bills carried forward that were not used to meet a previous spenddown,

b. carry-over expenses incurred during the retroactive spenddown budget period, the first prospective spenddown budget period, and/or a subsequent spenddown prospective budget period which were not deducted previously in establishing spenddown eligibility, IF:

- the individual established eligibility in each spenddown budget period preceding the current spenddown budget period, AND

- the expenses are unpaid and remain the individual's liability, are allowable by kind of service and are carried over from the preceding spenddown budget period(s) because the individual met each preceding spenddown without deducting all such incurred unpaid expenses,

c. paid or unpaid expenses incurred during the current spenddown budget period, and.

d. current payments made on all expenses (not used previously) incurred prior to the first day of the most recent break in spenddown eligibility.

B. Order of Deduction

The agency must deduct allowable incurred expenses that are the liability of the individual (see section M1340.1100 for expenses paid by a state or local program). Expenses are deducted in chronological order (date of service) first, and then by kind of service if multiple kinds are received on the same date.

Expenses, including expenses in a prepaid package of services, cannot be deducted prior to the date the service(s) is actually rendered.

1. Chronological Order

a. Unpaid balances on old bills and/or carry-over expenses are deducted first, on the first day of the spenddown budget period.

b. Paid or unpaid expenses incurred within the current spenddown budget period are deducted in chronological order by date of service.

c. Current payments are deducted in chronological order by the date of payment.

2. Kind of Service

If multiple service expenses are incurred on the same day, the expenses are deducted on that date in the following order:

a. expenses for Medicare and other health insurance premiums, and deductibles or coinsurance charges, including enrollment fees, deductibles and copayments imposed by Medicaid.

b. noncovered services - expenses for necessary medical or remedial care services which are not covered by the Virginia Medicaid State Plan, including those that exceed the plan's limits on amount, duration and scope of services.

c. covered services - expenses for necessary medical or remedial care services which are covered by the Virginia Medicaid State Plan.

M1340.1000 THIRD PARTY PAYMENTS

A. Policy

A third party is any individual, entity, or program that is or may be liable to pay all or part of the individual's expenses for medical or remedial care

services recognized under state law.

An incurred medical expense cannot be deducted from the spenddown liability until the third party has made a decision to either deny or make some payment on the expense. Only that portion of the expense which is the applicant's legal responsibility shall be deducted from excess income in determining spenddown eligibility, unless the expense was covered by a state or local public program. If the expense was covered by a state or local public program, see section M1340.1100 below.

The application processing time standards apply to the receipt of third party payment or verification of third party intent to pay. Efforts to determine the liability of a third party shall continue through the last day of the application processing time standard (90 days for disability determinations; 45 days for all other applicants). If information regarding third party liability is not received by this date, eligibility must be determined based on the information available, if any, about the actual amount of the third party's payment.

If the amount subject to payment by a third party cannot be determined based on information available, the bill in question to which the third party liability applies cannot be used in determining spenddown eligibility. However, if information becomes available at a later date, the spenddown eligibility shall be redetermined and the effective date of spenddown eligibility revised.

B. Determining The Amount of The Third Party Payment

Determine the balance of the expense for which the individual is legally liable to pay. Use the third party's explanation of benefits paid (EOB) or similar statement received by the individual which shows the date of service, type of service, service provider, amount charged, amount approved, and amount paid by the liable third party.

Use the EOB's statement of the individual's responsibility as the amount to deduct from the spenddown liability. If the EOB does not show this amount, calculate the individual's responsibility.

1. Service Provider Accepts Approved Charges

When the service provider accepts the third party's approved charges, subtract the amount of the third party's payment from the approved charges. The remainder is the individual's responsibility and is the amount deducted from the spenddown liability.

2. Service Provider Does Not Accept Charges

When the service provider does NOT accept the third party's approved charges, subtract the amount of the third party's payment from the provider's charges. The remainder is the individual's responsibility and is the amount deducted from the spenddown liability.

C. Procedures

1. Worker

a. Inform the applicant that:

1) an expense cannot be deducted until his/her insurance or other third party, if applicable, has taken action on the claim

2) the applicant must provide evidence documenting:

- the claim was denied, or
- the amount paid by the third party on the claim.

3) only the amount not covered by the third party(ies) and which remains the liability of the individual may be deducted from the spenddown (unless the expense was covered by a state or local public program as described in section M1340.1100 below).

b. The EW must take reasonable measures to determine the liability of a third party to pay for the incurred expense. However, because of the application processing time standards, do not delay a spenddown determination simply because the third party has not yet made payment or has not yet denied the expense. Complete the determination without deducting the expense. Note the medical expenses submitted but not deducted due to pending TPL on the Medical Expense Record. Notify the applicant of the decision and of which bills (expenses) were not used in the determination because documentation of the third party's action was not received.

2. Applicant

The applicant is responsible to submit:

- verification that a claim for the incurred expense was submitted, and
- evidence of the third party's denial or amount of payment.

M1340.1100 STATE OR LOCAL PUBLIC PROGRAMS

A. Policy

Expenses for incurred medical services received

- for which the applicant is or was legally liable, and

- which were or will be provided, covered, or paid for by a state or local (or territorial) public program

can be deducted from the spenddown even though the applicant does not owe anything for the service.

Expenses covered by federally-funded and/or administered programs such as Medicare and Medicaid cannot be deducted from spenddown. Local health department programs, although administered by the Virginia Department of Health, are not state or local public programs because the health departments receive some federal funds.

B. State or Local Public Programs

State or local public programs are state or local public health care programs which are wholly or partially funded and administered by local government,

and which do not have any federal funding or administration. State or local public programs include, but are not limited to:

1. State/Local Hospitalization (SLH).

2. General Relief (GR).

3. Community Service Boards (CSB) services.

4. *Department of Behavioral Health and Developmental Services (DBHDS*) institutional services.

5. Medical College of Virginia (MCV) and University of Virginia (UVA) clinics and hospitals.

6. Crime Victims Compensation (Virginia Industrial Commission).

7. Local "free" clinics funded and administered by local governments that do not charge any fee to any patient for any service.

8. Community Services or Neighborhood Assistance programs.

C. Procedures

1. Worker

a. Inform the applicant that expenses for medical services for which the applicant was legally liable and which were provided, covered, or paid for by a state or local public program will be deducted from the spenddown even though the applicant does not owe anything for the service.

b. The EW must take reasonable measures to determine the public program's payment or coverage of the medical or remedial care service. However, because of application processing time standards, do not delay a spenddown determination because the public program's payment is not verified. Complete the determination without deducting the expense, notify the applicant of the decision and that the public program expense(s) was not used in the determination because verification was not received.

2. Applicant

The applicant is responsible to submit:

- verification that the medical/remedial service was received and that a claim for the incurred expense was submitted, and

- evidence of the public program's amount of payment for the service.

M1340.1200 SPENDDOWN LIABILITY CALCULATION

A. Retroactive Spenddown Budget Period

The procedures for calculating a retroactive spenddown liability for a spenddown budget period follow:

1. Determine the total income for the assistance unit in each of the 3 retroactive months.

2. Subtract the appropriate ABD or F&C medically needy income exclusions from each month's total income. The remainder is the monthly countable income for each month.

3. Add each month's countable income together; the result is the countable income for the retroactive spenddown budget period.

4. Subtract the 3-months MNIL for the number of persons in the assistance unit in the locality group from the countable income for the retroactive spenddown budget period.

5. The remainder is the retroactive spenddown liability.

B. Prospective Budget Period

The procedures for calculating liability in a prospective budget period follow:

1. Determine total income anticipated to be received by the assistance unit in the application month.

2. Subtract the appropriate ABD or F&C medically needy income exclusions from the monthly income. The remainder is the monthly countable income.

3. Multiply the monthly countable income by 6 (6 months in the spenddown budget period). The result is the countable income for the spenddown budget period.

   NOTE: This procedure is not applicable to long-term care.

4. Subtract the semi-annual (6 months) MNIL for the number of persons in the assistance unit in the locality group from the countable income.

5. The remainder is the spenddown liability.

M1340.1300 SPENDDOWN ENROLLMENT

A. Retroactive Spenddown Budget Period

Enrollment in Medicaid begins the date the retroactive spenddown was met - the date within the retroactive period that the spenddown liability amount, after deducting incurred expenses, reached zero. When the spenddown is not met, retroactive spenddown eligibility does not exist.

- When the retroactive spenddown is met entirely by old bills or carry-over expenses, eligibility begins the first day of the retroactive spenddown budget period.

- When the retroactive spenddown is met by current payments or expenses incurred during the retroactive spenddown budget period,

eligibility begins the date the retroactive spenddown was met.

If the individual continues to meet the MN requirements, eligibility continues for the remainder of the retroactive spenddown budget period.

1. Begin Date The coverage begin date is the date the spenddown was met.

2. End Date The end date of Medicaid eligibility is the end date of the retroactive spenddown budget period, if the individual continued to meet the MN requirements throughout the period.

3. Coverage Type Enroll the individual in "Type 2" retroactive coverage. Coverage will automatically end after the coverage period end date.

4. Program Designation The program designation for the individual is the medically needy (MN) program designation (PD) of the individual's MN covered group.

5. Reference See Appendix 1 of this subchapter for further examples of retroactive spenddown budget periods.

B. Prospective Budget Period Enrollment in Medicaid begins the date the spenddown was met - the date within the prospective budget period that the spenddown liability amount, after deducting incurred expenses, reached zero. When the spenddown is not met, eligibility does not exist.

- When the spenddown is met entirely by old bills or carry-over expenses, eligibility begins the first day of the prospective budget period.
- When the spenddown is met by current payments or by expenses incurred during the prospective budget period, eligibility begins the date the spenddown was met.

If the individual continues to meet the MN requirements, eligibility continues for the remainder of the prospective budget period.

1. Begin Date The coverage begin date is the date the spenddown was met.

2. End Date The end date of coverage is the end date of the prospective budget period, if the individual continues to meet the MN requirements throughout the prospective budget period.

3. Coverage Type Enroll the individual in the appropriate coverage type (Type 3 or 4). If enrolled in "Type 4" the coverage will automatically terminate at the end of the coverage period. If "Type 4", enter the last day of the spenddown budget period as the coverage end date.

4. Program Designation The program designation for the individual is the medically needy (MN) program designation (PD) of the individual's MN covered group.

C. Example--First Prospective Budget Period

EXAMPLE #8: Mr. Not lives in Group III and applied for Medicaid on November 21, 1999, as disabled. The MDU determined that he is disabled. He had been on Medicaid once before after meeting a spenddown; his Medicaid was canceled at the end of the spenddown period on May 31, 1999.

He has an $8,400 hospital bill and a $1,500 physician's bill for July 10 to July 20, 1999 (total $9,900) on which he still owes a total of $9,000. He incurred a $578 outpatient hospital bill on October 3, 1999, which he paid. He has no health insurance. His income is $800 per month disability benefit from a private company. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His resources are within the Medicaid limit in November 1999 (application month).

The first prospective budget period is November 1, 1999 through April 30, 2000. The income limit is $1,950. His spenddown liability is $2,730:

$ 800	disability benefit
- 20	general income exclusion
780	countable income
x 6	months
4,680	countable income for first prospective budget period
-1,950	MNIL for first prospective budget period Group III
$2,730	first prospective spenddown liability

His verified balances on the July 1999 services (incurred during the break in spenddown budget periods) are old bills. His eligibility is calculated:

$ 2,730	spenddown liability
- 2,730	July hospital bill (old bill for November 21 application)
$ 0	spenddown balance on November 1, 1999

Because the spenddown was met on November 1, 1999, Mr. Not is entitled to Medicaid for the period November 1, 1999 - April 30, 2000. The unpaid balance of old bills not used to meet the spenddown can be applied to the budget period beginning May 1, 2000, if another application is filed and he is placed on a spenddown.

D. Example--Consecutive Budget Period

EXAMPLE #9 ***(Using June 2000 figures)*****:** Ms. Sub lives in Group I and applied for Medicaid on June 6, as disabled. She had applied the previous December and was on a retroactive spenddown for the period September 1 through November 30, which she met on September 12. She met her December 1 through May 31 spenddown on January 2. She verifies that she has a $1,300 noncovered dental bill for August 15 (an old bill based on the December initial application) and a $1,500 balance on a nonparticipating physician's bill for September 10 to September 12 which was not used to meet a prior spenddown. She pays $50 a month on each bill to each provider. She has no health insurance and is not eligible for Medicare.

Her income is projected from her $550 per month June SSA disability check. The budget period is June 1 through November 30; the income limit is $1,300. Her spenddown liability is $1,880.

$ 550	SSA disability
- 20	general income exclusion
530	countable income
x 6	months
3,180	countable income for subsequent budget period
- 1,300	MNIL for subsequent budget period Group I *(using June 2000 figures)*
$ 1,880	spenddown liability June 1 - November 30

The current budget period based on her re-application abuts her previous spenddown budget period. It is a consecutive budget period because she established eligibility in the preceding budget period and, therefore, the $1,300 balance owed on the old bill and the carry-over September expenses are deducted from her current spenddown liability. She owes a total of $2,800 on these expenses as of June 1. Her eligibility is calculated:

$ 1,880	spenddown liability June 1 - November 30
- 1,300	old bill balance from August dental bill
580	spenddown liability after deducting dental bill
- 580	September carry-over expense; balance of $920 remains
$ 0	spenddown balance on June 1

NOTE: The non-covered dental expense and the physician's bill meet the definition of an old bill. The remaining balance of the carry-over expense can be used in a consecutive budget period if still owed.

Because the spenddown was met on June 1, Ms. Sub is enrolled in Medicaid for the period June 1 through November 30, eligibility "Type 3", PD 58.

E. Reference

See Appendix 1 to this subchapter for further examples of spenddown budget periods.

MEDICAL EXPENSE RECORD – MEDICAID

FORM NUMBER - 032-03-023

PURPOSE OF FORM -
1. To inform the individual or family who is ineligible for Medicaid, due to excess income, of the amount which must be spent or incurred for medical services before eligibility can be established;
2. To provide space to keep a running record of medical expenses;
3. To enable the client to estimate with some degree of accuracy the appropriate time to submit expenses to the agency and request a re-evaluation of his spenddown; and
4. To provide the agency with a method of determining the specific date the spenddown was met.

USE OF FORM - Used by the individual or family with excess income to record all medical expenses for himself and/or others for whom he has requested Medicaid. At such time as he believes he has incurred expenses equal to his spenddown liability, the client should submit the form with his bills to the local agency where his spenddown will be re-evaluated. The "Agency Use Only" section will be completed by the agency when:

1. a client submits bills for medial expenses that have been paid or incurred or
2. the agency has knowledge that current medical expenses, such as hospitalization may result in a negative spenddown balance.

When an individual or family returns with the form and has medical bills, the worker must apply the bills to the spenddown liability in accordance with the procedures specified in chapter M13 in the Medicaid manual. In some instances the individual or family will not be able to keep a running record of medical expenses and the bills alone will provide sufficient information.

NUMBER OF COPIES - Original and one copy.

DISTRIBUTION OF COPIES - Original must be prepared for the client. A copy must be filed in the eligibility case file.

INSTRUCTION FOR PREPARATION OF FORM - Enter in the appropriate spaces:
1. the name of the county or city Department of Social Services.
2. the full name of the individual.
3. the Medicaid case number.
4. the dates identifying the spenddown budget period.
5. the amount of the spenddown liability.

Give the form to the client and place a copy in the eligibility case file.

When the form 032-03-023 showing medical expenses or medical bills paid or incurred in the spenddown period is returned by the client, the agency will determine if the spenddown has been met. In listing medical obligations, expenses for a period can be consolidated into a lump sum as long as there is a positive balance. As the balance approaches zero, the dates services were rendered must be listed chronologically (with amounts) in order to determine the specific date on which the spenddown was met. This evaluation can be done on either the client or the agency copy of Form 032-03-023. If the client's form is used, a copy of that evaluation must be placed in the agency record. Regardless of which form is used by the agency to evaluate the effect of the client's medical expenses on the spenddown, the client's copy of the Form 032-03-023 must be returned to him, showing the balance of the spenddown liability amount, or stating that the spenddown has been met.

COMMONWEALTH OF VIRGINIA DEPARTMENT OF SOCIAL SERVICES **MEDICAL EXPENSE RECORD - MEDICAID**	COUNTY/CITY
CASE NAME(S)	CASE NUMBER
BUDGET PERIOD (DATES)	SPENDDOWN LIABILITY FOR THE BUDGET PERIOD $

You are not eligible for full Virginia Medicaid coverage at this time because your countable income exceeds the Medicaid income limit. If your medical and dental expenses equal your spenddown liability (the amount by which your income exceeds the income limit) at any time during the period shown above, you may be eligible for Medicaid at that time for the remainder of the period, provided all other eligibility requirements continue to be met. Also, your medical bills you still owe may be used to reduce the spenddown liability balance. Once those bills are used to reduce a spenddown and you become eligible, they cannot be used against any future spenddown liability.

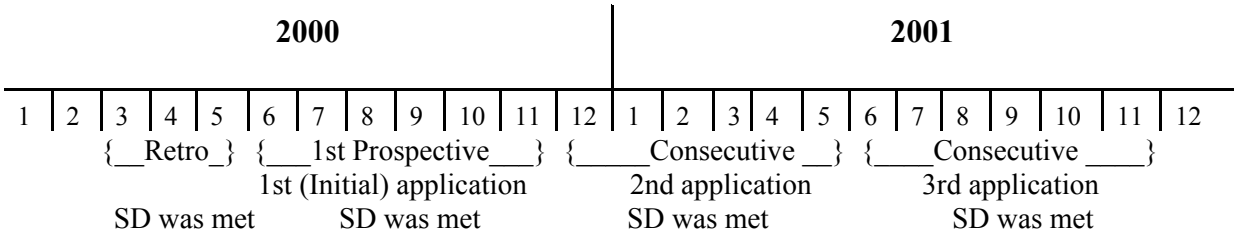
You should keep a daily record of all medical expenses for yourself and/or others for whom you have requested Medicaid. This will help you to know when you have medical expenses totaling the spenddown liability amount shown above. The space below is for your guidance and use. Include medical costs paid by other state and local programs such as General Relief or State-Local Hospitalization. When you believe you have met the spenddown, contact your worker at the Social Services Department.

AGENCY USE ONLY

DATE OF SERVICE MONTH/DAY/YEAR	WHO GAVE MEDICAL CARE	WHO RECEIVED THE SERVICE	AMT. PAID OR BILL AMOUNT	AMOUNT USED TO ACHIEVE ELIGIBILITY	BALANCE

DETERMINING SPENDDOWN ELIGIBILITY CHARTS

EXAMPLE #1:



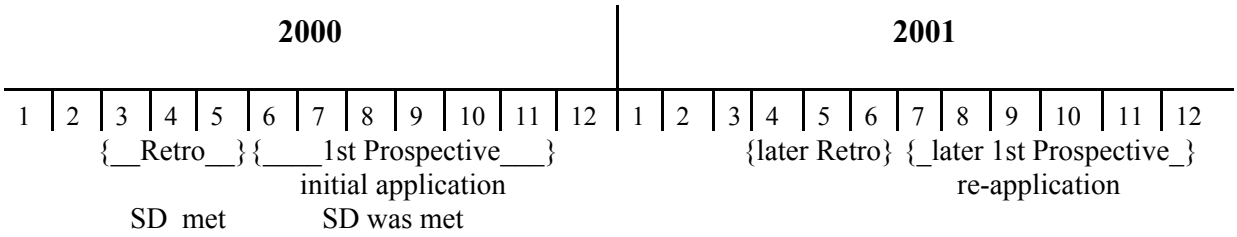
First application (initial application) date: June 2000. A retroactive budget period of March 1, 2000 - May 31, 2000 and a first prospective budget period of June 1, 2000 - November 30, 2000 were established.

Second application date December 2000. Spenddown budget period is December 1, 2000 - May 31, 2001.

Third application date June 2001. Spenddown budget period is June 1, 2001 - November 30, 2001.

Old bills are any bills incurred before March 2000. They are used to meet the retroactive spenddown. The unused balance is used to meet the 1st prospective spenddown and the consecutive spenddowns (until no old bill balance remains) because there is no break in spenddown eligibility (each spenddown was met).

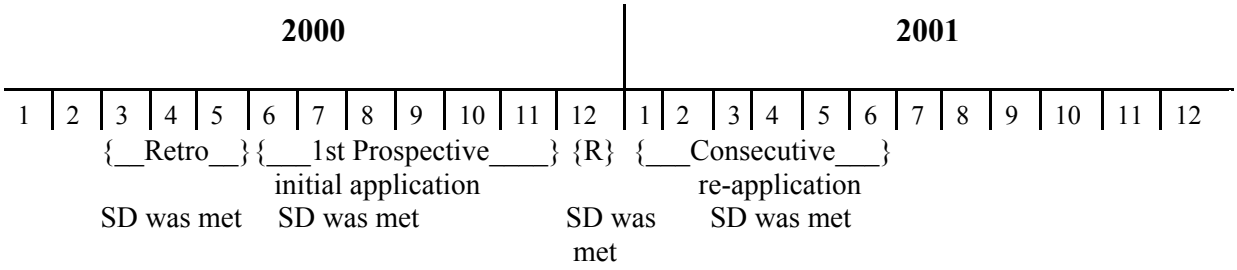
EXAMPLE #2:



The initial application was filed in June 2000. Retroactive budget period is March 1, 2000 - May 31, 2000 and first prospective budget period is June 1, 2000 - November 30, 2000. Old bills based on the initial application are any bills incurred prior to March 2000. Any bills incurred in March through May (the retroactive budget period), whether paid or unpaid, are carry-over expenses in the 1st prospective budget period.

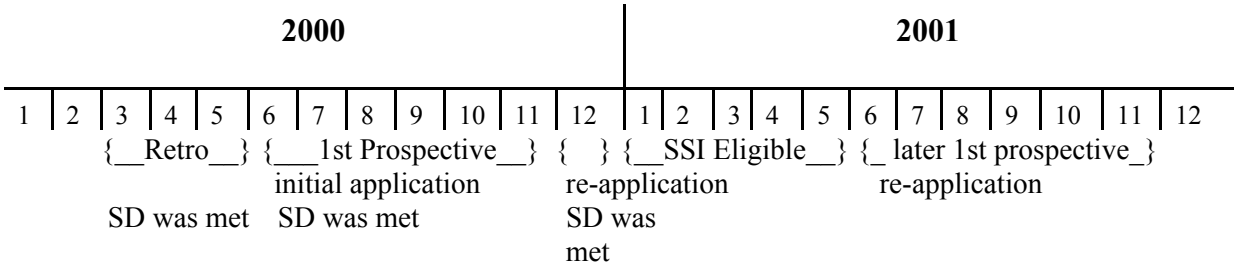
There is a break between spenddown budget periods. The new Medicaid application was filed July 2001. This is a re-application with a later retroactive budget period and a later 1st prospective budget period. For the July 2001 application, old bills are those incurred after November 30, 2000 and on or before March 31, 2001. The balance of any old bills incurred before December 1, 2000 cannot be applied to a later retroactive or prospective budget period. Only the current payments made on those prior expenses can be deducted.

EXAMPLE #3:



First application date is June 2000. The re-application date is January 2001. Old bills are those that were incurred before March 1, 2000, the initial application's retroactive budget period. Re-application is filed in January 2001, so the retroactive period based on the re-application is prorated to one month - December 1999. There is no break between spenddown budget periods and no break in spenddown eligibility; all these periods are consecutive.

EXAMPLE #4:



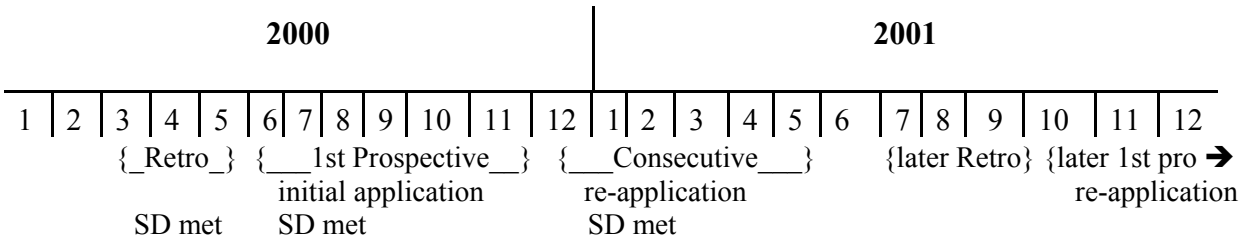
Initial application dated June 2000: a retroactive (March 1, 2000 - May 31, 2000) and a 1st prospective (June 1, 2000 - November 30, 2000) spenddown budget periods are established.

Re-application dated December 2000. Prorated consecutive budget period established for December 2000 only, because SSI was approved effective January 1, 2001. Individual is eligible without spenddown effective January 1, 2001.

SSI ends May 2001 and creates a first prospective spenddown budget period for June 1, 2001 - November 30, 2001.

All expenses incurred prior to January 1, 2001 are deducted as current payments because there has been a break in spenddown eligibility (January - May 2001 is CN budget period). Expenses incurred January 1, 2001, through May 31, 2001, are deducted as old bills for the June 2001 re-application.

EXAMPLE #5:



Initial application date June 2000.

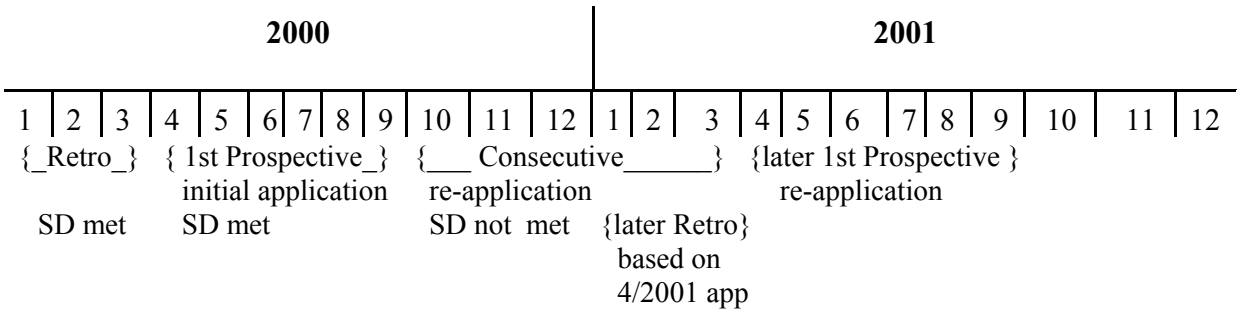
Old bills are any medical expenses incurred before March 2000 (the retroactive period based on the initial application). The retroactive budget period is March 2000 through May 2000. The first prospective budget period is June 2000 through November 2000. The retroactive and first prospective spenddowns were met.

A second application dated December 2000 is filed. The spenddown budget period is December 1, 2000, through May 31, 2001. Unpaid old bill balance, and unpaid balances of carry-over expenses incurred in retroactive & first prospective periods, are deducted on 1st day of consecutive budget period or December 1, 2000, because there was no break in spenddown eligibility.

Third application dated October 2001 is a re-application.

Old bills are only those incurred in June 2001 because there is a break in spenddown eligibility. Any unpaid balance on the old bills from the initial application is no longer deducted as an "old bill". Only current payments made on the old bill balance(s) can be deducted. Current payments are deducted the date paid in the October 2001 re-application's retroactive and/or first prospective budget periods.

EXAMPLE #6:



Initial application filed April 2000.

Old bills are any medical expenses incurred before January 2000 (the retroactive period based on the initial application). The retroactive budget period is January 2000 - March 2000. The first prospective budget period is April 2000 through September 2000. The retroactive and first prospective spenddowns were met.

Second application dated October 2000 is filed. The consecutive spenddown budget period is October 2000 - March 2001. Unpaid old bill balance, and unpaid balances of carry-over expenses incurred in retroactive & first prospective periods, are deducted on 1st day of consecutive budget period or October 1, 2000, because there was no break in spenddown eligibility. Expenses incurred during the consecutive

budget period are deducted on the date incurred. The October 2000 - March 2001 spenddown was not met.

Third application dated April 2001 is filed. The retroactive budget period is January 2001 - March 2001. Old bills are those incurred after September 30, 2000, and prior to January 1, 2001, and are deducted on January 1, 2001. Paid and unpaid expenses incurred during the retroactive period (January 2001 through March 2001) are deducted on the date incurred. All expenses incurred prior to October 1, 2000, are deducted as current payments because there has been a break in spenddown eligibility. The later first prospective budget period is April 2001 - September 2001. Unpaid balances on old bills (incurred after September 30, 2000, and prior to January 1, 2001) not used to meet the retroactive spenddown are deducted on April 1, 2001. Paid and unpaid expenses incurred during the retroactive spenddown budget period that were not used to meet the spenddown are deducted on April 1, 2001. Paid or unpaid expenses incurred during the later first prospective period (April 2001 through September 2001) are deducted on the date incurred. All expenses incurred prior to the break in spenddown eligibility (October 1, 2000) are deducted as current payments.

CHAPTER M13
SPENDDOWN

SUBCHAPTER 50

CHANGES PRIOR TO MEETING SPENDDOWN

M1350 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	pages 7, 8

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M1350.000 CHANGES PRIOR TO MEETING SPENDDOWN

M1350.100 CHANGES PRIOR TO MEETING SPENDDOWN

A. Policy

When changes occur in the individual's or family's situation after applying for Medicaid, but before meeting the spenddown liability, the amount of countable income, the spenddown liability and the spenddown budget period may change.

1. Retroactive Spenddown Budget Period

The retroactive spenddown budget period is prorated (shortened) when:

- one or two of the months in the retroactive period were included in a prior Medicaid medically needy spenddown budget period in which eligibility was established, or
- the only medically needy individual in the assistance unit dies in the first or second month of the retroactive period.

2. Prospective Budget Period

The prospective spenddown budget period is prorated when:

- the only medically needy individual in the assistance unit dies,
- the only medically needy individual in the assistance unit becomes ineligible before the end of the spenddown budget period because of excess resources or nonfinancial reasons, or
- the individual's or assistance unit's covered group classification changes from medically needy to categorically needy or categorically needy non-money payment.

B. Case Transfer

When the MN assistance unit moves to a new locality, transfer the case according to procedures in section M1520.600.

It is the responsibility of the sending agency to:

1. inform the applicant of the receiving agency's name, address, and telephone number;
2. deduct all known spenddown items from the spenddown balance on the worksheet before sending the case record to the new locality;
3. note the spenddown period and balance on the case transfer form.

It is the responsibility of the receiving agency to review the spenddown to determine if a recalculation based on a different income limit is required.

C. References

Procedures for handling changes that occur during the spenddown budget

period are in the following sections:

- M1350.200 Increase in Assistance Unit Size
- M1350.210 Decrease in Assistance Unit Size Not Due To Institutionalization
- M1350.220 Decrease in Assistance Unit Size Due To Institutionalization
- M1350.300 Income Changes
- M1350.400 Income Limit Changes
- M1350.500 Resource Changes
- M1350.600 Nonfinancial Eligibility Requirement Not Met
- M1350.700 Change of Covered Group Classification
- M1350.800 Individual Becomes Institutionalized
- M1350.900 Changes Due To Death

M1350.200 INCREASE IN ASSISTANCE UNIT SIZE

A. Policy

When the assistance unit size increases and Medicaid is requested for the additional member(s), the spenddown budget period remains the same but the spenddown liability amount must be recalculated.

1. Step 1

For the months prior to the month in which the change occurred, calculate the family's income based on the number of members in the assistance unit at the time of application.

For the months during which the additional member was added to the assistance unit, calculate the family's income based on the increased number in the assistance unit.

2. Step 2

Total the family's income for the entire 6-month spenddown budget period. The result is the family's recalculated income for the spenddown budget period.

3. Step 3

Determine the income limit for the assistance unit size for the number of months before the change occurred. Determine the income limit for the assistance unit size for the number of months in which the additional member was included. Add together the income limits. The result is the recalculated income limit for the spenddown budget period.

4. Step 4

Subtract the recalculated income limit from the family's recalculated income. The result is the recalculated spenddown liability for the spenddown budget period.

If the recalculated income is within the recalculated income limit for the spenddown budget period, the assistance unit is eligible for the entire spenddown budget period. However, the additional assistance unit member(s) (who was not included during the entire period) is only eligible for the month(s) when he was included in the unit.

B. Example--Increase In Assistance Unit Size

EXAMPLE #1 (Using June 2000 figures): Mr. D lives in Group II and applies for Medicaid on June 6 for himself and his family. He is temporarily disabled. He lives with his wife and 13 year old child. The assistance unit size is 3 persons when determining eligibility. The family's income totals $3,000 per month worker's compensation- $2,000 for Mr. D and $1,000 for Mrs. D; the child has no income. Since the F&C countable income exceeds the MI limit and they are within the resource limit for a family of 3, a MN determination is done. The first prospective budget period is June 1 through November 30. The MN income limit for a family of 3 living in a Group II locality, is $2,150. The spenddown liability is $15,850.

$ 3,000	total worker's compensation
x 6	months
18,000	countable income for the spenddown budget period
- 2,150	MNIL for 3 persons Group II for budget period
$15,850	spenddown liability for spenddown budget period June - November

The family has not met the spenddown. On September 5, they report that their eldest son, age 16, returned to the home to live with them on September 2 and they want to apply for Medicaid for him, as well. He has no income. The assistance unit size for September through November (3 months) is 4 persons; the income limit is $1,200. The family's income, income limit and spenddown liability are recalculated:

$ 3,000	total worker's compensation
x 6	months June - November
$18,000	countable income for spenddown budget period June - November

1,075	MNIL for 3 persons Group II June - August
+ 1,200	MNIL for 4 persons Group II September - November
2,275	MNIL for spenddown budget period June - November

$18,000	countable income for spenddown budget period June - November
- 2,275	MNIL for spenddown budget period
$15,725	spenddown liability for spenddown budget period June - November

The family's spenddown liability for the June 1 through November 30 spenddown budget period is $15,725.

M1350.210 DECREASE IN UNIT SIZE NOT DUE TO INSTITUTIONALIZATION

A. Policy

When the assistance unit size decreases (NOT due to institutionalization of an assistance unit member) and the decrease is reported by the applicant, the spenddown budget period remains the same but the spenddown liability must

be recalculated. See section M1350.220 for procedures to follow when an assistance unit member is institutionalized.

1. **Step 1** For the months prior to the month in which the change occurred, calculate the family's income based on the number in the assistance unit at the time of application.

   For the months during which the assistance unit decreased, calculate the family's income based on the decreased number in the assistance unit.

2. **Step 2** Total the family's income for the entire 6-month spenddown budget period. The result is the family's recalculated income for the spenddown budget period.

3. **Step 3** Determine the income limit for the assistance unit size for the months prior to the change and for the month the change occurred. Determine the income limit for the assistance unit size for the number of months after the change occurred. Add together the income limits. The result is the recalculated income limit for the spenddown budget period.

4. **Step 4** Subtract the recalculated income limit from the family's recalculated income. The result is the recalculated spenddown liability for the spenddown budget period.

   If the recalculated spenddown liability is within the recalculated income limit for the six-month spenddown budget period, the assistance unit is eligible for the entire spenddown budget period. However, the assistance unit member(s) who left the unit is only eligible for the month(s) when he was included in the unit.

B. Example--Decrease in Assistance Unit, Not Due To Institutionalization

EXAMPLE #2 (Using June 2000 figures): Mr. E lives in Group III and applies for Medicaid on June 8 for himself and his family. He lives with his wife and their 3 children ages 6, 8, and 11. Neither Mr. nor Mrs. E meet a Medicaid covered group. The assistance unit size is 5 persons when determining the children's eligibility (F&C). The family's income totals $3,500 per month private company pension - $3,000 for Mr. E and $500 for Mrs. E; the children have no income. The first prospective budget period is June 1 through November 30; the income limit for 5 persons in Group III is $3,150.

The spenddown liability is calculated:

$ 3,500	total family income per month
x 6	months
21,000	countable income for the spenddown budget period
- 3,150	MNIL for 5 persons Group III
$17,850	spenddown liability for spenddown budget period June 1 - November 30

The family has not met the spenddown. On August 30, they report that their eldest son, age 11, left home to live with relatives on August 29. The

assistance unit size for September through November (3 months) is 4 persons; the income limit is $1,450. The family's income, income limit and spenddown liability are recalculated:

$ 3,500	total income per month
x 6	months June - November
$21,000	countable for spenddown budget period June through November
1,575	5 persons MNIL Group III for June-August
+1,450	4 persons MNIL Group III for September-November
3,025	MNIL for budget period
$21,000	income for spenddown budget period June through November
- 3,025	MNIL for spenddown budget period June through November
$17,975	spenddown liability for spenddown budget period June through November

The family's spenddown liability for the June 1 through November 30 spenddown budget period is $17,975

M1350.220 DECREASE IN UNIT SIZE DUE TO INSTITUTIONALIZATION

A. Policy

An institutionalized individual becomes a separate assistance unit for the income eligibility determination purposes as of the first day of the month of institutionalization.

B. Recalculate Family's Spenddown

When the individual was included in the assistance unit with a spouse and/or children, the spouse's and/or children's spenddown liability is recalculated to reflect a decrease in assistance unit size. The decreased assistance unit size begins the first day of the month in which the individual is institutionalized.

Only those medical bills incurred by the institutionalized individual during the months in the spenddown budget period when he was in the assistance unit are deducted from the family's spenddown.

C. Institutionalized Individual

Determine the institutionalized individual's eligibility separately beginning the first day of the month during which he becomes institutionalized. See subchapter M1460 for instructions on determining eligibility for institutionalized individuals.

M1350.300 INCOME CHANGES

A. Policy

When an income change is reported, the spenddown liability must be recalculated based on the income actually received in the spenddown budget period. The spenddown budget period does not change. When the applicant reports an income change, request verification, take appropriate action and document the case record.

1. Reported Before Spenddown Budget Period Ends

If the change is reported before the end of the spenddown budget period, project the changed income for the remaining months in the spenddown budget period. Average any irregular income received and project the average for the remaining months in the spenddown budget period.

2. Reported After Spenddown Budget Period Ends

If the change is reported after the spenddown budget period ends, recalculate the spenddown liability using the actual income received during the spenddown budget period.

B. Example--Income Changes

EXAMPLE #3 (*Using June 2000 figures)*: Mr. Green lives in Group III and applies for Medicaid on June 8 for himself and his family. He lives with his wife and their 3 children ages 6, 8, and 11. Neither Mr. nor Mrs. Green meet a Medicaid covered group. The assistance unit size is 5 persons when determining the children's eligibility (F&C). The family's income totals $3,700 per month private company pension - $3,000 for Mr. Green and $700 for Mrs. Green; the children have no income. The first prospective budget period is June 1 through November 30, 1999; the income limit for 5 persons in Group III is $3,150. The spenddown liability is calculated:

$ 3,700	total family income per month
x 6	months
$22,200	countable income for the spenddown budget period June – November
- 3,150	MNIL for 5 persons Group III
$19,050	spenddown liability for spenddown budget period June through November

The family has not met the spenddown. On September 5, they report that their income changed on September 1; Mrs. Green no longer receives a pension benefit and she has no other income. The assistance unit's monthly income for September through November (3 months) is $3,000; their monthly income for June through - August (3 months) is $3,700. The family's spenddown liability is recalculated:

$ 3,700	income per month
x 3	months (June, July, and August)
$11,100	countable income for first 3 months

$ 3,000	total income per month
x 3	months (September, October, and November)
$ 9,000	countable income for second 3 months

$11,100	countable income for June through August
+ 9,000	countable income for September through November
20,100	countable income for spenddown budget period of June through September
- 3,150	MNIL for 5 persons Group III
$16,950	spenddown liability for spenddown budget period June through November

The family's recalculated spenddown liability for the June 1 - November 30 spenddown budget period is $16,950.

M1350.400 INCOME LIMIT CHANGES

A. Policy

Recalculate the spenddown liability for the spenddown budget period when:

- the applicant moves to a different locality group at some point within the spenddown budget period; or
- the Medicaid income limit(s) changes at some point within the spenddown budget period. ***Note that the effective date for changes in MN income limits is July 1.***

B. Procedure

1. Use the "old" income limit for the month in which the applicant moved. Multiply the "old" monthly income limit by the number of months in the spenddown budget period during which it was effective.
2. Multiply the "new" monthly income limit by the number of months in the spenddown budget period during which it was effective. Add both results together. The total is the recalculated income limit.
3. Subtract the applicant's countable income for the spenddown budget period from the recalculated income limit. The result is the recalculated spenddown liability for the spenddown budget period.

C. Example--Income Limit Changes When Individual Moves

EXAMPLE #4 (Using *July 2011* figures): Mr. E lives in Group III and applies for Medicaid on *July* 6 for himself. He is aged and lives alone. His income totals $1,575 per month SSA benefit. The first prospective budget period is *July* 1 through *December* 31. The income limit for 1 person in Group III is *$2,567.56*. His spenddown liability is *$6,762.44*.

$ 1,575.00	SSA per month
- 20.00	general income exclusion
1,555	countable monthly income
x 6	months
$9,330.00	countable income for the spenddown budget period
- 2,567.56	1 person *semi-annual* MNIL Group III for spenddown budget period
$6,762.44	spenddown liability for spenddown budget period *July* through *December*

On *September* 23 he moves to a Group II locality and requests re-evaluation of his spenddown.

His spenddown liability is recalculated for the *July -December* spenddown budget period:

$1,283.76	1 person MNIL Group III for 3 months *July - September*
+ 987.51	1 person MNIL Group II for 3 months *October - December*
2,271.27	MNIL for spenddown budget period
$ 9,330.00	countable income for the spenddown budget period
- 2,271.27	MNIL for spenddown budget period
$7,058.73	spenddown liability for the spenddown budget period *July 1 – December 31, 2011*

M1350.500 RESOURCE CHANGES

A. Policy

When determining if the spenddown is met, evaluate any change in resources owned or in the value of resources owned to determine if the assistance unit's resources are still within the Medicaid limit. When resources exceed the Medicaid limit in some months, the spenddown budget period and the spenddown liability must be recalculated. Prorate the spenddown budget period to include the month(s) before the first full month in which the excess resources create ineligibility.

If resources exceed the limit, send a written notice to the applicant informing him of his ineligibility for Medicaid spenddown for the month(s) in which the resources exceeded the limit during the entire month.

B. Notice Requirements

Send a written notice to the applicant that states:

- the reason for ineligibility for Medicaid (excess resources) for the months in which excess resources exist (specify the months), and
- the spenddown liability amount for the months during which resources were within the limit (specify the months). Include the explanation that if medical or dental bills equal or exceed the spenddown liability, he may be eligible for limited Medicaid eligibility for the month(s) during which his resources were within the Medicaid limit (specify the dates).

C. Example-- Resource Changes

EXAMPLE #5 (Using June 2000 figures): Mr. G lives in Group I and applies for Medicaid on June 6 for himself. He is disabled and lives alone. His income totals $1,475 per month SSA benefit. The first prospective budget period is June 1 through November 30; the income limit for 1 person in Group I is $1,300. His spenddown liability is $7,430.

$1,475	SSA per month
- 20	general income exclusion
1,455	monthly countable income
x 6	months
8,730	countable income for the spenddown budget period
- 1,300	1 person MNIL Group I for spenddown budget period
$7,430	spenddown liability for spenddown budget period June 1-November 30

His application is denied and he is placed on spenddown. When he requests re-evaluation of his spenddown on October 26, the worker finds that his resources exceed the Medicaid limit for the entire month of October, but were within the limit in June - September. The worker prorates the spenddown budget period to 4 months - June 1 through September 30. The worker recalculates the spenddown liability:

$1,455.00	monthly countable income
x 4	months (June- September)
5,820.00	countable income for the spenddown budget period
- 866.68	1 person MNIL Group I for 4 months spenddown budget period
$4,953.32	spenddown liability for spenddown budget period June 1 - September 30

The worker determines that verified incurred expenses totaling $800 on August 18 and $45 on September 4 do not meet the spenddown liability. A liability balance of *$4,108.32* remains for the prorated spenddown budget period.

The worker sends Mr. E a notice which states:

- You are not eligible for Medicaid for the months of June through September 30 because of excess income. Your spenddown liability is *$4,953.32*. You have incurred $845 in expenses, leaving a balance of *$4,108.32*. You have not met the spenddown.

- You are not eligible for Medicaid for the month of October because of excess resources. If you want your Medicaid eligibility determined again, you must reapply for Medicaid.

M1350.600 NONFINANCIAL ELIGIBILITY REQUIREMENT NOT MET

A. Policy

When an individual fails to meet a nonfinancial Medicaid eligibility requirement (such as MN covered group not met), he cannot become eligible by meeting a spenddown. At the time a change is reported in the individual's or family's nonfinancial Medicaid eligibility, evaluate the change to determine if the individual or family continues to meet the nonfinancial Medicaid eligibility requirements.

If a nonfinancial eligibility requirement(s) is not met in any month in the spenddown budget period, send a written notice to the individual specifying the new denial reason (specify the nonfinancial requirement(s) that is not met).

If all nonfinancial requirements are not met in any of the months of the spenddown budget period, the spenddown liability and spenddown budget period will change. Prorate the spenddown budget period to include the month(s) before the first full month in which the nonfinancial requirement was not met.

B. Notice Requirements

Send a written notice to the applicant that states the new reason for denial:

- specify the nonfinancial requirement that is not met, and for which months the requirement is not met (specify the months), and

- the spenddown liability amount for the months during which the requirements were met (specify the months). Include the explanation that if medical or dental bills equal or exceed the spenddown liability by the end of the month for the new prorated spenddown budget period, the individual may be eligible for Medicaid coverage for the month(s) during which the Medicaid nonfinancial eligibility requirements were met.

C. Example-- Nonfinancial Eligibility Requirement Not Met

EXAMPLE #6 (*Using June 2000 figures)*: Mr. H lives in Group I and applies for Medicaid on June 8 for himself. He is disabled (MDU determined) and lives alone. His income totals $*1,475* per month private disability benefit. The first prospective budget period is June 1 through November 30. The income limit for 1 person in Group I is $1,300. His spenddown liability is *$7,430.*

$ 1,475	income per month
- 20	general income exclusion
1,455	monthly countable income
x 6	months
$ 8,730	countable income for the spenddown budget period

$ 8,730	countable income for spenddown budget period
- 1,300	1 person MNIL Group I for spenddown budget period
$ 7,430	spenddown liability for spenddown budget period June 1 - November 30

His application is denied and he is placed on spenddown. He requests re-evaluation of his spenddown on October 26. The worker finds he is no longer disabled as of September 30, per an MDU review. The worker prorates the spenddown budget period to 4 months - June 1 through September 30.

The worker recalculates the spenddown liability:

$1,455.00	monthly countable income
x 4	months
5,820.00	countable income for the spenddown budget period
- 866.68	1 person MNIL Group I for 4 months spenddown budget period
$4953.32	spenddown liability for spenddown budget period June 1 - September 30

The worker verified $500 incurred expenses on July 8 and $245 on August 4. The spenddown liability was not met. A liability balance of $4,208.32 remains for the prorated spenddown budget period.

The worker notifies Mr. H that he did not meet his spenddown for the spenddown budget period June 1 through September 30, of the MDU determination that he is no longer disabled and that he does not meet another Medicaid covered group. The notice states:

- You are not eligible for Medicaid for the months of June through September 30 because of excess income. Your spenddown liability is $4,953.32. You have incurred $745 in expenses, leaving a balance of $4,208.32. You have not met the spenddown.

- You are not eligible for Medicaid for the month of October 1999 because the MDU determined that you are no longer disabled. You do not meet another Medicaid covered group as of October 1. Should your condition worsen, it is necessary for you to reapply if you want your Medicaid eligibility determined again.

M1350.700 CHANGE OF COVERED GROUP

A. Policy

An individual is entitled to Medicaid in a new classification effective the first day of the month in which he meets that new classification.

1. Assistance Unit of One

The spenddown budget period changes and the spenddown is recalculated when an individual who is an assistance unit of one person becomes eligible for Medicaid in a non-medically needy covered group.

The individual remains on a spenddown for the month(s) before the change in classification.

When an individual is institutionalized, his covered group classification changes to CNNMP if his gross income is within the 300% SSI income limit. If his gross income exceeds the 300% SSI limit, he remains medically needy and his classification does not change. However, his spenddown budget period and spenddown liability must be changed. See section M1350.800 below.

EXAMPLE #7 (Using June 2000 figures): A disabled, single man living in Group I receives worker's compensation of $600 per month. He applies for Medicaid on June 10. The Medicaid Disability Unit determines him disabled. Disability onset was prior to March 1 of that year. His total monthly countable income was and is $600. The MNIL is $1,300. He did not incur any medical bills during the retroactive period. He does not have any old bills. The first prospective budget period is June through November. His spenddown liability is $2,180.

$ 600	income per month
- 20	general income exclusion
580	monthly countable income
x 6	months
3,480	countable income for the spenddown budget period
-1,300	1person MNIL Group I for spenddown budget period
$2,180	spenddown liability for spenddown budget period June 1 - November 30

His application is denied. He is placed on a spenddown for the first prospective budget period. On September 20, he requests re-evaluation of his spenddown due to his receipt of $512 per month SSI effective September. His worker's compensation income ended August 31. He incurred $1,000 in medical bills during July. He is eligible for Medicaid as categorically needy beginning September 1.

His spenddown budget period is prorated to June - August (3 months). His spenddown liability for the prorated spenddown budget period is recalculated:

$ 580	countable income for June - August
x 3	months
1,740	countable income for prorated spenddown budget period June - August
- 650	1 person MNIL Group I for 3 months
$1,090	spenddown liability for spenddown budget period June 1 - August 31

He incurred $1,100 worth of medical bills on July 15. He met his spenddown on that date. He is eligible effective July 15 - August 31 as medically needy, Type 3, PD 58. Effective September 1, he is eligible as categorically needy, Type 1, PD 51.

2. Assistance Unit of Two or More

When the entire assistance unit's classification changes, the spenddown budget period changes and the spenddown liability is recalculated. Eligible family members are entitled to Medicaid in the new classification effective the first day of the month in which they meet that new classification. They

remain on spenddown for the month(s) before the change in classification. When all children in the assistance unit become eligible as *MI*, the spenddown budget period changes and the spenddown liability is recalculated. The children are eligible as *MI* effective the first day of the month in which they meet the *MI* requirements. They remain on a spenddown for the months prior to *establishing MI* eligibility.

The assistance unit size decreases when an individual member of an assistance unit of two or more becomes eligible in another classification. The individual is no longer included in the original assistance unit. The spenddown liability is recalculated using the procedures in section M1350.210 above.

M1350.800 INDIVIDUAL BECOMES INSTITUTIONALIZED

A. Policy

When an individual becomes institutionalized and his gross income exceeds the 300% SSI limit, he remains medically needy. His classification does not change. However, his spenddown budget period must be changed. His spenddown liability is recalculated.

1. Prorate Spenddown Budget Period & Recalculate Spenddown Liability

Prorate the individual's spenddown budget period for the month(s) in which he was not institutionalized. Do not include the month in which he became institutionalized.

Total the monthly countable income he received in the prorated spenddown budget period. Subtract the MN income limit for the number of months in the prorated spenddown budget period. The remainder is the recalculated spenddown liability for the months during which he was not institutionalized.

2. Determine Institutional-ized Spenddown

The MN budget period for an institutionalized individual is one month. Go to subchapter M1460 to determine the individual's spenddown as an institutionalized individual.

B. Example--Individual Becomes Institutionalized

EXAMPLE #8 (Using June 2000 figures): A disabled, single man living in Group I receives worker's compensation of $1,550 per month. He applies for Medicaid on June 6. This is his initial application. The Medicaid Disability Unit determines him disabled. Disability onset is February. His monthly countable income was and is $1,550. The MNIL is $1,300. He did not incur any medical bills during the retroactive period. He does not have any old bills. The first prospective budget period is June through November. His spenddown liability is calculated:

$1,550	income per month
- 20	general income exclusion
1,530	countable monthly income
x 6	months
9,180	countable income for the spenddown budget period June 1 – November 30
- 1,300	1 person MNIL Group I for spenddown budget period
$7,880	spenddown liability for spenddown budget period June 1 - November 30

His application is denied. He is placed on spenddown for the first prospective budget period. On October 20, he becomes institutionalized when he is admitted to a nursing facility for permanent care. His worker's compensation income has not changed. He incurred $5,000 in medical bills during September. His spenddown budget period is prorated to June - September (4 months). His spenddown liability for the prorated spenddown budget period is recalculated:

$1,530.00	monthly countable income for June - September
x 4	months (June-September)
6,120.00	countable income prorated for spenddown budget period June - September
- 866.68	1 person MNIL Group I for 4 months
$5,253.32	spenddown liability for spenddown budget period June 1 – September 30

He incurred $5,000 in medical bills in September. He did not meet the prorated spenddown. The worker sends Mr. T a notice informing him that he did not meet his spenddown for the prorated spenddown budget period of June 1 through September 30. The $5,000 in medical bills did not meet the prorated spenddown of $5,253.32. He has a balance left of $253.32. His spenddown eligibility as an institutionalized individual is determined according to policy in subchapter M1460.

M1350.900 CHANGES DUE TO DEATH

A. Policy

1. Individual Applicant

When an individual who meets an MN covered group, dies within the spenddown budget period, the spenddown budget period and the spenddown liability change. The spenddown liability and spenddown budget period are recalculated using actual income received.

2. Death of a Assistance Unit Member

When an individual member of an assistance unit dies, and at least one other assistance unit member meets a MN covered group, the family's assistance unit size decreases. The policy and procedures in section M1350.210 above apply.

B. Example-- Individual Applicant Dies

EXAMPLE #9 (*Using June 2000 figures)*: Mr. T is an aged widower living in Group I. He receives an SSA benefit of *$620* per month. He applies for Medicaid on June 6. His monthly countable income was and is *$620*. The MNIL is $1,300. The spenddown budget period is June through November. His spenddown liability is *$2,300*. He has Medicare Parts A & B. He did not incur any medical bills during the retroactive period. He does not have any old bills.

$ *620*	SSA income per month
- 20	general income exclusion
600	countable monthly income
x 6	months (June - November)
$3,600	countable income for the spenddown budget period June - November

$3*,600*	countable income for the spenddown budget period
-1,300	1 person MNIL Group I for spenddown budget period
$2,300	spenddown liability for spenddown budget period June through November

His application is denied. He is placed on a spenddown for the first prospective budget period. On September 20, his daughter reports that Mr. T died on September 10. He incurred medical expenses in August and September. She requests re-evaluation of his spenddown. He incurred $*1,400* in Medicare hospital deductible and coinsurance charges on August 21. He incurred a $25 per day Medicare coinsurance charge for physician's services for 10 days - August 30 through September 8. His spenddown budget period is prorated to June - September. His spenddown liability is recalculated:

$ *600.00*	monthly countable income
x 4	months
2,400.00	total countable income for June - September
- 866.68	MNIL for 1 person Group I for 4 months
1*,533.32*	spenddown liability for spenddown budget period June - September
- 45.50	Medicare premium June 3
1*,487.82*	spenddown liability balance June 3
- 45.50	Medicare premium July 3
1,442.32	spenddown liability balance on July 3
- 45.50	Medicare premium August 3
1*,396.82*	spenddown liability balance August 3
-1400.00	hospital deductible and coinsurance charges August 21
$ 0	spenddown balance on August 21

The *$1,400.00* in medical expenses incurred on August 21, met his spenddown liability on that date. He is eligible for Medicaid effective August 21 through September 10 (date of death).

CHAPTER M13
SPENDDOWN

SUBCHAPTER 60

CHANGES AFTER SPENDDOWN IS MET

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M1360.000 CHANGES AFTER SPENDDOWN IS MET

M1360.100 CHANGES AFTER SPENDDOWN IS MET

A. Policy

Spenddown budget periods do not change when changes occur in an individual's or family's situation after meeting a spenddown liability within a spenddown budget period. The amount of countable income and the spenddown liability may change, but the spenddown budget period never changes.

B. Decrease in Assistance Unit

Do not recalculate the spenddown liability when the assistance unit decreases. Cancel the Medicaid coverage of the deleted assistance unit member(s). The remaining unit members are eligible until the end of the spenddown budget period.

C. Increase in Assistance Unit

When the assistance unit size increases, Medicaid may be requested for the additional member(s). Recalculate the spenddown liability based on the changes in the income limit and the family's income (if any) for the month(s) that the individual(s) is added to the unit and for subsequent month(s).

The additional family member's(s') medical bills (including old bills) can be deducted only for the months during which he is included in the assistance unit.

1. Spenddown Liability Decreases

Re-enroll the family with an earlier coverage begin date if the spenddown liability decreases and is met earlier because of the decrease. Enroll the additional unit member(s) no earlier than the date he became a part of the unit.

EXAMPLE #1 ***(Using April 2000 figures)*****:** Mr. D lives in Group II and applies for Medicaid on April 6 for himself and his family. He is disabled and lives with his wife and 13 year old child. They have no health insurance. The assistance unit size is 3 persons when determining Mrs. D's and the child's eligibility (F&C); Mr. D's unit size is 1 person (ABD). The family's income totals $2,800 per month. Mr. D receives a $1,000 SSA and a $1,000 private pension. Mrs. D receives $800 worker's compensation. The first prospective budget period is April 1 through September 30. The income limit for the F &C MN determination is $2,150. The spenddown liability is $14,650.

$ 2,800	total countable income per month
x 6	months
16,800	countable income for the spenddown budget period
- 2,150	MNIL for 3 persons Group II
$14,650	spenddown liability for spenddown budget period April 1 - September 30

The family incurs $14,650 in hospital and physicians' expenses as of May 28. The child is enrolled in Medicaid effective May 28, Type 3 eligibility

(which will be canceled effective September 30). On July 15, the family reports their eldest son, age 16, returned to the home to live with them on July 12. They want to apply for Medicaid for him, as well. He has no income. The assistance unit size for July through September (3 months) is 4 persons; the income limit is $2,400.

The family's income limit and spenddown liability is recalculated:

1,075	MNIL for 3 persons Group II April - June
+ 1,200	MNIL for 4 persons Group II July - September
2,275	MNIL for spenddown budget period
$16,800	countable income for the spenddown budget period
- 2,275	MNIL for spenddown budget period
$14,525	spenddown liability for budget period

The family's recalculated spenddown liability for the April 1 through September 30 budget period is $14,525. The worker redetermines the spenddown and determines that the family incurred $14,525 in medical expenses on May 25. Because this date is earlier than the May 28 coverage begin date originally determined, the 13 year old child (but not the 16-year-old son) is re-enrolled in Medicaid beginning May 25 (ending September 30). The 16 year-old is enrolled in Type 3 eligibility beginning July 1, the first day of the month he came to live with the family, and ending September 30.

2. Liability Increases

When the spenddown liability increases, the spenddown budget period does not change. Cancel the family's coverage if the recalculated spenddown liability has not been met.

If the recalculated spenddown liability has been or is met, enroll the additional assistance unit member(s) no earlier than the date he became part of the unit.

EXAMPLE #2 ***(Using April 2000 figures)*****:** Ms. S lives in group III and applies for Medicaid on April 6 for herself and her family. She lives with her husband and 13 year old child. They have no health insurance. The assistance unit size is 3 persons when determining the child's eligibility (F&C MN child < 18). Their income exceeds the CNNMP limit. Mr. and Mrs. S do not meet an MN covered group.

The family's income totals $2,400 per month SSA retirement - $1,200 for Mr. S and $1200 for Mrs. S; the child has no income. The first prospective budget period is April 1 through September 30. The income limit is $2,650. The spenddown liability is calculated:

$ 2,400	total SSA retirement per month
x 6	months
14,400	countable income for the spenddown budget period
- 2,650	MNIL for 3 persons Group III
$ 11,750	spenddown liability for spenddown budget period April 1 - September 30

The family incurs $11,750 in hospital and physicians' expenses as of June 12. The child is enrolled in Medicaid beginning June 12 (ending September 30). On August 1, they report that their eldest son, age 16, returned to the home to live with them on July 1. They want to apply for Medicaid for him, as well. He has no income. However, Mr. S's income increased in July to $1,400 per month. The assistance unit size for July through September (3 months) is 4 persons; the income limit is $2,900. The family's income, income limit and spenddown liability are recalculated:

$ 2,400	total family income per month
x 3	months April - June
$ 7,200	total family income for April - June

$ 2,600	total family income per month
x 3	months July - September
$ 7,800	total family income for July - September
+ 7,200	total family income for April - June
$15,000	total income for spenddown budget period April - September

1,325	MNIL for 3 persons Group III April - June
+ 1,450	MNIL for 4 persons Group III July - September
2,775	MNIL for spenddown budget period April - September

$15,000	countable income for the spenddown budget period
- 2,775	MNIL for spenddown budget period
$12,225	spenddown liability for spenddown budget period

The family's recalculated spenddown liability for the April 1 through September 30 budget period is $12,225. The worker determines that the family has a spenddown liability balance of $475 left on June 12. Because the spenddown liability has not been met, the family members' Medicaid coverage is canceled effective July 31 because of excess income; spenddown liability balance of $475. The 16-year-old son is not eligible for Medicaid and is not enrolled.

D. Income Decreases

Recalculate the spenddown liability for the spenddown budget period based on the actual income received. If the recalculated spenddown liability is met earlier in the spenddown budget period, re-enroll the eligible members of the unit with the earlier eligibility begin date.

E. Income Increases

Recalculate the spenddown liability for the spenddown budget period based on the actual income received. If the new spenddown liability has not been met, cancel eligibility. Notify the recipient of the new spenddown liability and the balance of the spenddown liability which must be met by the last day of the spenddown budget period.

NOTE: **This subsection does not apply to medically needy pregnant women who apply for and are enrolled in Medicaid on or before the date their pregnancies terminate. Income increases are excluded for these MN pregnant women.**

F. Resource Changes

Redetermine the assistance unit's eligibility based on a change in resources.

1. Resources Within Limit

When resources are within the Medicaid limit, the unit remains eligible as medically needy for the remainder of the spenddown budget period.

2. Resources Exceed Limit

When the resources exceed the limit, cancel the unit's Medicaid eligibility after the advance notice is sent if the effective date of cancellation is prior to the end of the spenddown budget period. Do not change the spenddown liability or the spenddown budget period.

3. Example--Resource Change

EXAMPLE #3: Mr. and Mrs. Jones applied for Medicaid on July 10. They were put on a spenddown for the spenddown budget period July - December, which they met on August 3. They were enrolled effective August 3 though December 31. On September 2, they reported that they inherited some real property worth $20,000. It is not excluded since it is saleable. They are sent an advance notice on September 4 stating their Medicaid eligibility is canceled effective September 30 because of excess resources.

CHAPTER M13
SPENDDOWN

SUBCHAPTER 70
SPENDDOWN - ABD MEDICALLY INDIGENT
(EXCLUDING ABD 80% FPL)

M1370 Changes

Changed With	Effective Date	Pages Changed
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M1370.000 SPENDDOWN - ABD MEDICALLY INDIGENT (EXCLUDING ABD 80% FPL)

M1370.100 SPENDDOWN - ABD MEDICALLY INDIGENT

A. Introduction

This policy applies to aged, blind or disabled (ABD) medically indigent (MI) enrollees in one of the following groups:

- Qualified Medicare Beneficiaries (QMBs),
- Special Low-income Medicare Beneficiaries (SLMBs),
- Qualified Individuals (QIs), and
  - Qualified Disabled Working Individuals (QDWIs).

These ABD MI enrollees are eligible for only a limited package of Medicaid services. They do not receive full Medicaid coverage, therefore they must be evaluated to determine if they could become eligible for full Medicaid coverage as medically needy (MN) by meeting a spenddown.

This policy does not apply to individuals in the ABD 80 % FPL covered group. Individuals in the ABD 80% FPL covered group receive full Medicaid coverage.

1. *Placement* on Spenddown

At application and redetermination, QMB, SLMB, and QDWI MI enrollees who meet the MN covered group and resource requirements are placed on two six-month spenddown budget periods within the 12 month *renewal* certification period. They may also be eligible for retroactive MN spenddown eligibility.

QI enrollees who meet the MN covered group and resource requirements are placed on two six month spenddown budget periods at a time, beginning with the month of application. Spenddown budget periods continue to run consecutively, with no new application required, as long as the individual remains QI eligible.

When only one spouse of an ABD couple is eligible as ABD MI (i.e., one spouse has Medicare and the other does not), the couple is an assistance unit of two for spenddown purposes and placed on two six-month spenddowns.

2. QMB, SLMB, and QDWI

If an enrolled QMB, SLMB, or QDWI does not meet the spenddown, he continues to be eligible as ABD MI. If he remains eligible as ABD MI, the *ABD* Medicaid Renewal form (#032-03-0186) may be used as an application for establishing additional spenddown budget periods. The Eligibility Review Part A (#032-03-729A) and the Eligibility Review Part B (#032-03-729B) forms should only be used when they are required by another program under which the individual is receiving benefits.

The spenddown budget period is based on the application date. At renewal, the new spenddown budget period begins the month following the end of the previous spenddown budget period if the renewal is filed in the last month of the spenddown budget period or the following month. If the renewal is filed two or more months after the end of the last spenddown budget period, the new spenddown budget periods (retroactive or prospective) are based on the

date the renewal form was received in the LDSS. Do not complete an early renewal on a spenddown case because the spenddown period must not be shortened by the completion of an early renewal.

3. QI

The QI medically indigent enrollees who meet the MN covered group and resource requirements are placed on a MN spenddown. If an enrolled QI medically indigent enrollee does not meet the spenddown, he continues to be eligible as QI for the calendar year, or as long as the program is funded.

QI coverage can be renewed for the following year as long as the QI completes and returns the ABD Medicaid Renewal form (#032-03-0186) *and the renewal is completed by December 31 of each year. If the renewal form is not returned and the QI renewal is not completed by December 31, the individual must reapply for Medicaid for the coverage to resume.*

Spenddown budget periods for QIs are based on the initial application month. Unless the individual applied in January, his spenddown budget periods will not coincide with the renewal certification period. Spenddown budget periods continue to run consecutively, with no new application required, as long as the QI's Medicaid coverage remains open.

4. QI Spenddown Procedures

a. New Applications

At the time of initial application, the agency will calculate two spenddown periods. When the second spenddown period expires, the agency will continue to calculate additional spenddown periods, two at a time, without a new application as long as the person remains active in Medicaid. The worker shall send a Notice of Action containing the information about the new spenddown periods each time the worker calculates another two spenddown periods.

b. QIs who were enrolled and on a spenddown as of July 1, 2010

When the QI's current spenddown period ends, the agency will continue to calculate additional spenddown periods, two at a time, without a new application as long as the person remains active in Medicaid. The worker shall send a Notice of Action containing the information about the new spenddown periods each time the worker calculates another two spenddown periods.

When bills are submitted, the worker shall contact the individual to see if living situation, income or resources have changed. If changes have occurred, verification must be provided and a re-evaluation must be completed.

The spenddown cycle does not affect the QI renewal cycle—QI renewals will be due in December regardless of when the person applied for Medicaid.

***C.* References**

The spenddown eligibility determination and enrollment procedures for an ABD MI enrollee are contained in the following sections:

- M1370.200 Qualified Medicare Beneficiaries (QMBs), Special Low-income Medicare Beneficiaries (SLMB), & Qualified Disabled Working Individuals (QDWIs).
- M1370.300 Qualified Individuals (QI).

M1370.200 QMBs, SLMBs & QDWIs

A. Policy

QMBs are eligible only for Medicaid coverage of their Medicare premiums, the Medicare deductible and coinsurance charges for Medicare covered services. Medicare does not cover all of the services that Medicaid covers. For example, Medicare does not cover non-emergency transportation.

SLMBs and QDWIs are eligible only for Medicaid coverage of their Medicare premiums.

B. Entitlement After Meeting Spenddown

When an enrolled QMB, SLMB or QDWI meets a medically needy spenddown, he is eligible for Medicaid as medically needy beginning the date the spenddown was met and ending the last day of the spenddown budget period.

C. Enrollment Procedures

The MMIS enrollment must be canceled and then reinstated in order for the individual to receive the full scope of Medicaid services for the portion of the spenddown budget period in which he is eligible as medically needy. Take the following actions:

1. Cancel ABD MI Coverage

Cancel the enrollee's current coverage line that has the medically indigent aid category (AC).

a. Cancel date is the date **before** the date the spenddown was met.

b. Cancel reason is "024".

2. Reinstate MN Coverage

Reinstate the enrollee in the appropriate medically needy aid category (AC).

- enter the eligibility begin date as the date the spenddown was met.
- enter the eligibility end date - the date the spenddown budget period ends.

Be sure that the application date is the first month in the spenddown budget period. The MMIS will cancel eligibility effective the end date entered.

D. Continuing Eligibility and Enrollment After Spenddown Ends

When the spenddown budget period ends, reinstate the enrollee's Medicaid eligibility as medically indigent beginning the day after the MN spenddown budget period eligibility cancel date. Use the original Medicaid application date. ABD MI eligibility resumes the first day of the month following the end of the spenddown budget period. The month in which the spenddown budget period ends is considered the month in which the agency determines the enrollee's ABD MI eligibility.

To establish a new spenddown budget period, use the ABD Medicaid Renewal form (#032-03-669). The Eligibility Review Part A (#032-03-729A) and Eligibility Review Part B (#032-03-729B) forms should only be used when they are required by another program under which the individual is receiving benefits. When the annual redetermination is filed, new spenddown budget periods are established. Eligibility for each spenddown budget period is evaluated.

E. Example--QMB Meets Spenddown

EXAMPLE #1: Mr. B is 69 years old. He has Medicare Parts A & B. He applied for Medicaid on July 14, 2005. Resources are within the medically needy limit. His income exceeds the medically needy limit, but is less than the QMB limit. His eligibility is determined on August 1, 2005. He is enrolled in Medicaid QMB coverage effective September 1, 2005, the month following the month the agency determined his QMB eligibility. He is placed on two consecutive 6-month spenddown budget periods, July 1, 2005 through December 31, 2005 and January 1 through June 30, 2006. The agency enrolls him in the MMIS with an eligibility begin date of September 1, 2005, AC 023.

On September 15, 2005, he brings in prescription drug bills. He meets the spenddown on September 13, 2005. On September 25, 2005, the agency cancels his QMB coverage (AC.023) effective September 12, 2005. He is reinstated with MN Medicaid eligibility as AC 028 (dual-eligible medically needy aged) with a begin date of September 13, 2005, an application date of July 14, 2005, and an end date of December 31, 2005.

His spenddown eligibility ends December 31, 2005. On January 1, 2006, the agency worker reinstates his QMB-only Medicaid coverage with a begin date of January 1, 2006, AC 023, application date July 14, 2005. He remains on a spenddown for the spenddown budget period January 1, 2006 through June 30, 2006.

M1370.300 QUALIFIED INDIVIDUALS (QI)

A. Introduction

QIs are eligible only for limited Medicaid payment of their Medicare premiums. They are NOT eligible for any other Medicaid-covered services.

If all eligibility factors are met in the application month, eligibility for Medicaid as QI begins the first day of the application month and ends December 31 of the calendar year, if funds are still available. *QI coverage can be renewed for the following year if the renewal form is submitted by December 31 of each year. If the renewal form is not returned by December 31, the individual must reapply for Medicaid for the coverage to resume.*

B. Entitlement After Meeting Spenddown

When an enrolled QI meets a spenddown, he is eligible for Medicaid as medically needy. MN eligibility begins the date the spenddown was met and ends the last day of the spenddown budget period.

C. Enrollment Procedures

The MMIS ABD MI enrollment must be canceled and the MN coverage reinstated in order for him to receive the full scope of Medicaid services for the portion of the spenddown budget period in which he is MN-eligible. Take the following actions:

1. Cancel QI Coverage

Cancel the enrollee's current eligibility in the QI aid category.

a. Cancel date is the date before the date the spenddown was met.

b. Cancel reason is "024".

2. Reinstate MN Coverage

Reinstate the enrollee in the appropriate MN AC **(NOT dual-eligible).**

- enter the eligibility begin date as the date the spenddown was met.
- enter the end date as the last date of the spenddown budget period.

Be sure that the application date is the first month in the spenddown budget period. The MN coverage will end the last date of the spenddown budget period.

D. Continuing Eligibility and Enrollment After Spenddown Ends

When the spenddown budget period ends, reinstate the enrollee's Medicaid eligibility as medically indigent QI beginning the day after the MN spenddown eligibility cancel date. Use the initial Medicaid application date. The QI medically indigent coverage begin date is the first day of the month following the end of the spenddown budget coverage period.

E. Example- QI Meets Spenddown

EXAMPLE #2: Mr. P. is 69 years old. He has Medicare Parts A & B, and applied for Medicaid on May 14. Resources are within the medically needy limit. His income exceeds the medically needy limit, but is less than the QI limit. His eligibility is determined on June 1. He is enrolled in Medicaid QI coverage beginning May 1. He is placed on a spenddown for the budget period May 1 through October 31. The agency enrolls him in the MMIS with an eligibility begin date of May 1, AC 056.

On July 15 he brings in prescription drug bills. He meets the spenddown on July 13. On July 25 the agency cancels his QI (AC 056) coverage effective July 12. His Medicaid eligibility as MN is reinstated using AC 018 (medically needy aged) with an application date May 14, eligibility begin date of July 13, and eligibility end date of October 31.

His spenddown eligibility ends October 31. On November 1, the agency worker reinstates his QI Medicaid coverage with a begin date of November 1, AC 056, application date May 14. *Because his coverage was uninterrupted, he is placed on two additional spenddowns, November 1 through April 30 of the following year and May 1 through October 31 of the following year. He completes an ABD Renewal form and returns it to the agency in December, and his QI coverage is also renewed for the following year.*

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TN #96	10/1/11	pages i, ii

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CHAPTER M14
LONG-TERM CARE
SUBCHAPTER 10

GENERAL RULES FOR LONG-TERM CARE

M1410 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	page 11, 12
TN #95	3/1/11	pages 13, 14 Page 15 was removed.
TN #94	9/1/10	pages 6, 7, 13
TN #93	1/1/10	pages 1, 7, 9, 12
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M1410.010 GENERAL--LONG-TERM CARE

A. Introduction

Chapter M1410 contains the rules that apply to individuals needing long-term care (LTC) services. The rules are contained in the following subchapters:

- M1410 General Rules
- M1420 Pre-admission Screening
- M1430 Facility Care
- M1440 Community-based Care Waiver Services
- M1450 Transfer of Assets
- M1460 Financial Eligibility
- M1470 Patient Pay - Post-eligibility Treatment of Income
- M1480 Married Institutionalized Individuals' Financial Eligibility

The rules found within this Chapter apply to those individuals applying for or receiving Medicaid who meet the definition of institutionalization.

B. Definitions

The definitions found in this section are for terms used when policy is addressing types of long-term care (LTC), institutionalization, and individuals who are receiving that care.

1. Authorized Representative

An **authorized representative** is a person who is authorized to conduct business for an individual. A competent individual must designate the authorized representative in a written statement, which is signed by the individual applicant. The authorized representative of an incompetent or incapacitated individual is the individual's

- spouse
- parent, if the individual is a child under age 18 years
- attorney-in fact (person who has the individual's power-of-attorney)
- legally appointed guardian
- legally appointed conservator (formerly known as the committee)
- trustee.

EXCEPTION: Patients in the *Department of Behavioral Health and Developmental Services (DBHDS)* facilities may have applications submitted by *DBHDS* staff.

2. Institutionalization

Institutionalization means receipt of 30 consecutive days of

- care in a medical institution (such as a nursing facility), or
- Medicaid Community-Based Care (CBC) services; or
- a combination of the two.

The definition of institutionalization is also met when an individual has a signed hospice election that has been in effect for 30 consecutive days.

The 30 days begins with the day of admission to the medical institution or receipt of Medicaid CBC. The date of discharge into the community (not in LTC) or death is **NOT** included in the 30 days.

The institutionalization provisions may be applied when the individual is already in a medical facility at the time of the application, or the

individual has been screened and approved to receive LTC services and it is anticipated that he is likely to receive the services for 30 or more consecutive days. If it is known at the time the application is processed that the individual did not or will not meet the 30 consecutive day requirement, the individual is not to be treated as an institutionalized individual.

The 30-consecutive-days requirement is expected to be met if the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC). This allows the agency to begin the evaluation of the applicant in the 300% SSI covered group for institutionalized individuals and to use the special rules for married institutionalized individuals who have a community spouse, if appropriate. However, prior to approval of the individual for Medicaid payment of LTC services, the worker must have received the DMAS-96 that was signed by the supervising physician or the signed Waiver Level of Care form. Applicants must be evaluated as non-institutionalized individuals for the months prior to the month in which the completed form is dated.

The worker must verify that LTC services started within 30 days of the date on the Notice of Action on Medicaid. If services do not start within 30 days of the Notice of Action on Medicaid, the individual can no longer be considered an institutionalized individual and continued eligibility must be re-evaluated as a non-institutionalized individual.

CBC Waiver applicants cannot receive Medicaid payment of CBC services prior to the date the DMAS-96 was signed by the supervising physician. For applicants for whom a Waiver Level of Care form is the appropriate authorization document, Medicaid payment of CBC services cannot begin prior to the date the form has been signed.

For purposes of this definition, continuity is broken by 30 or more consecutive day's absence from a medical institution or by non-receipt of waiver services. For applicants in a nursing facility, if it is known at the time of application processing that the individual left the nursing facility and did not stay for 30 consecutive days, the individual is evaluated as a non-institutionalized individual. Medicaid recipients without a community spouse who request Medicaid payment of LTC services, except MN individuals, and are in the nursing facility for less than 30 consecutive days will have a patient pay determination (see M1470.350).

3. Institution

An establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more persons unrelated to the proprietor is an **institution**.

4. In An Institution

"In an institution" refers to an individual who is admitted to live in an institution and receives treatment or services provided there that are appropriate to his requirements.

5. Long-term Care

Long-term care is medical treatment and services directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or lessening of illness, disability or pain which have been received, or are expected to be received, for longer than 30 consecutive days.

6. Medical Institution (Facility)

A **medical institution** is an institution (facility) that:

- is organized to provide medical care, including nursing and convalescent care,
- has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
- is authorized under state law to provide medical care, and
- is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

An acute care hospital is a medical institution.

7. Patient

An individual who is receiving needed professional services that are directed by a licensed practitioner of the healing arts toward maintenance, improvement, or protection of health or lessening of illness, disability, or pain, is a **patient.**

8. Inpatient

An **inpatient** is a patient who has been admitted to a medical institution on the recommendation of a physician or dentist **and** who:

- receives room, board, and professional services in the institution for a 24-hour period or longer, **or**

- is expected by the institution to receive room, board, and professional services in the institution for a 24-hour period or longer even though it later develops that the patient dies, is discharged or is transferred to another facility, and does not actually stay in the institution for 24 hours.

M1410.020 NON-FINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

To be eligible for Medicaid payment of long-term care, an individual must be eligible for Medicaid. The Medicaid non-financial eligibility requirements in chapter M02 apply to all Medicaid applicants and recipients, including those individuals in long-term care. The non-financial requirements and the location of the manual policy for each requirement are:

B. Citizenship/ Alienage

The citizenship and alien status policy is found in M0220.

C. Virginia Residency

The Virginia state resident policy for patients in medical institutions is found in subchapter M1430.101; the state resident policy for CBC patients is found in M0230.

D. Social Security Number

The social security number policy is found in M0240.

E. Assignment of Rights/Coopera-tion

The assignment of rights and support cooperation policy is found in M0250 and M0260.

F. Application for Other Benefits

The application for other benefits policy is found in M0270.

G. Institutional Status

The institutional status policy for facility patients is in subchapter M1430.100. The institutional status policy for CBC waiver services patients is found in subchapter M1440.010.

H. Covered Group (Category)

The Medicaid covered groups eligible for long-term care services are listed in subchapter M1460. The category requirements for the covered groups are found in chapter M03.

M1410.030 FACILITY CARE

A. Introduction

Medicaid covers care provided in a medical institution to persons whose physical or mental condition requires nursing supervision and assistance with activities of daily living. *Some institutions have both medical and residential sections. An individual in the medical section of the institution is a patient in a medical facility; however, an individual in the residential portion of the institution is a resident of a residential facility NOT a patient in a medical facility.*

This section contains descriptions of the types of **facilities** (medical institutions) in which Medicaid provides payment for services received by eligible patients. See subchapter M1430 for specific policy and procedures which apply to patients in facilities.

B. Ineligible Individuals

The following individuals are not eligible for Medicaid:

- an inmate in a public institution; see section M1430.102 for the definition of an inmate in a public institution.
- Individuals under age 65 who are patients in an institution for mental diseases (IMD), unless they are under age 22 and receiving inpatient psychiatric services.

C. Types of Medical Institutions

The following are types of medical institutions in which Medicaid will cover part of the cost of care for eligible individuals:

1. Chronic Disease Hospitals

Specially certified hospitals, also called **"long-stay hospitals"**. There are two of these hospitals enrolled as Virginia Medicaid providers:

- Hospital for Sick Children in Washington, D.C., and
- Lake Taylor Hospital in Norfolk, Virginia.

2. Hospitals and/or Training Centers for the Mentally Retarded

Facilities (medical institutions) that specialize in the care of mentally retarded individuals. Intermediate Care Facilities for the Mentally Retarded (ICF/MRs) are certified by the Department of Health to provide care in a group home setting. Patients in these facilities may have income from participating in work programs.

NOTE: Medically needy (MN) individuals are not eligible for Medicaid payment of LTC services in an ICF/MR because ICF/MR services are not covered for the medically needy.

3. Institutions for Mental Diseases (IMDs)

A hospital, nursing facility or other medical institution that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, of persons with mental diseases. An institution for the mentally retarded is not an IMD.

NOTE: Medically needy (MN) patients age 65 or older are not eligible for Medicaid payment of LTC in an IMD because these services are not covered for medically needy individuals age 65 or over.

4. Intermediate Care Facility (ICF)

A medical institution licensed by the state to provide, on a regular basis, health-related services to patients who do not require hospital or skilled nursing facility care, but whose mental or physical condition requires services in addition to room and board which can be made available only in an institutional setting.

5. Nursing Facility

A medical institution licensed by the state to provide, on a regular basis, health-related services to patients who do not require hospital care, but whose mental or physical condition requires services, such as nursing supervision and assistance with activities of daily living, in addition to room and board and such services can be made available only in an institutional setting. Nursing facilities provide either skilled nursing care services or intermediate care services, or both.

6. Rehabilitation Hospitals

A hospital certified as a rehabilitation hospital, or a unit of a hospital certified by the Department of Health as excluded from the Medicare prospective payment system, which provides inpatient rehabilitation services.

M1410.040 COMMUNITY-BASED CARE WAIVER SERVICES

A. Introduction

Medicaid covers long-term care in a community-based setting to individuals whose mental or physical condition requires nursing supervision and assistance with activities of daily living.

This section provides general information about the Community-based Care (CBC) Waiver Services covered by Medicaid. The detailed descriptions of the waivers and the policy and procedures specific to patients in CBC are contained in subchapter M1440.

B. Community-Based Care Waivered Services (CBC)

Community-Based Care Waiver Services or Home and Community-based Care or CBC are titles that are used interchangeably. These terms are used to mean a variety of in-home and community-based services reimbursed by the Department of Medical Assistance Services (DMAS) that are authorized under a Section 1915(c) waiver designed to offer individuals an alternative to institutionalization. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid nursing facility placement.

C. Virginia's Waivers

Virginia has approved Section 1915(c) home and community-based *care* waivers. These waivers contain services that are otherwise not available to the general Medicaid population. The target population and service configuration for each waiver is outlined in subchapter M1440. An individual cannot receive services under two or more waivers simultaneously; the individual can receive services under only one waiver at a time.

1. Elderly *or* Disabled *with Consumer-Direction* Waiver

The Elderly or Disabled with Consumer-Direction (EDCD) waiver serves aged individuals and disabled individuals who would otherwise require institutionalization in a nursing facility. The recipient may choose to receive agency-directed services, consumer-directed services or a combination of the two. Under consumer-directed services, supervision of the personal care aide is furnished directly by the recipient and/or the person directing the care for the recipient. If an individual is incapable of directing his own care, a spouse, parent, adult child, or guardian may direct the care on behalf of the recipient. Services available through this waiver include:

- *agency-directed and consumer-directed personal care*
- *adult day health care*
- *agency-directed respite care (including skilled respite) and consumer-directed respite care*
- *Personal Emergency Response System (PERS).*

2. *Intellectual Disabilities/* Mental Retardation Waiver

The *Intellectual Disabilities/*Mental Retardation (*ID*/MR) Waiver program is targeted to provide home and community-based services to individuals with mental retardation and individuals under the age of six years at developmental risk who have been determined to require the level of care provided in an ICF/MR, and to individuals with related conditions currently residing in nursing facilities who require specialized services. Services available through the *ID*/MR waiver include:

- day support
- supported employment
- residential support
- therapeutic consultation
- personal assistance
- respite care
- nursing services
- environmental modification
- assistive technology

3. AIDS Waiver

The AIDS Waiver provides services to individuals with HIV infection, who have been diagnosed and are experiencing the symptoms associated with AIDS (Acquired Immunodeficiency syndrome) or who are HIV positive and are symptomatic; the services provided through the waiver are expected to prevent placement in a hospital or nursing facility.

Services available to recipients of the AIDS Waiver include:

- case management
- nutritional supplements
- private duty nursing
- personal care
- respite care.

4. Technology-Assisted Individuals Waiver

"Technology-Assisted" individual is one who is chronically ill or severely impaired, who needs both a medical device to compensate for the loss of a vital body function and substantial and ongoing skilled nursing care to avert death or further disability. The services provided through the waiver are expected to prevent placement, or to shorten the length of stay, in a hospital or nursing facility.

The services provided under this waiver include:

- private duty nursing
- respite care
- nutritional supplements
- medical supplies and equipment not otherwise available under the Medicaid State Plan.

5. Individual and Family Developmental Disabilities Support Waiver (DD Waiver)

The Individual and Family Developmental Disabilities (DD) waiver provides home and community-based services to individuals with developmental disabilities who do not have a diagnosis of mental retardation. The developmental disability must have manifested itself before the individual reached age 21 and must be likely to continue indefinitely.

The services provided under this waiver include:

- support coordination (case management)
- adult companion services
- assistive technology
- crisis intervention/stabilization
- environmental modifications
- residential support
- skilled nursing
- supported employment
- therapeutic consultation
- respite care
- personal attendant services
- consumer-directed personal and respite care.

6. Day Support Waiver for Individuals with *Intellectual Disabilities*/ Mental Retardation

The Day Support Waiver for Individuals with *Intellectual Disabilities*/Mental Retardation (DS Waiver) is targeted to provide home and community-based services to individuals with mental retardation who have been determined to require the level of care provided in an ICF/MR. These individuals may currently reside in an ICF/MR or may be in the community at the time of assessment for DS Waiver services. Only those individuals on the urgent and non-urgent waiting lists for the *ID*/MR Waiver are considered for DS Waiver services. Individuals may remain on the *ID*/MR Waiver waiting list while receiving DS Waiver Services.

The services provided under this waiver include:

- day support
- prevocational services.

7. Alzheimer's Assisted Living Waiver

The Alzheimer's Assisted Living (AAL) Waiver is available only to individuals who are Auxiliary Grants (AG) recipients, have a diagnosis of Alzheimer's Disease or a related dementia, no diagnosis of mental illness or mental retardation, and who are age 55 or older. The AAL Waiver allows for the provision of services to individuals in approved assisted living facilities who, without the waiver, might require nursing home placement.

Individuals in this waiver do not have Medicaid eligibility determined as institutionalized individuals, and there are no post-eligibility requirements.

The services provided under the AAL waiver include:

- assistance with activities of daily living
- medication administration by licensed professionals.

- nursing services for assessments and evaluations
- therapeutic social and recreational programming which provides daily activities for individuals with dementia.

D. Children's Mental Health Program—Not Medicaid CBC

Children's Mental Health Program services are home and community-based services to children who have been discharged from psychiatric residential treatment facilities. **Children's Mental Health Program services are NOT Medicaid CBC services.** See M1520.100 E. for additional information.

E. Program for All-Inclusive Care for the Elderly (PACE)

PACE is the State's community model for the integration of acute and long-term care. Under the PACE model, Medicaid and Medicare coverage/funding are combined to pay for the individual's care. PACE is centered around the adult day health care model and provides the entire spectrum of acute and long-term care services to enrollees without limitations on the duration of services or the dollars spent. Participation in PACE is in lieu of the EDCD Waiver and is voluntary. PACE serves individuals aged 55 and older who (1) meet the nursing facility level of care criteria and (2) reside in their own communities. PACE provides all of an individual's health care and medical long-term care needs.

PACE is NOT a CBC Waiver; however, the preadmission screening, financial eligibility and post eligibility requirements for individuals enrolled in PACE are the same as those for individuals enrolled in the EDCD Waiver.

M1410.050 FINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

An individual in LTC must meet the financial eligibility requirements that are specific to institutionalized individuals; these requirements are contained in this chapter:

B. Asset Transfer

The asset transfer policy is found in subchapter M1450.

C. Resources

The resource eligibility policy for individuals in LTC who do not have community spouses is found in subchapter M1460 of this chapter.

The resource eligibility requirements for married individuals in LTC who have community spouses are found in subchapter M1480 of this chapter.

D. Income

The income eligibility policy for individuals in LTC who do not have community spouses is found in subchapter M1460 of this chapter.

The income eligibility policy for individuals in LTC who have community spouses is found in subchapter M1480.

M1410.060 POST-ELIGIBILITY TREATMENT OF INCOME (PATIENT PAY)

A. Introduction

Medicaid-eligible individuals must pay a portion of their income to the LTC provider; Medicaid pays the remainder of the cost of care. The portion of their income that must be paid to the provider is called "patient pay."

B. Patient Pay

The policies and procedures for patient pay determination are found in subchapter M1470 of this chapter for individuals who do not have community spouses and in subchapter M1480 for individuals who have community spouses.

M1410.100 LONG-TERM CARE APPLICATIONS

A. Introduction

The general application requirements applicable to all Medicaid applicants/ recipients found in chapter M01 also apply to applicants/recipients who need LTC services. This section provides those additional or special application rules that apply only to persons who meet the institutionalization definition.

B. Responsible Local Agency

The local social services department in the Virginia locality where the institutionalized individual (patient) last resided outside an institution retains responsibility for receiving and processing the application.

If the patient did not reside in Virginia prior to admission to the institution, the local social services department in the county/city where the institution is located has responsibility for receiving and processing the application.

Community-Based Care (CBC) applicants apply in their locality of residence.

ABD patients in state *Department of Behavioral Health and Developmental Services (DBHDS)* facilities for more than 30 days have eligibility determined by Medicaid technicians located in the state *DBHDS* facilities. When an enrolled ABD Medicaid recipient is admitted to a state *DBHDS* facility, the local department of social services transfers the case to the Medicaid technician after the recipient has been in the facility for 30 days or more. See section M1520.600 for case transfer policy.

C. Procedures

1. Application Completion

A signed application is received. A face-to-face interview with the applicant or the person authorized to conduct his business is not required, but is strongly recommended, in order to correctly determine eligibility.

2. Pre-admission Screening

Notice from pre-admission screener is received by the local Department of Social Services (DSS).

NOTE: Verbal communications by both the screener and the local DSS Eligibility Worker (EW) may occur prior to the completion of screening. Also, not all LTC cases require pre-admission screening; see M1420.

3. Processing

EW completes the application processing. Processing includes receipt of required verifications, completion of the non-financial and financial eligibility determinations, and necessary case record documentation. See chapter M15 for the processing procedures.

An individual's eligibility is determined as an institutionalized individual if he is in a medical facility or has been screened and approved for Medicaid. For any month in the retroactive period, an individual's eligibility can only be determined as an institutionalized individual if he met the definition of institutionalization in that month (i.e. he had been a patient in a medical institution—including nursing facility or an ICF-MR-- for at least 30 consecutive days).

If it is known at the time the application is processed that the individual did not or will not receive LTC services (i.e. the applicant has died since making the application) do not determine eligibility as an institutionalized individual.

If the individual's eligibility was determined as an institutionalized individual prior to the receipt of waiver services, the EW must verify that LTC services started within 30 days of the date of the Notice of Action on Medicaid. If LTC services did not start within 30 days of the date of the Notice of Action on Medicaid, the individual's continued eligibility must be re-evaluated as a non-institutionalized individual.

If the individual later begins receiving LTC services within the one-year screening certification period, the individual's eligibility as an institutionalized individual is determined without a new screening certification. However, the begin date of service must be verified prior to Medicaid enrollment.

4. Notices

See section M1410.300 for the required notices.

M1410.200 INITIATING LONG-TERM CARE FOR CURRENT RECIPIENTS

A. Introduction

Individuals who currently receive Medicaid and enter LTC must have their eligibility redetermined using the special rules that apply to LTC.

For example, an enrollee may be ineligible for Medicaid payment of LTC services because he/she transferred assets without receiving adequate compensation. The asset transfer policy found in M1450 applies to individuals who receive any type of long-term care. Individuals who are ineligible for Medicaid payment of LTC may remain eligible for other Medicaid-covered services.

B. Pre-admission Screening

A pre-admission screening is used to determine if an individual living outside of a nursing facility meets the level of care for Medicaid payment for LTC services. Medicaid enrollees living outside a nursing facility must be screened and approved before Medicaid will authorize payment for LTC services.

C. Recipient Enters LTC

A re-evaluation of eligibility must be done when the EW learns that a Medicaid recipient has started receiving LTC services. If the recipient has been in a nursing facility for at least 30 consecutive days, a pre-admission

screening is not required (See M1420.400). If an individual is receiving private-pay home health services, a pre-admission screening **is required** (see M1410.200 B. above).

If an annual renewal **has been** done within the past six months, a partial review to address factors pertinent to receipt of LTC, such as asset transfer, spousal resource assessment, etc., must be done. If an annual renewal **has not** been done within the past six months, a complete renewal must be done. A new application is not required; *complete the renewal telephonically o*r use the Medicaid Redetermination for Long-Term Care form (032-03-369), available on SPARK at: http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi.

- *For an SSI recipient who has no community spouse and owns no countable real property, verify continued receipt of SSI through SOLQ-I or SVES, obtain information regarding asset transfer from the enrollee or authorized representative, and document the case record.* See section M1430.104 for additional information regarding an SSI recipient who enters a nursing facility.

- Rules for married institutionalized recipients who have a community spouse are found in subchapter M1480.

D. Notification

When the re-evaluation is done, the EW must complete and send all required notices. See section 1410.300 below. If it is known at the time of application processing that the individual did not or will not receive LTC services, do not determine eligibility as an institutionalized individual.

M1410.300 NOTICE REQUIREMENTS

A. Introduction

A notice to an applicant or recipient provides formal notification of the intended action or action taken on his/her case, the reason for this action and the authority for proposing or taking the action. The individual needs to clearly understand when the action will take place, the action that will be taken, the rules which require the action, and his right for redress.

Proper notice provides protection of the client's appeal rights as required in 1902(a)(3) of the Social Security Act.

The Notice of Action on Medicaid provides an opportunity for a fair hearing if action is taken to deny, suspend, terminate, or reduce services.

The Medicaid Long-term Care Communication Form (DMAS-225) notifies the LTC provider of changes to an enrollee's eligibility for Medicaid and for Medicaid payment of LTC services.

The notice requirements found in this section are used for all LTC cases.

Individuals in the AAL Waiver have Medicaid eligibility determined in the AG covered group (see M0320.202) and do not have Medicaid eligibility determined as institutionalized individuals. There are no post-eligibility requirements. The enrollment and notification procedures used with non-institutionalized Medicaid recipients are followed (see M0130.300).

B. Forms to Use

1. Notice of Action on Medicaid & FAMIS (#032-03-0008)

The EW must send the Notice of Action on Medicaid, available on SPARK at: http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi, to the applicant/ recipient and the person who is authorized to conduct business for the applicant to notify him of the agency's decision on the initial Medicaid application, and on a redetermination of eligibility when a recipient starts LTC services.

2. Notice of Obligation for Long-Term Care Costs (#032-03-0062)

The Notice of Obligation for Long-term Care Costs is sent to the applicant/enrollee or the authorized representative to notify them of the amount of patient pay responsibility. The form is generated and sent by the Medicaid Management Information System (MMIS) on the day the patient pay information is entered into MMIS. The report of all Notices sent by MMIS each day is posted by FIPS code on SPARK in the Medicaid Management Reports.

3. Medicaid LTC Communication Form (DMAS-225)

The Medicaid Long-term Care (LTC) Communication Form is available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi.. The form is used by LTC providers and local departments of social services (LDSS) to exchange information, other than patient pay information, such as:

- the Provider National Provider Identifier (NPI)/Atypical Provider Identifier(API) number;
- a change in the LTC provider, including when an individual moves from CBC to a nursing facility or the reverse;
- the enrollee's physical residence, if different than the LDSS locality;
- changes in the patient's deductions *(e.g. a medical expense allowance);*
- admission, death or discharge to an institution or community-based care service;
- changes in eligibility status; and
- changes in third-party liability.

Do not use the DMAS-225 to relay the patient pay amount. Providers are able to access patient pay information through the Department of Medical Assistance Services (DMAS) provider verification systems.

a. When to Complete the DMAS-225

The EW completes the DMAS-225 at the time initial patient pay information is added to MMIS, when there is a change in the enrollee's situation, including a change in the enrollee's LTC provider, or when a change affects an enrollee's Medicaid eligibility.

b. Where to Send the DMAS-225

1) For hospice services patients, *including hospice patients in a nursing facility or those who are also receiving CBC services*, send the original form to the hospice provider.

2) For facility patients, send the original form to the nursing facility.

3) For PACE or *adult day health care* recipients, send the original form to the PACE or *adult day health care* provider.

4) For Medicaid CBC, send the original form to the following individuals

- the case manager at the Community Services Board, for the *ID*/MR and DS waivers;
- the case manager (support coordinator), for the DD Waiver,
- the personal care provider, for agency-directed EDCD personal care services and other services. *If the patient receives both personal care and adult day health care, send the DMAS-225 to the personal care provider.*
- the service facilitator, for consumer-directed EDCD services,
- the case manager, for any enrollee with case management services, and
- the case manager at DMAS, for the Tech Waiver, at the following address:

  Department of Medical Assistance Services
  Division of LTC, Waiver Unit,
  600 E. Broad St,
  Richmond, VA 23219.

Retain a copy of the completed DMAS-225 in the case record.

4. Advance Notices of Proposed Action

The recipient must be notified in advance of any adverse action that will be taken on his/her Medicaid eligibility or patient pay.

a. Advance Notice of Proposed Action (#032-03-0018)

The Advance Notice of Proposed Action, available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi, must be used when:

- eligibility for Medicaid will be canceled,
- eligibility for full-benefit coverage Medicaid changes to QMB, SLMB, or QWDI limited coverage, or

- Medicaid payment for LTC services will be terminated because of an asset transfer.

b. Notice of Obligation for Long-Term Care Costs

When a change in the patient pay amount is entered in MMIS, a "Notice of Obligation for Long-term Care Costs" will be generated and sent by MMIS as the advanced notice to the recipient or the authorized representative.

Patient pay must be entered into MMIS no later than close-of-business on the **15th** day of the month, to meet the advance notice requirement.

Do not send the "Advance Notice of Proposed Action" when patient pay increases.

5. Medicaid Redetermination For Long-term Care (#032-03-0369)

The Medicaid Redetermination for Long-term Care Form is used to redetermine Medicaid eligibility of an individual who is in long-term care. The individual or his authorized representative completes and signs the form where indicated. The EW completes and signs the eligibility evaluation sections on the form.

The Medicaid Redetermination for Long-Term Care Form is available on SPARK at: http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi.

5. Medicaid Redetermination For Long-term Care (#032-03-*0369*)

The Medicaid Redetermination for Long-term Care Form is used to redetermine Medicaid eligibility of an individual who is in long-term care. The individual or his authorized representative completes and signs the form where indicated. The EW completes and signs the eligibility evaluation sections on the form.

The Medicaid Redetermination for Long-Term Care Form is available on SPARK at:
http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi.

CHAPTER M14
LONG-TERM CARE
SUBCHAPTER 20

PRE-ADMISSION SCREENING

M1420 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	Table of Contents pages 3-5 Appendix 3
TN #93	01/01/2010	pages 2, 3, 5 Appendix 3, page 1 Appendix 4, page 1

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M1420.000 PRE-ADMISSION SCREENING

M1420.100 PRE-ADMISSION SCREENING *PROCESS*

A. Introduction

The *Medicaid* nursing home pre-admission screening *process* was implemented in 1977 to ensure that Medicaid eligible individuals placed in nursing facilities *met the required level of care for Medicaid payment of long-term care (LTC) services*. In 1982, *the screening process for LTC* was expanded to require pre-admission screening for individuals *requesting Medicaid payment of LTC services through the* Medicaid Home and Community-based Care Waivers(CBC) or institutional long-term care. *In 2007, the screening process was expanded again to require a pre-admission screening for individuals requesting Medicaid payment of LTC services through the Program for the All-Inclusive Care of the Elderly (PACE).*

This subchapter describes the pre-admission screening process; the eligibility implications; the communication requirements; the inter-agency cooperation requirements; and *eligibility worker responsibilities in the pre-admission screening process.*

B. Operating Policies

1. Payment Authorization

A pre-admission screening provides authorization for Medicaid payment of facility (medical institution), CBC, *and PACE* long-term care services for Medicaid recipients.

2. When a Pre-admission Screening is *Required*

A pre-admission screening is used to determine if an individual entering LTC care meets the nursing facility level of care criteria, or if living outside of a nursing facility *meets the criteria to receive nursing facility, CBC, or PACE services. A pre-admission screening is not needed when an individual is already in a nursing facility or* received Medicaid LTC in one or more of the preceding twelve months*, and his* LTC terminated for a reason other than no longer meeting the level of care*. The exceptions to the pre-admission screening requirement are listed in M1420.400 B. 1*.

The approval by the screening committee/team for receipt of Medicaid LTC services allows the individual to be evaluated using the eligibility rules for institutionalized individuals. See M1420.100 B.3.

After an individual is admitted to a nursing facility, Medicaid CBC or PACE, the provider is responsible for certifying that the individual continues to meet the level of care for LTC services.

3. Eligibility Rules

The pre-admission screening form is used to determine the appropriate rules used for the eligibility determination (which LTC rules to use, or whether to use non-institutional Medicaid eligibility rules). An individual who is screened and approved for LTC services is treated as an institutionalized individual in the Medicaid eligibility determination. The pre-admission screening document also certifies the type of LTC service and provides information for the personal needs/maintenance allowance.

M1420.200 RESPONSIBILITY FOR PRE-ADMISSION SCREENING

A. Introduction

In order to qualify for Medicaid payment of LTC services, an individual must be determined to meet both functional and medical components of the level of care criteria through the pre-admission screening process. The pre-admission screening is completed by a designated screening team or committee. The screening team or committee that completes the pre-admission screening depends on the type(s) of services needed by the individual. Below is a listing of the types of LTC services an individual may receive and the committees/teams responsible for completion of the pre-admission screening certification for those services.

B. Nursing Facility Screening

This evaluation is completed by local teams composed of agencies contracting with the Department of Medical Assistance Services (DMAS) or by staff of acute care hospitals.

The local committees usually consist of the local health department director, a local health department nurse, and a local social services department service worker.

Patients placed directly from acute care hospitals are usually screened by hospital screening teams.

A state level committee is used for patients being discharged from State *Department of Behavioral Health and Developmental Services (DBHDS)* institutions for the treatment of mental illness, and mental retardation.

Patients in a Veterans Administration Medical Center (VAMC) who are applying to enter a nursing facility are assessed by VAMC staff. VAMC discharge planning staff use their own Veterans' Administration assessment form, which serves as the pre-admission screening certification.

C. CBC Screening

Entities other than hospital or local health committees are authorized to screen individuals for CBC. The following entities are authorized to screen patients for Medicaid CBC:

1. Elderly or Disabled with Consumer-Direction (EDCD) Waiver

Local and hospital screening committees or teams are authorized to screen individuals for the EDCD waiver.

2. Technology-Assisted Individuals (Tech)Waiver

Local and hospital screening committees or teams are authorized to screen individuals for the Tech waiver.

3. *Intellectual Disabilities*/ Mental Retardation (*ID*/MR) Waiver

Local Community Mental Health Services Boards (CSBs) and the Department of Rehabilitative Services (DRS) are authorized to screen individuals for the *ID*/MR waiver. Final authorizations for *ID*/MR waiver services are made by DBHDS staff.

4. AIDS Waiver

Local and hospital screening committees or teams are authorized to screen individuals for the AIDS waiver.

5. Individual and Family Developmental Disabilities Support (DD) Waiver

DMAS and the Virginia Health Department child development clinics are authorized to screen individuals for the DD waiver.

6. Alzheimer's Assisted Living (AAL)Waiver

Local screening committees or teams and hospital screening committees or teams are authorized to screen individuals for the AAL waiver; however, a copy of the pre-admission screening is not required for the Medicaid eligibility record. Documentation of the verbal assurance by the screeners must be included in the case record.

7. Day Support Waiver for Individuals with *Intellectual Disabilities*/ Mental Retardation (DS) Waiver

Local CSB and DBHDS case managers are authorized to screen individuals for the DS waiver. Final authorizations for DS waiver services are made by DBHDS staff.

D. PACE

Local screening committees or teams and hospital screening committees or teams are authorized to screen individuals for PACE. If the individual is screened and approved for LTC, the committee/team will inform the individual about any existing PACE program that serves the individual's locality.

M1420.300 COMMUNICATION PROCEDURES

A. Introduction

To ensure that nursing facility/PACE placement or receipt of Medicaid CBC services are be arranged as quickly as possible, there must be prompt communication between screeners and eligibility staff.

B. Procedures

1. LDSS Contact

The LDSS agency should designate an appropriate staff member for screeners to contact. Local social services staff, hospital staff and DRS staff should be given the name and contact information for that person to facilitate timely communication between screeners and eligibility staff.

2. Screeners

Screeners must inform the individual's eligibility worker when the screening process has been initiated and completed.

3. Eligibility Worker (EW) Action

The EW must inform both the individual and the provider once eligibility for Medicaid payment of LTC services has been determined. If the individual is found eligible for Medicaid and verbal or written assurance of approval by the screening committee has been received, the eligibility worker must give the LTC provider the enrollee's Medicaid identification number.

M1420.400 SCREENING CERTIFICATION

A. Purpose

The screening certification authorizes the local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals, including the 300% SSI covered group and the special rules for married institutionalized individuals with a community spouse. The screening certification is valid for one year.

B. Exceptions to Screening

Pre-admission screening is NOT required when:

- the individual is a patient in a nursing facility at the time of application;
- the individual received Medicaid LTC in one or more of the preceding 12 months and LTC was terminated for a reason other than no longer meeting the level of care;
- the individual is no longer in need of long-term care but is requesting assistance for a prior period of long term care;
- the individual enters a nursing facility directly from the EDCD/AIDS waiver or PACE;
- the individual leaves a nursing facility and begins receiving EDCD/AIDS waiver services or enters PACE and a pre-admission screening was completed prior to the nursing facility admission; or
- the individual enters a nursing facility from out-of-state.

C. Documentation

If the individual has not been institutionalized for at least 30 consecutive days, the screener's certification of approval for Medicaid long-term care must be substantiated in the case record by one of the following documents:

- Medicaid Funded Long-term Care Service Authorization Form (DMAS-96) for nursing facilities, PACE and EDCD, Tech and AIDS Waivers (see Appendix 1);
- Technology Assisted Waiver Level of Care Eligibility Form (see Appendix 2);
- *ID/*MR Waiver Level of Care Eligibility Form (see Appendix 3);
- DS Waiver Level of Care Eligibility Form (see Appendix 4); or
- DD Waiver Level of Care Form (see Appendix 5).

Medicaid payment for CBC services cannot begin prior to the date the screener's certification form is signed and prior authorization of services for the individual has been given to the provider by DMAS or its contractor.

1. Nursing Facility/PACE

Individuals who require care in a nursing facility or elect PACE will have a DMAS-96 signed and dated by the screener and the supervising physician.

The "Medicaid Authorization" section will have a number in the box that matches one of the numbers listed under the "Pre-admission Screening" section. These numbers indicate which of these programs was authorized. Medicaid payment of PACE services cannot begin prior to the date the DMAS-96 is signed and dated by the supervising physician and prior-authorization of services for the individual has been given to the provider by DMAS.

2. EDCD Waiver

Individuals screened and approved for the EDCD waiver must have a DMAS-96 signed and dated by the screener and the physician.

If the individual elects consumer-directed services, DMAS or its contractor must give final authorization. If services are not authorized, the service facilitator will notify the LDSS, and the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

3. Tech Waiver

Individuals screened and approved for the Tech Waiver will have either a DMAS-96 signed and dated by the screener and physician, or a Technology Assisted Waiver Level of Care Eligibility Form signed and dated by a DMAS representative.

4. *ID*/MR Waiver Level of Care Eligibility Form

Individuals screened and approved for the *ID*/MR waiver will have the *ID*/MR Waiver Level of Care Eligibility Form signed and dated by the DBHDS representative. The *ID*/MR Waiver Level of Care Eligibility Form will include the individual's name, address and the date of DBHDS approval.

5. DS Waiver Level of Care Eligibility Form

Individuals screened and approved for the DS waiver will have the DS Waiver Level of Care Eligibility Form signed and dated by the DBHDS representative. The DS Waiver Level of Care Eligibility Form will include the individual's name, address and the date of DBHDS approval.

6. DD Waiver Level of Care Eligibility Form

Individuals screened and approved for the DD waiver will have the DD Waiver Level of Care Eligibility Form signed and dated by a DMAS Health Care Coordinator. The form letter will include the individual's name, address and the date of approval for waiver services.

D. Authorization for LTC Services

If the form is not available when placement needs to be made, verbal assurance from a screener or DMAS that the form approving long-term care will be mailed or delivered is sufficient to determine Medicaid eligibility as an institutionalized individual. However, the appropriate form must be received prior to approval and enrollment in Medicaid as an institutionalized individual.

1. **Authorization Not Received**

If a pre-admission screening is required and the appropriate documentation is not received, Medicaid eligibility for an individual who is living in the community must be determined as a non-institutionalized individual.

2. **Authorization Rescinded**

The authorization for Medicaid *payment of LTC services* may be rescinded by the physician or by DMAS at any point that the individual is determined to no longer meet *the required* Medicaid level of care criteria.

When an individual is no longer eligible for a CBC Waiver service, the EW must re-evaluate *the individual's* eligibility as a non-institutionalized individual.

When an individual leaves the PACE program and no longer receives LTC services, the EW must re-evaluate the individual's eligibility as a non-institutionalized individual.

For an individual in a nursing facility who no longer meets the level of care but continues to reside in the facility, continue to use the eligibility rules for institutional individuals even though the individual no longer meets the level of care criteria. If *the individual is* eligible *for Medicaid*, Medicaid will not make a payment to the facility for *LTC*.

MEDICAID FUNDED LONG-TERM CARE SERVICE AUTHORIZATION FORM

I. RECIPIENT INFORMATION:

Last Name: _____ First Name: _____ Birth Date: ___/___/_____

Social Security_____ Medicaid ID _____ Sex: _____

II. MEDICAID ELIGIBILITY INFORMATION:

Is Individual Currently Medicaid Eligible? ☐
1 = Yes
2 = Not currently Medicaid eligible, anticipated within 180 days of nursing facility admission **OR** within 45 days of application or when personal care begins.
3 = Not currently Medicaid eligible, not anticipated within 180 days of nursing facility admission

If no, has Individual formally applied for Medicaid? ☐
0 = No 1 = Yes

Is Individual currently Auxiliary Grant eligible? ☐
0 = No
1 = Yes, or has applied for Auxiliary Grant
2 = No, but is eligible for General Relief

Dept of Social Services:
(Eligibility Responsibility)_____

(Services Responsibility)_____

III. PRE-ADMISSION SCREENING INFORMATION: (to be completed only by Level I, Level II, or ALF screeners)

MEDICAID AUTHORIZATION

Level of Care ☐
1 = Nursing Facility (NF) Services
2 = PACE/LTCPHP
3 = AIDS/HIV Waiver Services
4 = Elderly or Disabled w/Consumer Direction (EDCD) Waiver
11 = ALF Residential Living
12 = ALF Regular Assisted Living
14 = Individual/Family Developmental Disabilities Waiver
15 = Technology Assisted Waiver
16 = Alzheimer's Assisted Living Waiver

Exceptions: Authorizations for NF, PACE, AIDS or the EDCD Waivers are interchangeable. Screening updates are not required for individuals to move between these services because the alternate institutional placement is a NF. **NF = EDCD, AIDS, or PACE**
Alzheimer's Assisted Living Waiver's alternate institutional placement is a NF, however, the individual must also have a diagnosis of Alzheimer's Or Alzheimer's Related Dementia and meet the NF criteria.
NF = Alzheimer's ALF
PACE participants can also meet assisted living facility criteria and reside in an assisted living facility and receive the Auxiliary Grant while accessing PACE services. **PACE = NF or ALF**

NO MEDICAID SERVICES AUTHORIZED
8 = Other Services Recommended
9 = Active Treatment for MI/MR Condition
0 = No other services recommended

Targeted Case Management for ALF ☐
0 = No 1 = Yes

ALF Reassessment Completed ☐
1 = Full Reassessment 2 = Short Reassessment

ALF provider name: _____
ALF provider number: _____
ALF admit date: _____

SERVICE AVAILABILITY ☐
1 = Client on waiting list for service authorized
2 = Desired service provider not available
3 = Service provider available, care to start immediately

LENGTH OF STAY (If approved for Nursing Home) ☐
1 = Temporary (less than 3 months)
2 = Temporary..(less than 6 months)
3 = Continuing (more than 6 months)
8 = Not Applicable

NOTE: Physicians may write progress notes to address the length of stay for individuals moving between Nursing Facility, PACE, HIV/AIDS waiver and the EDCD Waiver. The progress notes should provided to the local departments of social services Eligibility workers.

LEVEL I/ALF SCREENING IDENTIFICATION
Name of Level I/ALF screener agency and provider number:

1._____
☐☐☐☐☐☐☐☐☐☐

2._____
☐☐☐☐☐☐☐☐☐☐

LEVEL II OR CSB 101B ASSESSMENT DETERMINATION
Name of Level II OR CSB Screener and ID number who have completed the Level II or 101B for a diagnosis of MI, MR, or RC.

1._____
☐☐☐☐☐☐☐☐☐☐

0 = Not referred for Level II OR 101B assessment
1 = Referred, Active Treatment needed
2 = Referred, Active Treatment not needed
3 = Referred, Active Treatment needed but individual chooses NH ☐

Did the individual expire after the PAS/ALF Screening decision but before services were received? 1 = Yes 0 = No ☐

SCREENING CERTIFICATION - This authorization is appropriate to adequately meet the individual's needs and assures that all other resources have been explored prior to Medicaid authorization for this recipient.

_____ ___/___/_____
Level I/ALF Screener **Title** **Date**

_____ ___/___/_____
Level I/ALF Screener **Title** **Date**

_____ ___/___/_____
Level I Physician **Date**

DMAS-96 (revised 06/08)

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Suite 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
804/225-4612 (Fax)
804/343-0634 TDD)

Technology Assisted Waiver Level of Care Eligibility Form

Name:
Address:
City:

Date of Approval by DMAS:

This person has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. This person is authorized to have eligibility determined using the special institutional rules.

DMAS/ Tech Waiver Unit
Phone: 804-225-4222

COMMONWEALTH of VIRGINIA

Department of
Behavioral Health and Developmental Services
Post Office Box 1797
Richmond, Virginia 23218-1797

JAMES REINHARD
COMMISSIONER

Telephone (804) 786-3921
Voice/TDD (804) 371-8977
www.dbhds.virginia.gov

ID/MR Waiver Level of Care Eligibility Form

Name: _____

Address: _____

City: _____ VA. Zip Code: _____

Date of Approval by DBHDS: _____

This person has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. This person is authorized to have eligibility determined using the special institutional rules.

DBHDS Representative: _____
Date: _____
Phone: _____

COMMONWEALTH of VIRGINIA

Department of
Behavioral Health and Developmental Services
Post Office Box 1797
Richmond, Virginia 23218-1797

JAMES REINHARD
COMMISSIONER

Telephone (804) 786-3921
Voice/TDD (804) 371-8977
www.dbhds.virginia.gov

DS Waiver Level of Care Eligibility Form

Name: _____

Address: _____

City: _____ VA. Zip Code: _____

Date of Approval by *DBHDS*: _____

This person has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. This person is authorized to have eligibility determined using the special institutional rules.

DBHDS Representative: _____

Date: _____

Phone: _____

Confidentiality Statement: This document contains confidential health information that is legally privileged. This information is intended only for the use of the individuals or entities listed above. If you are not the intended recipient, you are hereby notified that any disclosure, copying, distribution, or action taken in reliance on the contents of this document is strictly prohibited. If you have received this information in error, please notify the sender immediately and arrange for the return or destruction of this document.

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

Suite 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
804/225-4612 (Fax)
804/343-0634 TDD)

DD Waiver Level of Care Eligibility Form

Name: _____

Address: _____

City: _____ VA. Zip Code: _____

Date of Approval by DMAS: _____

This person has met the level of care requirements for Medicaid waiver services and needs a Medicaid eligibility determination completed. This person is authorized to have eligibility determined using the special institutional rules.

DMAS Health Care Coordinator: _____
Date: _____
Phone: _____

CHAPTER M14
LONG-TERM CARE

SUBCHAPTER 30

FACILITY CARE

M1430 Changes

Changed With	Effective Date	Pages Changed
TN #93	01/01/2010	Appendix 1, page 1
Update (UP) #1	07/01/2009	Appendix 1, page 1

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M1430.000 FACILITY CARE

A. Introduction

Medicaid covers care provided in a facility to persons whose physical or mental condition requires nursing supervision and assistance with activities of daily living.

This subchapter (M1430) contains the specific policy and rules that apply to individuals needing or receiving long-term care (LTC) services in medical institutions (facilities).

B. Definitions

Definitions for terms used when policy is addressing types of long-term care (LTC), institutionalization, and individuals who are receiving that care are found in Subchapter M1410.

M1430.010 TYPES OF FACILITIES & CARE

A. Introduction

This section contains descriptions of the types of medical facilities in which Medicaid provides payment for services received by eligible patients.

B. Medical Facility Defined

A **medical facility** is an institution that:

- is organized to provide medical care, including nursing and convalescent care,
- has the necessary professional personnel, equipment, and facilities to manage the medical, nursing and other health needs of patients,
- is authorized under state law to provide medical care, and
- is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

C. Types of Medical Facilities

The following are types of medical facilities in which Medicaid will cover part of the cost of care:

1. Chronic Disease Hospitals

Chronic disease hospitals are specially certified hospitals, also called "long-stay hospitals". There are two of these hospitals enrolled as Virginia Medicaid providers:

- Hospital for Sick Children in Washington, D.C.;
- Lake Taylor Hospital in Norfolk, Virginia.

2. Institutions for the Mentally Retarded

An **institution for the mentally retarded or persons with related conditions** is an institution or a distinct part of an institution that

- is primarily for the diagnosis, treatment or rehabilitation of individuals with mental retardation or related conditions, and

- provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination and integration of health or rehabilitative services to help each individual function at his greatest ability.

Some community group homes are certified as Intermediate Care Facilities for the Mentally Retarded (ICF-MRs) by the Department of Health. Patients in these facilities may have income from participating in work programs.

NOTE: Medically needy (MN) individuals are not eligible for Medicaid payment of LTC services in an ICF-MR because ICF-MR services are not covered for the medically needy.

3. Institutions for Treatment of Mental Diseases (IMDs)

An **IMD** is a hospital, nursing facility or other institution with more than 16 beds that is primarily engaged in providing diagnosis, treatment or care, including medical attention, nursing care and related services, of persons with mental diseases. An institution for the mentally retarded is NOT an IMD.

NOTE: Medically needy (MN) patients over 65 years of age are not eligible for Medicaid payment of LTC services in an IMD because these services are not covered for medically needy individuals age 65 or over. For a list of IMDs in Virginia, see Appendix 1 to this subchapter.

NOTE: Any individual over age 21 but under age 65 who is in an IMD is not eligible for Medicaid while residing in the IMD.

4. Nursing Facility

A nursing facility is a medical institution licensed by the state to provide, on a regular basis, health-related services to patients who do not require hospital care, but whose mental or physical condition requires services, such as nursing supervision and assistance with activities of daily living, in addition to room and board and such services can be made available only in an institutional setting. Nursing facilities provide either skilled nursing care services or intermediate care services, or both.

5. Rehabilitation Hospitals

A rehabilitation hospital is a hospital certified as a rehabilitation hospital, or a rehabilitation unit of a hospital certified by the Department of Health as excluded from the Medicare prospective payment system, which provides inpatient rehabilitation services.

M1430.100 BASIC ELIGIBILITY REQUIREMENTS

A. Overview

To be eligible for Medicaid payment of long-term care, an individual must be eligible for Medicaid. The Medicaid non-financial eligibility requirements in *Chapter M02* apply to all individuals in long-term care. The eligibility requirements and the location of the manual policy are listed below in this section.

B. Citizenship/ Alienage

The citizenship and alien status policy is found in subchapter M022.

C. Virginia Residency

The Virginia state resident policy specific to facility patient is found in subchapter M0230 and section M1430.101 below.

D. Social Security Number

The social security number policy is found in subchapter M0240.

E. Assignment of Rights

The assignment of rights is found in subchapter M0250.

F. Application for Other Benefits

The application for other benefits policy is found in subchapter M0270.

G. Institutional Status

The institutional status requirements specific to long-term care in a facility are in subchapter M0280.

H. Covered Group (Category)

The Medicaid covered groups eligible for LTC services are listed in M1460. The requirements for the covered groups are found in chapter M03.

I. Financial Eligibility

An individual who has been a patient in a medical institution (such as a nursing facility) for at least 30 consecutive days of care or who has been screened and approved for LTC services is treated as an institutionalized individual for the Medicaid eligibility determination. Financial eligibility for institutionalized individuals is determined as a one-person assistance unit separated from his/her legally responsible relative(s).

The 30-consecutive-days requirement is expected to be met if the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC). If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has 30 days from the date on the Notice of Action to begin services.

For unmarried individuals and for married individuals without community spouses, the resource and income eligibility criteria in subchapter M1460 is applicable.

For married individuals with community spouses, the resource and income eligibility criteria in subchapter M1480 is applicable.

The asset transfer policy in M1450 applies to all facility patients.

M1430.101 VIRGINIA RESIDENCE

A. Policy

An individual must be a resident of Virginia to be eligible for Virginia Medicaid while he/she is a patient in a medical facility. There is no durational requirement for residency. *Additional Virginia residency requirements are in subchapter M0230.*

B. Individual Age 21 or Older

An institutionalized individual age 21 years or older is a resident of Virginia if:

- the individual is in an institution in Virginia with the intent to remain permanently or for an indefinite period; or
- the individual became incapable of declaring his intention to reside in Virginia at or after becoming age 21 years, he/she is residing in Virginia and was not placed here by another state government agency.

1. Determining Incapacity to Declare Intent

An individual is incapable of declaring his/her intent to reside in Virginia if:

- he has an I.Q. of 49 or less or has a mental age of less than 7 years;
- he has been judged legally incompetent; or
- medical documentation by a physician, psychologist, or other medical professional licensed by Virginia in the field of mental retardation supports a finding that the individual is incapable of declaring intent to reside in a specific state.

2. Became Incapable Before Age 21

An institutionalized individual age 21 years or older who became incapable of stating intent before age 21 is a resident of Virginia if:

- the individual's legal guardian or parent, if the parents reside in separate states, who applies for Medicaid for the individual resides in Virginia;
- the individual's legal guardian or parent was a Virginia resident at the time of the individual's institutional placement;
- the individual's legal guardian or parent who applies for Medicaid for the individual resides in Virginia and the individual is institutionalized in Virginia; or
- the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia, and the person who files the individual's Medicaid application resides in Virginia.
- if a legal guardian has been appointed for the individual and parental rights have been terminated, the guardian's state of residence is used to determine residency instead of the parent's.

C. Individual Under Age 21

An institutionalized individual under age 21 years who is not emancipated is a resident of Virginia if:

- the individual's legal guardian or parent was a Virginia resident at the time of the individual's institutional placement;
- the individual's legal guardian or parent who applies for Medicaid for the individual resides in Virginia and the individual is institutionalized in Virginia; or
- the individual's parent(s) has abandoned the individual, no legal guardian has been appointed, the individual is institutionalized in Virginia, and the person who files the individual's Medicaid application resides in Virginia.
- if a legal guardian has been appointed for the individual and parental rights have been terminated, the guardian's state of residence is used to determine residency instead of the parent's.

D. Placed by Another State's Government

When an individual is placed in a facility by another (not Virginia) state or local government agency, the placing state retains responsibility for the individual's Medicaid. Placement by a government agency is any action taken by the agency beyond providing general information to the individual and the individual's family to arrange the individual's admission to an institution. A government agency includes any entity recognized by State law as being under contract with the state government.

E. Individual Placed Out-of-state by Virginia

An individual retains Virginia residency for Medicaid if he/she is placed by a Virginia government agency in an institution outside Virginia. Placement into an out-of-state LTC medical facility must be pre-authorized by DMAS.

When a competent individual voluntarily leaves the facility in which Virginia placed him/her, he/she becomes a resident of the state where he/she is physically located.

F. Disputed or Unclear Residency

If the individual's state residency is unclear or is disputed, contact your Regional Coordinator for help. When two states cannot resolve the residency dispute, the state where the individual is physically located becomes his/her state of residency for Medicaid purposes.

M1430.10*2* ADVANCE PAYMENTS

A. Introduction

There are instances when a family member, or other individual, makes an advance payment to the facility for a prospective Medicaid patient prior to or during the Medicaid application process. This assures the patient's admission to, and continued care in, the facility. The individual may have been promised by the facility that the advance payment will be refunded if the patient is found eligible for Medicaid.

Advance payments which are expected to be reimbursed to an individual other than the Medicaid applicant once Medicaid is approved, and payments made to the facility to hold the bed while the patient is hospitalized, are not counted as income for either eligibility or patient pay determinations.

B. Reimbursement

Any monies contributed toward the cost of the patient's care pending Medicaid eligibility determination must be reimbursed to the contributing party by the facility when Medicaid eligibility is established. The only exception is when the payment is made from the patient's own funds which exceeded the resource limit.

M1430.*103* SSI RECIPIENTS

A. Introduction

This section provides information about SSI recipients who are admitted to medical facilities.

B. Unmarried SSI Recipient

When an unmarried Medicaid-eligible SSI recipient enters a facility for LTC, review his/her Medicaid eligibility, especially institutional status, asset transfer and home property ownership.

1. Temporary Period

An SSI recipient who is admitted to a medical facility temporarily, for 3 months or less, retains his/her usual monthly SSI payment and remains eligible for Medicaid if resources are within Medicaid limits. This "temporary" SSI payment is not counted available for patient pay. See M1470.

2. Indefinite Period

If not admitted temporarily, or when the 3-month temporary period ends, the SSI income limit is reduced to $30 per month. If the individual has no other countable income, his SSI payment will usually be $30 per month. If he has countable income of $30 or more, his SSI payment will terminate.

Review his income eligibility when the SSI payment terminates. See M1460.

C. Married SSI Recipient

When a married Medicaid-eligible SSI recipient enters a facility for LTC, review his/her Medicaid eligibility, especially institutional status, asset transfer and resources. Use the married institutionalized individuals' policy in M1480 to determine resource eligibility and patient pay.

1. Temporary Period

An SSI recipient who is admitted to a medical facility temporarily, for 3 months or less, usually retains his/her usual monthly SSI payment and remains eligible for Medicaid if resources are within Medicaid limits. This "temporary" SSI payment is not counted available for patient pay. See M1470.

2. Indefinite Period

If not admitted temporarily, or when the 3-month temporary period ends, the SSI income limit is reduced to $30 per month. If the individual has no other countable income, his SSI payment will usually be $30 per month. If he has countable income of $30 or more, his SSI payment will terminate. Review his income eligibility when the SSI payment terminates. See M1460.

List Of IMDs In Virginia

Catawba Hospital
P.O. Box 200
Catawba, VA 24070-*0200*

Central State Hospital
P.O. Box 4030
Petersburg, VA 23803-*0030*
(NOTE: Hiram Davis Medical Center is not an IMD)

Eastern State Hospital
4601 Ironbound Road
Williamsburg, VA 23188-*2652*

Northern Virginia Mental Health Institute
3302 Gallows Road
Falls Church, VA 2204*2-3398*

Piedmont Geriatric Hospital
P.O. Box 427
Burkeville, VA 23922-*0427*

Southern Virginia Mental Health Institute
382 Taylor Drive
Danville, VA 24541-*4023*

Southwestern VA Mental Health Institute
340 Bagley Circle
Marion, VA 24354-*3126*

Western State Hospital
1301 Richmond Avenue
Staunton, VA 2440*2-2500*

CHAPTER M14
LONG-TERM CARE
SUBCHAPTER 40

COMMUNITY-BASED CARE WAIVER SERVICES

Virginia DSS, Volume XIII

M1440 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/2010	Table of Contents pages 13, 16, 18b, 19-22
TN #93	01/01/2010	pages 14, 16
TN #91	05/15/2009	Table of Contents page 12 pages 17-18c

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M1440.000 COMMUNITY-BASED CARE WAIVER SERVICES

M1440.001 GOVERNING LAWS

A. Introduction

This subchapter provides information about the Medicaid Community-Based Care (CBC) waivers, the individuals eligible for waiver services, and information about the services provided in the waivers.

B. Community-Based Care Waiver Services (CBC)

Community-Based Care Waiver Services or Home and Community-Based Care or CBC are titles that are used interchangeably. These terms are used to mean a variety of in-home and community-based services reimbursed by DMAS that are authorized under a Section 1915(c) waiver designed to offer individuals an alternative to institutionalization in a medical facility. Individuals may be preauthorized to receive one or more of these services either solely or in combination, based on the documented need for the service or services to avoid nursing facility placement.

C. Federal Law

Section 1915 of the Social Security Act has provisions which allow states to waive certain requirements of Title XIX as a cost saving measure. Virginia uses 1915(c) which allows the state to provide services not otherwise available under the State Plan to specifically targeted individuals. Individuals who may be targeted are those which it (the state) can show would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded, the cost of which would be reimbursed under the State plan.

Under a 1915(c) waiver, the state may waive the requirements of Section 1902 of Title XIX, related to statewideness and comparability of services, and may apply the institutional deeming income and resource rules for home and community-based recipients. This allows individuals with catastrophic medical needs to retain income for their maintenance in the home.

Any waiver granted under Section 1915(c) must satisfy requirements established by the Secretary regarding cost-effectiveness (the cost to Medicaid of home and community-based services for recipients must not exceed 100% of the cost to Medicaid for their institutional care), the necessary safeguards taken to protect the health and welfare of individuals, financial accountability, evaluations and periodic re-evaluations of the need for an institutional level of care, the impact of the waiver and recipient choice informing procedure.

D. Virginia's Waivers

Virginia has approved Section 1915(c) home and community-based waivers. These waivers contain services that are otherwise not available to the general Medicaid population. The target population and service configuration for each waiver is outlined in this subchapter.

M1440.010 BASIC ELIGIBILITY REQUIREMENTS

A. Introduction

Services provided through the Waivers can be covered by Medicaid when the applicant or recipient meets the Medicaid eligibility requirements in this section.

B. Waiver Requirements

The individual must meet the pre-admission screening criteria for CBC waiver services and the targeted population group requirement. Some of the targeted population groups are:

- *individuals age 65 or older, blind or disabled*
- individuals with mental retardation
- individuals who have AIDS or are HIV-positive
- individuals who need a medical device to compensate for loss of a vital bodily function
- *individuals with developmental disabilities who do not have a diagnosis of mental retardation*

The eligibility worker does NOT make the determination of whether the individual meets the waiver requirements; this is determined by the pre-admission screener or by DMAS.

NOTE: The individual *cannot* be authorized to receive services under more than one waiver at a time.

C. Non-financial Eligibility

The individual must meet the Medicaid non-financial and financial eligibility requirements listed below:

1. Citizenship/ Alienage

The citizenship and alien status policy is found in *subchapter M0220.*

2. Virginia Residency

The Virginia state resident policy specific to CBC waiver services patients is found in *subchapter M0230.*

3. Social Security Number

The social security number policy is found in *subchapter M0240.*

4. Assignment of Rights/ Cooperation

The assignment of rights and support cooperation policy is found in *subchapters M0250 and M0260.*

5. Application for Other Benefits

The application for other benefits policy is found in *subchapter M0270.*

6. Institutional Status

The institutional status requirements specific to CBC waiver services recipients are in section M1440.020 below.

7. Covered Group

The requirements for the covered groups are found in *subchapters M0320 and M0330.*

D. Financial Eligibility

An individual who has been screened and approved for CBC services is treated as an institutionalized individual for the Medicaid eligibility determination. Financial eligibility is determined as a one-person assistance unit separated from his legally responsible relative(s) with whom he lives.

If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has 30 days from the date on the Notice of Action to begin receiving CBC services.

For unmarried individuals and for married individuals without community spouses, the resource and income eligibility criteria in subchapter M1460 is applicable.

For married individuals with community spouses, the resource and income eligibility criteria in subchapter M1480 is applicable.

The asset transfer policy in M1450 applies to all CBC waiver services recipients.

M1440.020 INSTITUTIONAL STATUS

A. Introduction

To be eligible for Medicaid, an individual approved for CBC waiver services must meet the institutional status requirement. A CBC waiver services recipient usually is not in a medical institution; most CBC recipients live in a private residence in the community. However, an individual who resides in a residential facility such as an adult care residence (ACR) may be eligible for some CBC waiver services.

This section contains the Medicaid institutional status policy, inmate of a public institution policy and procedures for determining whether a CBC waiver services patient meets the institutional status eligibility requirement.

B. Definitions

1. Institution

An **institution** is an establishment that furnishes (in single or multiple facilities) food, shelter and some treatment or services to four or more persons unrelated to the proprietor.

2. Public Institution

A **public institution** is an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control.

The following are NOT public institutions for this section's purposes:

- a medical facility, including a nursing facility;
- a publicly operated community residence that serves no more than 16 residents;
- a child care institution, for children who receive foster care payments under Title IV-E or AFDC foster care under Title IV-A, that accomodates no more than 25 children;

accomodates no more than 25 children;

- an institution certified as an ICF-MR for individuals with mental retardation or related conditions.

3. Publicly Operated Community Residence

A **publicly operated community residence** is a public residential facility (institution) that provides some services beyond food and shelter such as social services, help with personal living activities or training in socialization and life skills. Occasional medical or remedial care may also be provided.

Publicly operated community residences do NOT include the following facilities even though they serve no more than 16 residents:

- residential facilities located on the grounds of, or adjacent to, any large institution;

- correctional or holding facilities for individuals who are prisoners, who have been arrested or detained pending disposition of charges, or who are held under court order as material witnesses or juveniles;

- detention facilities, forestry camps, training schools or any other facility for children determined to be delinquent;

- educational or vocational training institutions that primarily provide an approved, accredited or recognized program to individuals residing there.

  NOTE: An individual residing in a public educational or vocational training institution for purposes of securing education or vocational training is NOT an inmate of a public institution, and therefore may be eligible for Medicaid, even though the educational or training facility is not a publicly operated community residence that serves no more than 16 residents.

4. Child Care Institution

A **child care institution** is a

- non-profit private child-care institution, or

- a public child care institution that accomodates no more than 25 children

which has been licensed by the state in which it is located or has been approved by the agency of the state responsible for licensing or approval of institutions of this type, as meeting the standards established for licensing.

The term "child care institution" does NOT include detention facilities, forestry camps, training schools or any other facility operated primarily

for the detention of children who are determined to be delinquent.

5. Facility for the Mentally Retarded

A facility (institution) for the mentally retarded (ICF-MR) is not an IMD. Therefore, an individual under age 65 who is in a facility for the mentally retarded meets the institutional status eligibility requirement, unless he is incarcerated, as defined below.

C. Policy

Two groups of individuals are NOT eligible for Medicaid:

- individuals who are inmates of a public institution.
- individuals under age 65 years who are patients in an institution for the treatment of mental diseases (IMDs), unless they are under age 22 and are receiving inpatient psychiatric services.

Because a patient in an IMD cannot receive Medicaid CBC waiver services, this section only addresses the inmate of a public institution policy and procedures.

1. Private Residence or Group Home

An individual who lives in a private residence in the community that is not an institution (it is an establishment that provides food, shelter and some services to three or less persons unrelated to the proprietor) is not living in an institution. A group home that has three or less residents is not an institution.

However, the individual may be an inmate of a public institution because he/she is considered incarcerated or a juvenile in detention, as described below. If the individual is considered incarcerated or a juvenile in detention, he/she is not eligible for Medicaid because he does not meet the institutional status eligibility requirement.

2. Private Residential Facility

A resident of any age in a private residential facility meets the institutional status requirement for Medicaid UNLESS the individual is incarcerated, as defined below.

3. Public Residential Facility

A resident of any age in a PUBLIC residential facility meets the institutional status requirement for Medicaid UNLESS:

- the public residential facility has more than 16 beds, or
- the individual is incarcerated or a juvenile in detention as described below.

D. Inmate of a Public Institution

Inmates of public institutions fall into three groups:

- individuals living in public residential facilities;
- incarcerated individuals;
- juveniles in detention.

An individual is an inmate of a public institution from the date of admission to the public institution until discharge, or from the date of actual incarceration in a prison, county or city jail or juvenile detention facility until permanent release, bail, probation or parole.

An individual is considered incarcerated until permanent release, bail, probation or parole. For example, an individual released from jail due to a medical emergency who would otherwise be incarcerated but for the medical emergency is still considered incarcerated and is an inmate of a public institution. An individual released from jail under a court **probation order** due to a medical emergency is NOT an inmate of a public institution because he is no longer incarcerated.

1. Public Residential Facility Residents

An individual who lives in a public residential facility that serves **more than 16 residents** is NOT eligible for Medicaid.

a. District Homes

The District Homes are public residential facilities that serve more than 16 residents. A District Home may have other portions of the institution certified as a nursing facility. There are two District Homes in Virginia, one in Waynesboro and one in Manassas.

Residents in the residential portions of the District Homes are inmates of a public institution and are not eligible for Medicaid, because the residential portion is a public residential facility of more than 16 beds.

Patients in the certified nursing facility portion of the District Home are NOT inmates of a public institution because that portion is a medical institution. Patients in the nursing facility portion of the District Home meet the institutional status requirement and may be eligible for Medicaid.

2. Incarcerated Individuals

An incarcerated individual is an inmate of a public institution, even when he/she is in a medical facility. The key element is whether the incarcerated individual resided in a jail or prison **immediately prior** to admission to the medical facility.

The following incarcerated individuals are inmates of a public institution:

- an inmate in a prison,
- an inmate in a county or city jail,
- an incarcerated individual who can leave prison, jail or work release center on work release or work furlough and must return to prison or jail at specific intervals,
- an incarcerated individual released due to a medical emergency who would otherwise be incarcerated but for the medical

emergency,

- *an individual in prison or jail who transfers temporarily to a halfway house or residential treatment facility prior to a formal probation,*

- an inmate in a prison or jail prior to arraignment, conviction, or sentencing.

  Exception: He/she may be eligible for Medicaid if he/she is out on bail or his/her own recognizance.

3. Juveniles in Detention

In determining whether a juvenile (individual under age 18 years) is incarcerated and an inmate of a public institution, the federal Medicaid regulations distinguish between the nature of the detention, pre- and post-disposition situations, and types of facilities.

a. Prior to Court Disposition

1) A juvenile who is in a detention center **due to criminal activity** is an inmate of a public institution. Incarceration in a detention center due to criminal activity makes the individual an inmate of a public institution. The length of stay in the detention center is irrelevant. A short incarceration in a detention facility is NOT temporary placement pending other arrangements.

   A juvenile who has criminal charges pending (no court disposition has been made) who is ordered by the judge to go to a treatment facility, then come back to court for disposition when the treatment is completed, is an inmate of a public institution.

2) A juvenile who is in a detention center **due to care, protection or in the best interest of the child** is NOT an inmate of a public institution.

b. After Court Disposition

Juveniles who are on probation with a plan of release which includes residence in a detention center are inmates of a public institution. If they go to any of the secure juvenile correctional facilities, they are inmates of a public institution. If they go to a nonsecure group home, they are NOT inmates of a public institution because a nonsecure group home is not a detention center.

c. Type of Facility

The type of facility, whether it is residential or medical and whether it is public or private must be determined. A juvenile is not eligible if he/she is a resident of a public residential facility.

EXAMPLE #1: A juvenile is detained for criminal activity. He is placed on probation with specific conditions of release, including a stay of 30 days or longer at a detention facility. The facility is identified as a juvenile detention center, not a treatment center. Upon release from the detention center, he will be placed on probation and will live with his mother. Because of the nature of his custody (criminal activity) and the nature of the

facility (a detention center is a public institution) he is not eligible for Medicaid during the period of incarceration. After he is released from the detention center and while he is on probation, he is NOT an inmate of a public institution and may be eligible for Medicaid

4. Ineligible Juveniles in Detention

The following juveniles in detention are inmates of a public institution and are not eligible:

a. A minor in a juvenile detention center prior to disposition (judgement) due to criminal activity is not eligible for Medicaid.

b. A minor placed on probation by a juvenile court with specific conditions of release, including residence in a secure juvenile detention center is not eligible for Medicaid.

E. Who Is NOT An Inmate of a Public

An individual is NOT an inmate of a public institution, and may be eligible for Medicaid, if

- he is in a public educational or vocational training institution for purposes of securing education or vocational training OR
- he is in a public institution for a temporary period pending other arrangements appropriate to his needs.

An individual residing in a public educational or vocational training institution for purposes of securing education or vocational training is NOT an inmate of a public institution, and therefore may be eligible for Medicaid.

1. Admitted Under TDO

An individual over age 18 who was arrested or detained, but did not reside overnight in a prison or jail before being admitted to a public institution under a temporary detention order (TDO) is NOT an inmate of a public institution because he did not reside in the jail or prison immediately before admission to the treatment facility.

2. Arrested Then Admitted to Medical Facility

An individual who, after arrest but before booking, is escorted by police to a hospital for medical treatment and held under guard may be eligible for Medicaid.

3. Probation, Parole, or Conditional Release

An individual permanently released from prison or jail on probation, parole, or release order with a condition of:

- home arrest
- community services
- outpatient treatment
- inpatient treatment

is not an inmate of a public institution and may be eligible for Medicaid.

An individual released from prison or jail under a court probation order due to a medical emergency may be eligible for Medicaid.

4. Juvenile in Detention Center Due to Care, Protection, Best Interest

A minor in a juvenile detention center prior to disposition (judgement) due to care, protection or the best interest of the child (e.g., Child Protective Services [CPS]), if there is a specific plan for that child that makes the detention center stay temporary, may be eligible for Medicaid.

This could include a juvenile awaiting placement but who is still physically present in the juvenile detention center.

5. On Probation in Secure Treatment Center

A minor placed on probation by a juvenile court and placed in a secure treatment facility may be eligible for Medicaid.

6. Juvenile On Conditional Probation

A minor placed on probation by a juvenile court with, as a condition of probation, treatment in a psychiatric hospital or a residential treatment center, or treatment as an outpatient may be eligible for Medicaid. However, if the minor is NOT on probation but is ordered to the treatment facility, he remains an inmate of a public institution and is not eligible for Medicaid.

F. Procedures

In this order, determine:

1. Is the Individual in an Institution?

Ask: is the individual living in a home or establishment that provides food, shelter and some services to four or more persons unrelated to the proprietor?

a. If NO, the individual is not in a facility. Individual meets the institutional status eligibility requirement for Medicaid. STOP.

b. If YES, the individual is in a facility. Go to item 2. below.

2. Is the Facility Medical?

Ask: is the institution, or portion of the institution, in which the individual resides a medical facility?

a. If NO, the facility is residential. Go to item 3. below.

b. If YES, the individual is in a medical facility. Go to subchapter M1430.

3. Is the Individual in a Public Institution?

Determine if the residential facility is a public institution as defined in M1440.020 C above. Ask: is the residential facility public?

a. If NO, go to item 4. below (determine if the individual is incarcerated and an inmate of public institution).

b. If YES, ask: how many beds does it have?

1) If it has 16 beds or less, go to item 4. below (determine if the individual is incarcerated and an inmate of public institution).

2) If it has more than 16 beds, the individual DOES NOT meet the institutional status requirement and is not eligible for Medicaid. STOP.

4. Is the Individual An Inmate of a Public Institution?

Is the individual incarcerated and an inmate of a public institution? Ask the following questions:

Was he in a secure facility (jail, prison, secure detention) immediately before admission?

a. If NO, he is not an inmate of a public institution and meets institutional status requirement for Medicaid. STOP.

b. If YES, ask: is he a juvenile (under age 18)?

1) NO: he is an inmate of a public institution and is NOT eligible for Medicaid. STOP.

2) YES: Ask: Is this facility a secure treatment facility?

a) NO: Ask: Was he in a juvenile detention center prior to admission due to criminal activity?

(1) NO: he is not an inmate of a public institution and meets institutional status requirement for Medicaid. STOP.

(2) YES: Ask: Was he placed on probation by a juvenile court with, as a condition of probation, treatment in a psychiatric hospital or a residential treatment center, or treatment as an outpatient?

(a) NO: he is an inmate of a public institution and is NOT eligible for Medicaid. STOP.

(b) YES: he is not an inmate of a public institution and may be eligible for Medicaid. STOP.

b) YES: Ask: Is the secure treatment facility part of the criminal

justice system?

(1) NO: he is NOT an inmate of a public institution and may be eligible for Medicaid. STOP.

(2) YES: he is an inmate of a public institution and is NOT eligible for Medicaid. STOP.

M1440.100 CBC WAIVER DESCRIPTIONS

A. Introduction

This section provides a brief overview of the Medicaid CBC waivers. The overview is a synopsis of the target populations, basic eligibility rules, available services, and the assessment and service authorization procedure for each waiver.

The eligibility worker does not make the determination of whether the individual is eligible for the waiver services; this is determined by the pre-admission screener or by DMAS. The policy in the following sections is only for the eligibility worker's information to better understand the CBC waiver services.

B. Definitions

Term definitions used in this section are:

1. Financial Eligibility Criteria means the rules regarding asset transfers; what is a resource; when and how that resource counts; what is income; when and how that income is considered.

2. Non-financial Eligibility Criteria means the Medicaid rules for non-financial eligibility. These are the rules for citizenship and alienage; state residence; social security number; assignment of rights and cooperation; application for other benefits; institutional status; cooperation with spousal support and DCSE; and covered group and category requirements.

3. Patient an individual who has been approved by a pre-admission screener to receive Medicaid waiver services.

M1440.101 ELDERLY *OR* DISABLED *WITH CONSUMER-DIRECTION WAIVER*

A. General Description

The Elderly *or* Disabled *with Consumer-Direction (EDCD)* Waiver is targeted to provide home and community-based services to individuals age 65 or older, or who are disabled, who have been determined to require the level of care provided in a medical institution and are at risk of facility placement.

Recipients may select agency-directed services, consumer-directed services, or a combination of the two. Under consumer-directed services, supervision of the personal care aide is furnished directly by the recipient. Individuals who are incapable of directing their own care may have a spouse, parent, adult child, or guardian direct the care on behalf of the recipient. Consumer-directed services are monitored by a Service Facilitator.

B. Targeted Population

This waiver serves persons who are:

a. age 65 and over, or

b. disabled; disability may be established either by SSA, DDS, or a pre-admission screener (provided the individual meets a Medicaid covered group and another category).

Waiver services are provided to any individual who meets a Medicaid covered group and is determined to need an institutional level of care by a pre-admission screening. The individual does not have to meet the Medicaid disability definition.

C. Eligibility Rules

All individuals receiving waiver services must meet the Medicaid non-financial and financial eligibility requirements for an eligible patient in a medical institution.

The resource and income rules are applied to waiver-eligible patients as if the patients were in a medical institution.

NOTE: EDCD Waiver services shall not be offered to any patient who resides in a nursing facility, an intermediate care facility for the mentally retarded, a hospital, or an adult care residence licensed by DSS. The income limit used for this waiver is 300% of the current SSI payment standard for one person, or the medically needy income limit (spenddown).

D. Services Available

LTC services available through this waiver include:

- adult day health care
- agency-directed and consumer-directed personal care
- agency-directed respite care (including skilled respite) and consumer-directed respite care
- Personal Emergency Response System (PERS).

E. Assessment and Service Authorization

The nursing home pre-admission screeners assess and authorize EDCD Waiver services based on a determination that the individual is at risk of nursing facility placement.

PACE provides the entire spectrum of acute and long-term care services to enrollees without limitations on the duration of services or the dollars spent and is centered on an adult day health care model.

The following services are provided through PACE:

- *adult day care that offers nursing, physical, occupational, speech and recreational therapies;*
- *meals and nutritional counseling; social services;*
- *medical care provided by a PACE physician; personal care and home health care;*
- *all necessary prescription drugs;*
- *access to medical specialists such as dentists, optometrists and podiatrists; respite care;*
- *hospital and nursing facility care when necessary; and*
- *transportation.*

*Participation in PACE is **voluntary**. The nursing home pre-admission screening team will advise the individual of the availability of PACE and will facilitate enrollment if the Medicaid enrollee chooses PACE. The PACE team is responsible for authorizing as well as providing the services.*

M1440.102 *INTELLECTUAL DISABILITIES/*MENTAL RETARDATION WAIVER

A. General Description

The *Intellectual Disabilities/*Mental Retardation *(ID/MR)* Waiver program is targeted to provide home and community-based services to individuals with mental retardation and individuals under the age of six years at developmental risk who have been determined to require the level of care provided in an *intermediate care facility for the mentally retarded* (ICF/MR).

B. Targeted Population

The targeted population groups of individuals who have been determined to require the level of care provided in an intermediate care facility for the mentally retarded are:

- individuals with diagnosis of *an intellectual disability or* mental retardation;
- individuals under the age of six who are at developmental risk and who have been determined to require the level of care provided in an ICF/MR. At age 6, these individuals must be determined to be *intellectually disabled or* mentally retarded in order to continue to receive CBC waiver services.

C. Eligibility Rules

All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid-eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individual were residing in a medical institution.

The income limit used for this waiver is 300% of the current SSI payment standard for one person. Medically needy individuals are not eligible for this waiver. If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.

D. Services Available

Services available under the *ID/*MR waiver include:

- *day support*
- *supported employment*
- *residential support*
- *therapeutic consultation*
- *agency-directed and consumer-directed personal assistance services*
- *agency-directed and consumer-directed respite care*
- *nursing services*
- *environmental modification*
- *assistive technology*
- *agency-directed and consumer-directed adult companion services*
- *crisis stabilization*
- *prevocational services*
- *Personal Emergency Response System (PERS)*
- *therapeutic consultation.*

E. Assessment and Service Authorization

The individual's need for CBC is determined by the Community Mental Health Services Board (CSB) or Department of Rehabilitative Services (DRS) case manager after completion of a comprehensive assessment.

All recommendations are submitted to *Department of Behavioral Health and Developmental Services (DBHDS)* or DMAS staff for final authorization.

1. CSB The CSB case manager may only recommend waiver services if:

- the individual is found Medicaid eligible; and
- the individual is mentally retarded, or is under age 6 and at developmental risk; and
- the individual is not an inpatient of a nursing facility or hospital.

2. DRS The DRS case manager may only recommend waiver services if:

- the individual is found Medicaid eligible, and
- the individual is in a nursing facility and has a related condition such as defined in the federal Medicaid regulations.

M1440.103 AIDS WAIVER

A. General Description The AIDS waiver provides services to individuals with HIV infection to prevent hospitalization or nursing facility placement.

B. Targeted Population The waiver services are for individuals with HIV infection, who have been diagnosed and are experiencing the symptoms associated with AIDS (Acquired Immunodeficiency Syndrome) or who are HIV positive and are symptomatic, and for whom the services provided through the waiver are expected to prevent placement in a hospital or nursing facility.

C. Eligibility Rules Patients receiving AIDS waiver services must meet the non-financial and financial Medicaid eligibility criteria applicable to the other Medicaid covered groups and must be Medicaid-eligible in a medical institution. These individuals are considered as if they were institutionalized for the purpose of applying institutional resource and income rules.

The income limit used for this waiver is 300% of the current SSI payment standard for one person, or the medically needy (MN) income limit and spenddown.

D. Services Available Services available under the AIDS Waiver include:

- case management
- nutritional supplements
- private duty nursing
- personal care
- respite care.

E. Assessment and Service Authorization Status as an AIDS individual in need of CBC shall be determined by the pre-admission screener.

Screenings can be completed by:

- Local and hospital screening committees
- AIDS services organizations (ASOs) contracted with DMAS

M1440.104 TECHNOLOGY-ASSISTED INDIVIDUALS WAIVER

A. General Description

"Technology-Assisted" means any individual defined as chronically ill or severely impaired who needs both a medical device to compensate for the loss of a vital body function and substantial and ongoing skilled nursing care to avert death or further disability. The objective of the waiver is to provide medically appropriate and cost-effective coverage of services necessary to maintain these individuals in the community.

B. Targeted Population

Individuals who need both 1) a medical device to compensate for the loss of a vital body function and 2) substantial and ongoing skilled nursing care.

C. Eligibility Rules

The individual must meet the following basic requirements:

1. has a live-in primary care giver who accepts responsibility for the individual's health and welfare.
2. is not receiving services in a general acute care hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded.
3. is not residing in a board and care facility or adult care residence.
4. All patients under the waiver must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid-eligible in a medical facility.
5. Financial eligibility rules that apply to institutionalized individuals apply to patients under this waiver. Resource and income rules apply to waiver eligible individuals as if the individual were residing in a medical institution.

   The income limit used for this waiver is 300% of the current SSI payment standard for one person, or the medically needy (MN) income limit and spenddown.

D. Services Available

The services provided under this waiver include:

- private duty nursing
- respite care

- nutritional supplements
- medical supplies and equipment not otherwise available under the Medicaid State Plan.

E. Assessment and Service Authorization

The initial assessment and development of the plan of care is conducted by DMAS staff.

The following entities are authorized to screen for the Technology-Assisted Individuals Waiver:

- DMAS Health Care Coordinator.

M1440.105 DAY SUPPORT WAIVER

A. General Description

The Day Support (DS) Waiver is targeted to provide home and community-based services to individuals with *intellectual disabilities* or mental retardation who have been determined to require the level of care provided in an ICF/MR. These individuals may reside in an ICF/MR or may be in the community at the time of the assessment for DS Waiver services.

B. Targeted Population

Only those individuals on the urgent and non-urgent waiting lists for the *ID/*MR Waiver are considered for DS Waiver services. Individuals may remain on the *ID/*MR Waiver waiting list while receiving DS Waiver Services.

C. Eligibility Rules

All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid-eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individual were residing in a medical institution.

The income limit used for this waiver is 300% of the current SSI payment standard for one person. Medically needy individuals are not eligible for this waiver. If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.

D. Services Available

Services available under the DS Waiver include:

- day support
- prevocational services.

E. Assessment and Service Authorization

The individual's need for CBC is determined by the CSB or DBHDS case manager after completion of a comprehensive assessment. All recommendations are submitted to DBHDS staff for final authorization.

M1440.106 ALZHEIMER'S ASSISTED LIVING WAIVER

A. General Description

The Alzheimer's Assisted Living (AAL) Waiver is available only to individuals who are Auxiliary Grants (AG) recipients. The AAL Waiver allows for the provision of services to individuals in approved assisted living facilities who, without the waiver, might require nursing home placement. **Individuals on this waiver do not have Medicaid eligibility determined as institutionalized individuals, and there are no post-eligibility requirements**.

The AAL waiver serves persons who are:

- Auxiliary Grants (AG) recipients,
- have a diagnosis of Alzheimer's or a related dementia and no diagnosis of mental illness or mental retardation, and
- age 55 or older.

B. Eligibility Rules

Individuals in the AAL Waiver have Medicaid eligibility determined in the AG covered group (see M0320.202) and do not have Medicaid eligibility determined as institutionalized individuals. There are no post-eligibility requirements.

The enrollment and notification procedures used with non-institutionalized Medicaid recipients are followed (see M0130.300).

C. Services Available

Services available under the AAL waiver are**:**

- assistance with activities of daily living
- medication administration by licensed professionals
- nursing services for assessments and evaluations
- therapeutic social and recreational programming which provides daily activities for individuals with dementia.

D. Assessment and Service Authorization

Local and hospital screening committees or teams are authorized to screen individuals for the AAL waiver; however, a copy of the pre-admission screening is not required for the Medicaid eligibility record.

M1440.107 INDIVIDUAL AND FAMILY DEVELOPMENTAL DISABILITIES SUPPORT WAIVER (DD WAIVER)

A. General Description

The Individual and Family Developmental Disabilities Support Waiver (DD waiver) provides home and community-based services to individuals with developmental disabilities, who do not have a diagnosis of mental retardation. The objective of the waiver is to provide medically appropriate and cost-effective coverage of services necessary to maintain these individuals in the community and prevent placement in a medical institution.

This waiver serves persons who:

- have a diagnosis of developmental disability attributable to cerebral palsy, epilepsy or autism, or
- any condition other than mental illness, found to be closely related to mental retardation.

The developmental disability must have been manifested prior to the individual reaching age 22 and must be likely to continue indefinitely.

B. Eligibility Rules

All patients receiving waiver services must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid eligible in a medical institution. The resource and income rules are applied to waiver eligible individuals as if the individuals were residing in a medical institution.

The income limit used for this waiver is 300% of the SSI limit (see M0810.002 A. 3.). Medically needy individuals are not eligible for this waiver. If the individual's income exceeds 300% SSI, the individual is not eligible for services under this waiver.

C. Services Available

Services available under the DD waiver are**:**

- support coordination (case management)
- adult companion services
- assistive technology
- crisis intervention/stabilization
- environmental modifications
- residential support
- skilled nursing
- supported employment
- therapeutic consultation
- respite care
- personal attendant services
- consumer-directed personal and respite care.

D. Assessment and Service Authorization

The initial assessment and development of the plan is conducted by qualified individuals under contract with DMAS. DMAS staff will review the contractor's plan and authorization.

M1440.108 PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

A. General Description

PACE is NOT a CBC Waiver, but rather is the State's community model for the integration of acute and long-term care. PACE combines Medicaid and Medicare funding. PACE provides the entire spectrum of acute and long-term care services to enrollees without limitations on the duration of services or the dollars spent and is centered on an adult day health care model.

B. Targeted Population

PACE serves individuals aged 55 and older who (1) meet the nursing facility level of care criteria and (2) reside in their own communities. PACE provides all of their health care and long-term care medical needs.

Individuals who meet the criteria for the EDCD Waiver may be enrolled in PACE in lieu of the EDCD Waiver.

C. Eligibility Rules

For Medicaid to cover PACE services, the individual must meet the non-financial and financial Medicaid eligibility criteria and be Medicaid eligible in a medical institution. The resource and income rules are applied to PACE-eligible individuals as if the individuals were residing in a medical institution.

The income limit used for PACE is 300% of the SSI limit (see M0810.002 A. 3.) or the MN income limit and spenddown.

PACE is not available to individuals who reside in an assisted living facility (ALF) and receive Auxiliary Grant (AG) payments. Individuals who reside in an ALF may be enrolled in PACE if they meet the functional, medical/nursing, and financial requirements, but they will not be permitted to receive an AG payment.

D. Services Available

The following services are provided through PACE:

- adult day care that offers nursing, physical, occupational, speech and recreational therapies;
- meals and nutritional counseling; social services;
- medical care provided by a PACE physician; personal care and home health care;
- all necessary prescription drugs;
- access to medical specialists such as dentists, optometrists and podiatrists; respite care;
- hospital and nursing facility care when necessary; and transportation.

E. Assessment and Service Authorization

*Participation in PACE is **voluntary**. The nursing home pre-admission screening team will advise the individual of the availability of PACE and will facilitate enrollment if the Medicaid enrollee chooses PACE. The PACE team is responsible for authorizing as well as providing the services.*

Eligibility for PACE must begin on the first day of a month and end on the last day of a month.

M1440.200 COVERED SERVICES

A. Introduction

This section provides general information regarding the LTC services provided under the waivers. This is just for your information, understanding, and referral purposes. The information does not impact the Medicaid eligibility decision.

B. Waiver Services Information

Information about the services available under a waiver is contained in the following sections:

- M1440.201 Personal Care/Respite Care Services
- M1440.202 Adult Day Health Services
- M1440.203 Case Management Services
- M1440.204 Private Duty Nursing Services

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M1440.201 PERSONAL CARE/RESPITE CARE SERVICES

A. What Are Personal Care Services

Personal Care services are defined as long term maintenance or support services which are necessary in order to enable the individual to remain at home rather than enter an institution. Personal Care services provide eligible individuals with aides who perform basic health-related services, such as helping with ambulation/exercises, assisting with normally self-administered medications, reporting changes in the recipient's conditions and needs, and providing household services essential to health in the home.

B. What are Respite Care Services

Respite Care services are defined as services specifically designed to provide temporary but periodic or routine relief to the primary caregiver of an individual who is incapacitated or dependent due to frailty or physical disability. To receive this service the individual must meet the same criteria as the individual who is authorized for Personal Care, but the focus in Respite Care is on the needs of the caregiver for temporary relief. This focus on the caregiver differentiates Respite Care from programs which focus on the dependent or disabled care receiver.

C. Relationship to Other Services

An individual may receive Personal Care or Respite Care in conjunction with Adult Day Health Care services as needed.

When an individual receives Hospice services, the hospice is required to provide the first 21 hours per week of personal care needed and a maximum of an additional 38.5 hours per week.

D. Who May Receive the Service

An individual must meet the criteria of the EDCD Waiver, the AIDS Waiver, the Technology-Assisted Waiver or the *ID/*MR Waiver in order to qualify for Personal/Respite Care services.

M1440.202 ADULT DAY HEALTH CARE SERVICES

A. What Is Adult Day Health Care

Adult Day Health Care (ADHC) is a congregate service setting where individuals receive assistance with activities of daily living (e.g., ambulating, transfers, toileting, eating/feeding), oversight of medical conditions, administration of medications, a meal, care coordination including referrals to rehabilitation or other services if needed, and recreation/social activities. A person may attend half or whole days, and from one to seven days a week, depending on the patient's capability, preferences, and available support system.

B. Relationship to Other Services

ADHC centers may provide transportation and individuals may receive this service, if needed, to enable their attendance at the center. An individual may receive ADHC services in conjunction with Personal Care or Respite Care services as needed.

C. Who May Receive the Service

An individual must meet the EDCD Waiver criteria to qualify for ADHC services.

M1440.203 CASE MANAGEMENT SERVICES

A. What is Case Management

Case Management services enable the continuous assessment, coordination and monitoring of the needs of the person that is HIV positive and symptomatic, or who has AIDS. Case Management services are viewed as an indirect service which enables the efficient and effective delivery of the other direct services included in the waiver. A patient may receive between 0 and 10 hours of Case Management services monthly.

B. Relationship to Other Services

AIDS Waiver patients may not be initially authorized to receive Case Management services alone. Case Management must be provided as an adjunct to the other direct waiver services. These other services are: personal care, nursing, nutritional supplements and respite care. An AIDS Waiver patient could, at some point after admission to the Waiver, be closed to a direct service and continue to receive Case Management.

C. Who May Receive the Service

An individual must meet the AIDS Waiver criteria to qualify for Case Management services.

M1440.204 PRIVATE DUTY NURSING SERVICES

A. What is Private Duty Nursing

Private Duty Nursing services are called "nursing services" in the *ID*/MR waiver. These services are offered to medically fragile patients who require substantial skilled nursing care. Patients receive nursing services from Registered Nurses or Licensed Practical Nurses. Services are offered as needed by the patient, but always exceed what is available through the Home Health program.

For example, in the Technology-Assisted waiver, most patients receive 8 hours or more of continuous nursing services at least four times per week. AIDS waiver patients usually need this service in lieu of home health services for monitoring the administration of potent intravenous drugs. *ID/*MR Waiver patients may need the service for either routine nursing or in lieu of Home Health nursing.

B. Relationship to Other Services

There are no requirements that other waiver services be or not be received.

C. Who May Receive the Service

An individual must meet the AIDS waiver criteria, Technology-Assisted waiver criteria, or be eligible under the *ID/*MR waiver for nursing services. A Medicaid recipient who qualifies under EPSDT (Early & Periodic Screening, Diagnosis & Treatment) to receive private duty nursing services may also receive private duty nursing.

M1440.205 NUTRITIONAL SUPPLEMENTS

A. What are Nutritional Supplements

Studies have indicated that the nutrition of a person with AIDS or HIV+ is one of the most important factors in maintaining their health and avoiding costly health care. Nutritional Supplements (enteral nutrition products) are provided through DME (durable medical equipment) providers for patients in the AIDS or Technology-Assisted waiver who have an identified nutritional risk. Nutritional supplements are ordered by the individual's physician to cover a six-month period and Medicaid payment is authorized by the pre-admission screener or DMAS.

B. Relationship to Other Services There are no requirements that other waiver services be or not be received.

C. Who May Receive the Service Individuals who qualify under the AIDS or Technology-Assisted waiver may receive nutritional supplements.

M1440.206 ENVIRONMENTAL MODIFICATIONS

A. What is Environmental Modification Environmental modification provides physical adaptations or modifications to the recipient's house or place of residence, work site or vehicle. The adaptations or modifications are needed to ensure the recipient's health or safety and enable him/her to live and function in a non-institutional setting.

B. Relationship to Other Services This service is available to patients who are receiving at least one other waiver service along with Case Management services.

C. Who May Receive the Service The service is available to individuals who qualify under the *ID/*MR waiver.

M1440.207 RESIDENTIAL SUPPORT SERVICES

A. What is Residential Support Residential Support services consist of training, assistance, and/or specialized supervision provided primarily in a recipient's home or in a licensed/certified residence considered to be his or her home. This cannot include room and board costs.

These services can be provided in the individual's own home or in a licensed Adult Care Residence or with a certified Foster Care/Family Care provider. The services may be provided by the ACR, the foster family or by an external provider.

B. Relationship to Other Services This service cannot be offered to an individual who receives assisted living services in an ACR.

C. Who May Receive the Service This service is available to *ID/*MR Waiver patients.

M1440.208 PERSONAL ASSISTANCE SERVICES

A. What is Personal Assistance Services Personal Assistance services are available to recipients who do not receive Residential Support services, and for whom training and skills development are not primary objectives or are received in another service or program. Assistance is provided with bathing, dressing, eating, personal hygiene, activities of daily living, medication and/or other medical needs, and monitoring health status and physical condition.

These services may be provided in residential and/or non-residential settings to enable the individual to maintain the health status and functional skills necessary to live in the community and/or participate in community activities.

B. Who May Receive the Service

Personal Assistance services cannot be offered to an individual who receives Assisted Living services in an Adult Care Residence. Personal Assistance services are available only to patients who are eligible under the *ID/*MR waiver.

M1440.209 ASSISTIVE TECHNOLOGY SERVICES

A. What is Assistive Technology

Assistive Technology (AT) is any device or environmental modification that increases the independence, safety or comfort of an individual.

AT ranges from simple devices such as a jar opener or eyeglasses to complex devices such as a voice synthesizer or a powered wheelchair.

B. Relationship to Other Services

This service is available only to persons who are receiving at least one other waiver service along with Case Management.

C. Who May Receive the Service

This service is provided only to recipients of the *ID/*MR Waiver.

This service may be provided in residential and/or non-residential settings.

M1440.210 DAY SUPPORT SERVICES

A. What is Day Support

Day Support services are provided primarily in non-residential settings, separate from the home or other community residence, to enable a person to acquire, improve, and maintain maximum functional abilities. This service includes a variety of training, support, and supervision. Prevocational training for patients who previously resided in a Medicaid-certified facility is included under this service.

B. Relationship to Other Services

This service is available only to persons who are receiving at least one other waiver service along with Case Management.

C. Who May Receive the Service

This service is available only to recipients of the DS and *ID/*MR waivers.

M1440.211 SUPPORTED EMPLOYMENT SERVICES

A. What is Supported Employment

Supported Employment is paid employment for persons with mental retardation for whom competitive employment at or above minimum wage is unlikely and who, because of the disability, need intensive ongoing

support, including supervision, training and transportation to perform in a work setting. Supported employment is conducted in a variety of community work sites where non-disabled persons are employed.

B. Relationship to Other Services This service is available only to recipients who are receiving at least one other waiver service along with Case Management.

C. Who May Receive the Service Supported Employment services are available only to recipients in the *ID/*MR waiver.

M1440.212 THERAPEUTIC CONSULTATION SERVICES

A. What is Therapeutic Consultation Therapeutic Consultation is consultation and technical assistance provided by members of psychology, behavioral analysis, therapeutic recreation, speech therapy, occupational therapy or physical therapy professions to the individual, parent/family members, and *ID/*MR Waiver service providers. These consultation services help the individual and his/her caregiver(s) to implement his/her individual plan of care.

B. Relationship to Other Services Behavioral Analysis may be provided in the absence of any other waiver service when the consultation given to informal caregivers is necessary to prevent institutionalization.

C. Who May Receive the Service Therapeutic Consultation services are available only to *ID/*MR Waiver recipients.

M1440.213 PERSONAL EMERGENCY RESPONSE SYSTEM (PERS)

A. What is PERS PERS is an electronic device that enables certain recipients who are at high risk of institutionalization to secure help in an emergency through the use of a two-way voice communication system that dials a 24-hour response or monitoring center upon activation and via the recipient's home telephone line. PERS may include medication monitoring to remind certain recipients at high risk of institutionalization to take their medications at the correct dosages and times.

B. Relationship to Other Services An individual may receive PERS services in conjunction with agency-directed or consumer-directed Personal Care or Respite Care services.

C. Who May Receive the Service PERS is available only to EDCD recipients who live alone or are alone for significant parts of the day, who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

M1440.214 PREVOCATIONAL SERVICES

A. What are Prevocational Services Prevocational Services are aimed at preparing an individual for paid or unpaid employment, but are not job-task oriented. Prevocational services are provided to individuals who are not expected to be able to join in the

general work force without supports or to participate in a transitional sheltered workshop within one year of beginning waiver services (excluding supported employment programs).

B. Relationship to Other Services

This service is available only to persons receiving Day Support Services.

C. Who May Receive the Service

This service is available only to recipients of the DS Waiver.

CHAPTER M14
LONG-TERM CARE
SUBCHAPTER 50

TRANSFER OF ASSETS

M1450 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	Table of Contents pages 4-8 pages 15, 16, 25, 26 pages 31-38 page 31a removed.
TN #95	3/1/11	pages 4, 24,32, 36, 37, 37a, pages 39, 42, 43
TN #94	9/1/10	Table of Contents pages 36-37a, 39-44
TN #93	1/1/10	Table of Contents pages 3, 17-18, 29 Appendix 2, page 1
TN #91	5/15/09	pages 41, 42

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M1450.000 TRANSFER OF ASSETS

M1450.001 OVERVIEW

A. Introduction

Individuals who are eligible for Medicaid may NOT be eligible for Medicaid payment of long-term *care (LTC)* services (facility or CBC) for a specific period of time (penalty period) if they or their spouses have transferred assets for less than fair market value without receiving adequate compensation. The asset transfer policy applies to all individuals in all types of long-term care.

B. Policy

The EW must evaluate an asset transfer according to the instructions found in the sections below. The applicable policy rules depend on

- when the transfer occurred;
- who transferred the asset;
- to whom the asset was transferred;
- what was transferred.

Information must be obtained from all Medicaid applicants *and recipients who require LTC services* about transfers of both income and resources that occurred during the **five years** before the Medicaid application date. Whether the transfer will affect LTC services eligibility depends on:

- the date the transfer occurred,
- to whom the asset was transferred,
- the type of asset that was transferred,
- the reason for the transfer,
- the value of the transferred asset
- the amount of compensation received.

M1420.002 LEGAL BASE

A. Public Law 96-611

This federal law established a transfer of property eligibility rule for the SSI program and also permitted states to adopt a transfer eligibility rule for their Medicaid programs which could be, in certain respects, more restrictive than in SSI or the money payment programs. The rule adopted by Virginia was more restrictive than the SSI rule.

B. Public Law 100-360

Public law 100-360 (The Medicare Catastrophic Coverage Act), enacted on July 1, 1988, changed the federal Medicaid law relating to property transfers. Further revisions were made by the Family Support Act of 1988 (Welfare Reform) Public Law 100-485, enacted on October 13, 1988.

C. Public Law 103-66 (OBRA)

Section 13611 of this federal law, enacted on August 10, 1993, revised transfer provisions for the Medicaid Program. It amended section 1917 of the Social Security Act by incorporating in section 1917 new requirements for asset transfers and for trusts.

D. Public Law 109-171 (DRA)

The Deficit Reduction Act (DRA) of 2005, enacted on February 8, 2006, further revised asset transfer provisions for the Medicaid program.

E. The Code of Virginia

Virginia state law governing the Department of Medical Assistance Services (DMAS) and the Medicaid program in Virginia is contained in sections 32.1-323 through 32.1-330. It includes a definition of assets, and it states that an asset transfer includes a disclaimer of interest(s) in assets.

Section 20-88.01 empowers DMAS to request a court order requiring the transferees of property to reimburse Medicaid for expenses Medicaid paid on behalf of recipients who transferred property.

M1450.003 DEFINITION OF TERMS

A. Adequate Compensation

For purposes of asset transfer, an individual is considered to have received "adequate compensation" for an asset when the fair market value of the asset or greater has been received.

***B.* Assets**

For the purposes of asset transfer, assets are all income and resources of the individual and the individual's spouse, including *any* income and resources to which *the* individual *or the spouse* is entitled but does not receive because of an action by:

- the individual or the spouse,
- any person, including a court or administrative body, with legal authority to act in the place of or on behalf of the individual or spouse, or
- a person, including a court or administrative body, acting at the direction or request of the individual or spouse.

The term "asset" may also include:

- life estate (life rights) in another individual's home, and
- the funds used to purchase a promissory note, loan, or mortgage.

***C.* Asset Transfer**

An **asset transfer** is any action by an individual or other person that reduces or eliminates the individual's ownership or control of an asset(s). Transfers include:

- giving away or selling property
- disclaiming an inheritance or not asserting inheritance rights in court
- clauses in trusts that stop payments to the individual
- putting money in a trust
- payments from a trust for a purpose other than benefit of the individual
- irrevocably waiving pension income
- not accepting or accessing injury settlements
- giving away income during the month it is received
- refusing to take legal action to obtain a court-ordered payment that is not being paid, such as alimony or child support
- placement of lien or judgment against individual's property when not an "arm's length" transaction (see below)
- other similar actions.

When the placement of a lien or a judgment against an individual's asset is not an "arm's length" transaction, it is an uncompensated transfer of assets. An arm's length transaction, as defined by Black's Law Dictionary, is a transaction negotiated by **unrelated** parties, each acting in his or her own self interest. When an individual's relative has a lien or judgment against the individual's property, the lien or judgment is an asset transfer that must be evaluated.

D. Baseline Date

The **baseline date** is the first date as of which the individual was both

- an institutionalized individual (as defined below) AND
- a Virginia Medicaid applicant.

When an individual is already a Medicaid recipient and becomes institutionalized, the baseline date is the first day of institutionalization.

E. Fair Market Value

Fair market value (FMV) is an estimate of an asset's value if it were sold at the prevailing price at the time it was actually transferred. Value is based on criteria used in determining the value of assets for the purpose of determining Medicaid eligibility.

NOTE: For an asset to be considered transferred for fair market value, or to be considered to be transferred for valuable consideration, the compensation received for the asset must be in tangible form with intrinsic value. A transfer for love and affection is not considered a transfer for fair market value.

Also, while relatives and family members legitimately can be paid for care they provide to the individual, it is presumed that services provided for free at the time were intended to be provided without compensation. Thus, a transfer to a relative for care provided for free in the past is a transfer of assets for less than fair market value. However, an individual can rebut this presumption with tangible evidence that is acceptable. For example, the individual proves that a payback arrangement had been agreed to in writing at the time services were provided.

F. Income

Any monies received by an individual or the individual's spouse to meet the individual's basic needs for food or shelter, is **income**. See subchapter M1460 for items that are not income.

G. Institutionalized Individual

For the purposes of asset transfer, an **institutionalized individual** is:

- a person who is an inpatient in a nursing facility;
- a person who is an inpatient in a medical institution and for whom payment for care is based on a level of care provided in a nursing facility. Included are persons in long-stay hospitals (including rehabilitation hospitals and rehabilitation units of general hospitals) and patients in Virginia *Department of Behavioral Health and Developmental Services (DBHDS)* facilities who

are housed in an area certified as a nursing facility or intermediate care facility for the mentally retarded; or

- a Medicaid applicant/enrollee who has been screened and approved for or is receiving Medicaid community-based care (CBC) waiver services, services through the Program of All Inclusive Care for the Elderly (PACE) or hospice services.

H. Legally Binding Contract

Virginia law requires written contracts for the sale of goods (not services) valued over $500, and for transactions involving real estate. Contracts for services may be oral.

To prove a contract is **legally binding**, the individual must show:

1. Parties Legally Competent

The parties to the contract were legally competent to enter into the contract. (Generally, this excludes (1) individuals declared to have mental incapacity or a diminished mental capacity and (2) children less than 18 years of age, who may not enter into a contract under Virginia law. The purpose here is to ensure that both parties knew what they were doing when they entered into the contract).

2. Valuable Consideration

"Valuable consideration" is received by each party when the "adequate compensation" requirement for the asset transfer rule is met.

3. Definite Contract Terms

Contract terms are sufficiently definite so that the contract is not void because of vagueness. Payments under contracts with immediate family members must be at reasonable rates. Those rates must be discernable from the terms of the contract. For example, it is not sufficient for a mother to agree to give her son all the stocks she owns upon her death in exchange for his agreeing to take care of her for an undefined period of time (such a contract might have to be written, depending on the value). The contract must set forth the per diem rate, specify a time period, or in some other manner establish definable and certain terms.

4. Mutual Assent

Contract terms were agreed to by mutual assent. Confirm that both parties understood and agreed upon the same specific terms of the contract when they entered into the contract.

I. Look-Back Date

The **look-back date** is the date that is 60 months before the first date the individual is both (a) an institutionalized individual and (b) has applied for Medicaid. The **look-back date** is the earliest date on which a penalty for transferring assets for less than fair market value can be imposed. Penalties can be imposed for transfers that take place on or after the look-back date. Penalties cannot be imposed for transfers that take place before the look-back date.

J. Look-back Period

The **look-back period** is the period of time that begins with the look-back date and ends with the baseline date. The look-back period is 60 months.

K. Other Person

Other person means:

- the individual's spouse or co-owner of an asset;
- a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; and
- a person, including a court or administrative body, acting at the direction, or upon the request, of the individual or the individual's spouse.

L. Payment Foreclosed

Payment to any individual from an irrevocable trust that is not for the benefit of the individual for whom the trust was created is an uncompensated transfer of assets. See M1140.404 B. 4. c. for information regarding when a trust is foreclosed.

M. Penalty Period

The **penalty period** is the period of time during which Medicaid payment for LTC services is denied because of a transfer of assets for less than market value. The length of the penalty period is based on the value of the uncompensated transfer of assets and the average cost of nursing facility care in Virginia.

N. Property/ Resources

"Property" and "resources" both refer to real and personal property legally available to the individual or the individual's spouse.

O. Uncompensated Value

The uncompensated value is the amount of an asset's fair market value that was not or will not be received as a result of the asset transfer.

The uncompensated value for **real property** at the time of transfer is:

- the difference between the asset's FMV and the Gross Amount Due to Seller, when the lien/other encumbrance against the asset is satisfied from the seller's proceeds, or
- the difference between the asset's equity value (FMV minus the lien) and the Gross Amount Due to Seller, when the lien is assumed by the buyer. Refer to examples in M1450.610 H.

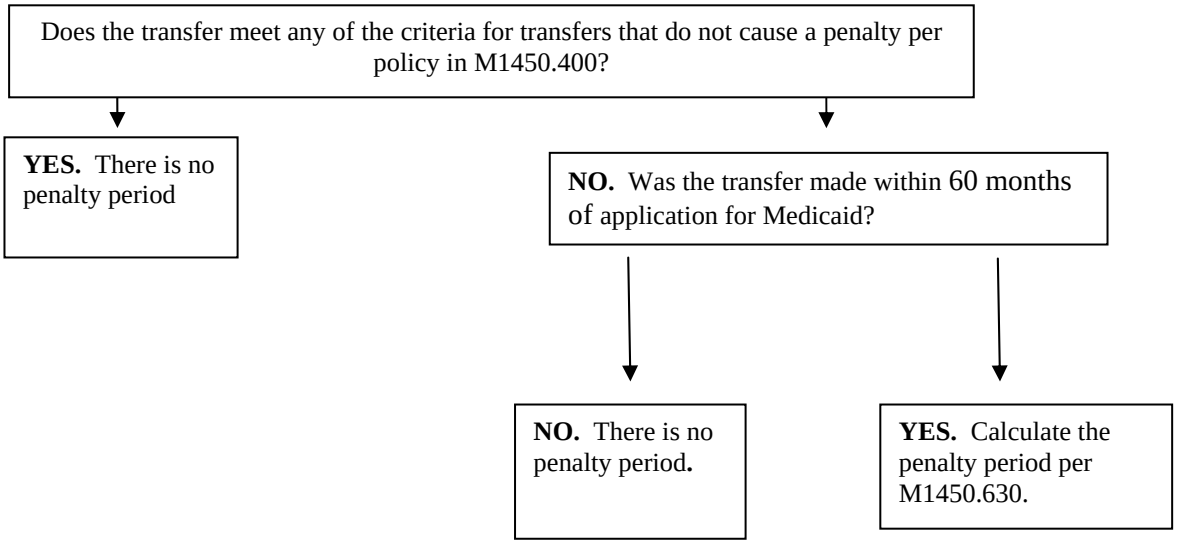
P. Undue Hardship

An undue hardship exists when the imposition of a penalty period would deprive the individual of medical care such that his health or his life would be endangered or be deprived of food, clothing, shelter, or other necessities of life.

M1450.004 TRANSFER OF ASSETS FLOW CHART

The flow chart below illustrates when an asset transfer penalty period is required.

Transfer of Assets Flow Chart



M1450.100 *RESERVED*

M1450.200 *POLICY PRINCIPLES*

A. Policy

An institutionalized individual who transfers (or has transferred), or whose spouse transfers or has transferred, an asset in ways not allowed by policy is not eligible for Medicaid payment of long-term care services. The DRA established new policy for evaluating transfers made on or after February 8, 2006. The look-back period for all transfers is 60 months; there is no distinction between transfers involving trusts and other transfers.

B. Procedures

When a Medicaid enrollee is institutionalized, review the individual's eligibility to determine if an asset transfer occurred within the 60 months prior to institutionalization. When a Medicaid applicant reports an asset transfer, or the worker discovers a transfer, determine if the transfer occurred within 60 months prior to the month in which the individual is both institutionalized and a Medicaid applicant/enrollee.

1. All Transfers

Determine if any assets of the individual or the individual's spouse were transferred during the 60 months (the "look-back period") prior to the first date on which the individual was both an institutionalized individual and a Medicaid applicant/enrollee.

2. Determine Effect

If an asset was transferred during the look-back periods specified above, determine if the transfer affects eligibility for LTC services' payment, using sections M1450.520 through M1450.550 below.

If the transfer affects eligibility and was for less than market value, determine the uncompensated value (M1450.610) and establish a penalty period (period of ineligibility for Medicaid payment of LTC services, M1450.630).

M1450.300 ASSETS THAT ARE NOT RESOURCES FOR TRANSFER RULE

A. Policy

The assets listed in this section are NOT resources for asset transfer purposes. Therefore, the transfer of any of the assets listed in this section does NOT affect eligibility for Medicaid payment of LTC services.

B. Personal Effects and Household Items

A transfer of personal effects or household items does not affect eligibility.

C. Certain Vehicles

The transfer of a vehicle that meets the following requirements does not affect Medicaid payment for LTC services:

- a vehicle used by the applicant/enrollee to obtain medical treatment.
- a vehicle used by the applicant/enrollee for employment.
- a vehicle especially equipped for a disabled applicant or enrollee.
- a vehicle necessary because of climate, terrain, distance, or similar factors to provide necessary transportation to perform essential daily activities.

If the vehicle was not used as provided above at the time of transfer, $4,500 of the trade-in value of the vehicle used for basic transportation is excluded. Any value in excess of $4,500 must be evaluated as an asset transfer.

D. Property Essential to Self Support

The transfer of property essential to the institutionalized individual's self-support (tools, equipment, etc. used by the individual to produce income), including up to $6,000 equity in income-producing real property(ies) owned by the applicant/recipient, does not affect eligibility for LTC services' payment.

To be income-producing, the property(ies) must usually have a net annual return that is:

- 6% of the equity, if the equity is $6,000 or less or
- $360 if the equity is more than $6,000.

If an unusual circumstance caused a temporary reduction in the net annual return and the net annual return is expected to meet the requirements the following year, the property is still considered income-producing.

E. Resources Under PASS

Transfer of resources specifically designated for a disabled or blind SSI recipient's plan of self-support (PASS), as determined by SSI, does not affect eligibility for LTC services' payment.

F. Certain Life Insurance

Transfer of term or group insurance that has no cash value, or transfer of life insurance with a total face value of $1,500 or less (total of all policies) on an individual, does not affect eligibility for LTC services' payment. Life insurance includes policies that presently do not have a cash value but will have a cash value in the future.

G. Certain Cash and In-kind Items

Transfer of cash or in-kind items received to replace/repair lost, damaged, or stolen exempted resources (see M1130.630) does not affect eligibility for LTC services' payment.

H. Burial Spaces or Plots

Transfer of burial spaces or plots held for the use of the individual, the individual's spouse, or the individual's immediate family does not affect eligibility for LTC services' payment.

I. Excluded Burial Funds

Transfer of up to $1,500 in resources excluded under the burial fund exclusion policy does not affect eligibility for LTC services' payment.

J. Cash to Purchase Medical/Social Services

Transfer of cash received from a governmental or nongovernmental program to purchase medical care or social services does not affect eligibility for LTC services' payment IF the cash was transferred in the receipt month or the month following the receipt month.

K. Alaskan Natives' Stock

Transfer of certain shares of stock held by Alaskan natives does not affect eligibility for LTC services' payment.

L. Other Assets That Are Not Resources

The transfer of the following resources, **if they have been kept separate from other resources**, do not affect eligibility for LTC services' payment:

- Payments from the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

- Payments from sections 25-239, 25-240, and 25-241 of the Code of Virginia for relocation assistance.
- Payments from sections 404(g) and 418 of the Domestic Volunteer Service Act of 1973.
- Retroactive Supplemental Security Income and/or retroactive Social Security payments for *nine (9)* months after the month of receipt of the payment(s).
- Retained disaster assistance.

M1450.400 TRANSFERS THAT DO NOT AFFECT ELIGIBILITY

A. Policy

An asset transfer does NOT affect eligibility for Medicaid payment of LTC services if the transfer meets the following criteria:

- *the transfer(s) of assets was made for reasons exclusive of becoming or remaining eligible for Medicaid payment of LTC services (M1450.400 B),*
- *the individual received adequate compensation for the asset(s), or*
- *the asset transfer meets the criteria in either section B, C or D below.*

If the transfer **does not** meet the criteria in this section, see section 1450.500 below to evaluate the asset transfer.

B. Reason Exclusive of Becoming or Remaining Medicaid Eligible

*Asset transfers do not affect eligibility if they were made for reasons **exclusive** of becoming or remaining eligible for Medicaid payment of LTC services.*

1. Evidence Required

The individual must provide convincing and objective evidence showing that the individual or spouse had no reason to believe that Medicaid payment of LTC services might be needed. The sudden loss of income or assets, the sudden onset of a disabling condition or personal injury may provide convincing evidence.

A subjective statement of intent or ignorance of the asset transfer provision is not sufficient. The individual must provide evidence that other assets were available at the time of transfer to meet current and expected needs of that individual, including the cost of nursing home or other medical institutional care.

2. Making an Asset Unavailable

A Medicaid applicant/recipient shall not directly or indirectly make an asset unavailable by any means or persons, which is unlawful and contrary to Medicaid statutes, regulations and policy. Any such transactions will be considered to have been made with the intent of becoming or remaining eligible for Medicaid payment of LTC services and will be regarded as uncompensated transfer of assets.

C. **Home Property Transferred to Certain Individuals**

Transfer of the individual's home, whether it was excluded or not excluded at the time of transfer, does NOT affect eligibility for LTC services' payment when the home property is transferred to one or more of the individuals listed below.

1. Spouse, Minor Child, Disabled/Blind Child

The transfer of the home property does not affect eligibility when transferred to the individual's

- spouse,
- child(ren) under age 21 years, or
- child(ren) of any age who is blind or disabled as defined by SSI or Medicaid.

2. Sibling

The transfer of the home property does not affect eligibility when transferred to the individual's sibling or half-sibling (not step-sibling) who:

- has an equity interest in the home, and
- who resided in the individual's home for at least one year immediately before the date the individual became an institutionalized individual.

3. Adult Child

The transfer of the home property does not affect eligibility when transferred to the individual's son or daughter (not including step-child) who resided in the home for at least two years immediately before the date the individual became an institutionalized individual, and *all of* the criteria listed in items a. through d. below *are met.*

a. Provided Care for 2 Years

The individual's son or daughter must have been providing care to the individual during the entire two-year period which permitted the individual to reside at home rather than in a medical institution or nursing facility.

b. Physician's Statement

The individual or his/her representative must provide a statement from his/her treating physician which states

- the individual's physical and/or mental condition during this two-year period,
- why the individual needed personal and/or home health care during this period, and
- the specific personal/home health care service needs of the individual.

c. Statement of Services Provided

The son or daughter must provide a statement showing:

1) the specific services and care he/she provided to the individual during the entire two years;

2) how many hours per day he/she provided the service or care;

3) whether he/she worked outside the home or worked from the home during this period; how the individual's needs were taken care of while he/she worked; and

4) if the son or daughter paid someone to actually give the care to the individual, who was paid, the rate of pay, the specific services, and the length of time the services were provided.

d. Third Party Statement

The individual or his/her representative must provide an objective statement from a third party(ies) who had knowledge of the individual's condition and his/her living and care arrangements during this period which corroborates the son or daughter's statement. The statement must specify the care/services the son or daughter provided and who cared for the individual when the son or daughter was not at home.

***D.* Transfer to Certain Individuals or Trusts**

Transfer of any asset

- to the individual's spouse or to another person for the sole benefit of the individual's spouse;
- to another individual by the spouse for the sole benefit of the spouse;
- to the individual's child under 21 or child of any age who is blind or disabled as defined by SSI or Medicaid;
- to a trust that is established solely for the benefit of the individual's
  1) child under age 21, or
  2) child of any age who is blind or disabled as defined by SSI or Medicaid when the trust meets the conditions in M1120.202;
- to a trust established solely for the benefit of an individual under 65 who is disabled as defined by SSI or Medicaid, when the trust meets the conditions in M1120.202;

does not affect eligibility for Medicaid payment of LTC services.

1. For the Sole Benefit of Spouse, Blind/disabled Child, or Disabled Individual

A transfer is for the sole benefit of a spouse, blind or disabled child or a disabled individual if the transfer is arranged in such a way that no individual or entity except the spouse, blind or disabled child or a disabled individual can benefit from the assets transferred in any way, whether at the time of transfer or at any time in the future. Similarly, a trust is established for the sole benefit of a spouse, blind or disabled child or a disabled individual if no one but the spouse, blind or disabled child or disabled individual can benefit from the assets in the trust, whether at the time of transfer or at any time in the future.

In order to be for the sole benefit of one of these individuals, the instrument or document must provide for the spending of the trust funds for the benefit of the individual that is actuarially sound based on the life expectancy of the individual involved. When the instrument or document does not so provide, any potential exemption from penalty or consideration for eligibility purposes is void. Exception: trusts established for disabled individuals, as described in M1120.202.

However, the trust may provide for reasonable compensation for a trustee(s) to manage the trust, as well as for reasonable costs associated with investing or otherwise managing the funds or property in the trust. In defining what is reasonable compensation, consider the amount of time and effort involved in managing a trust of the size involved, as well as the prevailing rate of compensation, if any, for managing a trust of similar size and complexity.

2. Not for the Sole Benefit of Spouse, Blind/disabled Child, or Disabled Individual

A transfer, transfer instrument, or trust that provides for funds or property to pass to a beneficiary who is NOT the spouse, a blind or disabled child or a disabled individual, is NOT considered established for the sole benefit of one of these individuals. Thus, the establishment of such a trust is a transfer of assets that affects eligibility for Medicaid payment of LTC services.

3. Trusts for Disabled Individuals Under Which the State Is Beneficiary

Trusts established for disabled individuals, as described in M1120.202, do not have to provide for an actuarially sound spending of the trust funds for the benefit of the individual involved. However, under these trusts, the trust instrument must provide that any funds remaining in the trust upon the death of the individual must go to the state, up to the amount of Medicaid benefits paid on the individual's behalf.

The trust does not have to provide for an actuarially sound spending of the trust funds for the benefit of the individual involved when:

- the trust instrument designates the state as the recipient of funds from the trust, and
- the trust requirements in M1120.202 require that the trust be for the sole benefit of an individual.

The trust may also provide for disbursal of funds to other beneficiaries provided that the trust does not permit such disbursals until the state's claim is satisfied. "Pooled" trusts may provide that the trust can retain a certain percentage of the funds in the trust account upon the death of the beneficiary.

4. Cross-reference

If the trust is not for the sole benefit of the individual's spouse, blind or disabled child or a disabled individual, and it does not meet the criteria in item 3 above, go to M1450.540 below to determine if the transfer of assets into the trust affects Medicaid payment for LTC services.

NOTE: Evaluate the trust to determine if it is a resource. See M1120.200, M1120.201 and M1120.202.

E. Other Asset Transfers

For asset transfers other than those described in sections M1450.400 B and C, the transfer does not affect eligibility for Medicaid payment of LTC services if the individual shows that he intended to receive or received adequate compensation for the asset. To show intent to receive adequate compensation, the individual must provide objective evidence according to items 1 through 3 below, and provide evidence that the transfer was made for reasons exclusive of becoming or remaining eligible for Medicaid payment of LTC services.

1. Evidence of Reasonable Effort to Sell

The individual must provide objective evidence for real property that he/she made an initial and continuing reasonable effort to sell the property. See M1130.140.

2. Evidence of Legally Binding Contract

The individual must provide objective evidence that he/she made a legally binding contract (as defined in M1450.003 above) that provided for his/her receipt of adequate compensation in a specified form (goods, services, money, etc.) in exchange for the transferred asset.

If the goods received include term life insurance, see M1450.510 below.

3. Irrevocable Burial Trust

The individual must provide objective evidence that the asset was transferred into an irrevocable burial trust. The trust is NOT compensation for the transferred money unless the individual provides objective evidence that all the funds in the trust will be used to pay for identifiable funeral services.

Objective evidence is the contract with the funeral home which lists funeral items and services and the price of each, when the total price of all items and services equals the amount of funds in the irrevocable burial trust.

NOTE: Evaluate the trust to determine if it is a resource. See M1120.200, M1120.201 and M1120.202.

F. Post-Eligibility Transfers by the Community Spouse

Post-eligibility transfers of resources owned by the community spouse (institutionalized spouse has no ownership interest) do not affect the institutionalized spouse's continued eligibility for Medicaid payment of LTC services.

Exception: The purchase of annuity by the community spouse on or after February 8, 2006 may be treated as an uncompensated transfer. See G. below.

G. Purchase of an Annuity by Community Spouse

For applications made on or after July 1, 2006, an annuity purchased by the community spouse on or after February 8, 2006, will be treated as an uncompensated transfer unless:

- the state is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant; or
- the state is named the remainder beneficiary in the second position after the community spouse or minor or disabled child. *If the spouse or the representative of a minor or disabled child disposes of any remainder for less than fair market value, the state must be named in the first position.*

H. Transfers Made on or After February 8, 2006 with Cumulative Value Less Than or Equal to $4,000

The policy in this subsection applies to *actions taken on* applications, *renewals or changes* on or after July 1, 2006 for transfers made on or after February 8, 2006.

Asset transfers made on or after February 8, 2006 that have a total cumulative value of less than or equal to $1,000 per calendar year will not be considered

a transfer for less than fair market value and no penalty period will be calculated.

Assets transferred on or after February 8, 2006, that have a total cumulative value of more than $1,000 but less than or equal to $4,000 per calendar year may not be considered a transfer for less than fair market value if documentation is provided that such transfers follow a pattern that existed for at least three years prior to applying for Medicaid payment of LTC services. Christmas gifts, birthday gifts, graduation gifts, wedding gifts, etc. meet the criteria for following a pattern that existed prior to applying for Medicaid payment of LTC services.

I. LTC Partnership Policy

The value of assets transferred that were disregarded as a result of an LTC Partnership Policy does not affect an individual's eligibility for Medicaid payment of LTC services. See M1460.160 for more information about LTC Partnership Policies.

J. Return of Asset

The transfer of an asset for less than fair market value does not affect eligibility for Medicaid LTC services' payment if the asset has been returned to the individual.

K. Home Foreclosure

The repossession and/or sale of a home by the mortgage lender for less than fair market value due to foreclosure is not evaluated as an uncompensated transfer. Documentation of the foreclosure must be retained in the case record.

L. Transfer of Income Tax Refund or Advance Payment Received After December 31, 2009 but Before January 1, 2013

Under Section 728 of the Tax Relief, Unemployment Insurance Reauthorization and Job Creation Act of 2010 (P.L. 111-312 , the transfer of an income tax refund or advance payment received after December 31, 2009 but Before January 1, 2013, to another individual or to a trust does NOT affect eligibility for Medicaid payment of LTC services. If the funds are given away or placed in a trust, other than a trust established for a disabled individual (see M1120.202), after the end of the exempt period, the transfer is subject to a transfer penalty or being counted under the Medicaid trust provisions, as applicable.

M1450.500 TRANSFERS THAT AFFECT ELIGIBILITY

A. Policy

If an asset transfer does not meet the criteria in sections M1450.300 or M1450.400, the transfer will be considered to have been completed for reasons of becoming or remaining eligible for Medicaid payment of LTC services, unless evidence has been provided to the contrary.

Asset transfers that affect eligibility for Medicaid LTC services payment include, but are not limited to, transfers of the following assets:

- cash, bank accounts, savings certificates,
- stocks or bonds,
- resources **over $1,500** that are excluded under the burial fund exclusion policy,
- cash value of life insurance when the total face values of all policies owned on an individual exceed $1,500
- interests in real property, including mineral rights,
- rights to inherited real or personal property or income**.**

B. Procedures

Use the following sections to evaluate an asset transfer:

- M1450.510 for a purchase of term life insurance.

- M1450.520 for a purchase of an annuity before February 8, 2006.
- M1450.530 for a purchase of an annuity on or after February 8, 2006.
- M1450.540 for promissory notes, loans, or mortgages.
- M1450.550 for a transfer of assets into or from a trust.
- M1450.560 for a transfer of income.

M1450.510 PURCHASE OF TERM LIFE INSURANCE

A. Policy

The purchase of any term life insurance after April 7, 1993, except term life insurance that funds a pre-need funeral under section 54.1-2820 of the Code of Virginia, is an uncompensated transfer for less than fair market value if the term insurance's benefit payable at death does not **equal or exceed twice the sum of all premiums paid for the policy.**

B. Procedures

1. Policy Funds Pre-need Funeral

Determine the purpose of the term insurance policy by reviewing the policy. If the policy language specifies that the death benefits shall be used to purchase burial space items or funeral services, then the purchase of the policy is a compensated transfer of funds and does not affect eligibility.

However, any benefits **paid** under such policy in excess of the actual funeral expenses are subject to recovery by the Department of Medical Assistance Services for Medicaid payments made on behalf of the deceased insured Medicaid enrollee.

2. Policy Funds Irrevocable Trust

Since **an irrevocable trust for burial is not a pre-need funeral**, the purchase of a term life insurance policy(ies) used to fund an irrevocable trust is an uncompensated transfer of assets for less than fair market value.

3. Determine If Transfer Is Uncompen-sated

When the term life insurance policy does not fund a pre-need funeral, determine if the purchase of the term insurance policy is an uncompensated transfer:

a. Determine the benefit payable at death. The face value of the policy is the "benefit payable at death."

b. From the insurance company, obtain the sum of all premium(s) paid on the policy; multiply this sum by 2. The result is "twice the premium."

c. Compare the result to the term insurance policy's face value.

1) If the term insurance's face value equals or exceeds the result (twice the premium), the purchase of the policy is a transfer for fair market value and does not affect eligibility.

2) If the term insurance's face value is less than the result (twice the premium), the purchase of the policy is an uncompensated transfer for less than fair market value. Determine a penalty period per M1450.620 or M1450.630 below.

EXAMPLE #1: Mr. C. uses $5,000 from his checking account to purchase a $5,000 face value term life insurance policy on August 13, 1995. Since the policy was purchased after April 7, 1993, and $5,000 (benefit payable on death) is not twice the $5,000 premium, the purchase is an uncompensated transfer. The uncompensated value and the penalty period for Medicaid payment of long-term care services must be determined.

M1450.520 PURCHASE OF ANNUITY BEFORE FEBRUARY 8, 2006

A. Introduction

An annuity is a sum paid yearly or at other specific times in return for the payment of a fixed sum. Annuities may be purchased by an individual or by an employer. For Medicaid purposes, an annuity is a contract reflecting payment to an insurance company, bank or other registered or licensed entity by which one receives fixed, non variable payments on an investment for a lifetime or a specified number of years.

Although usually purchased to provide a source of income for retirement, annuities are sometimes used to shelter assets so that the individuals purchasing them can become eligible for Medicaid. To avoid penalizing individuals who validly purchased annuities as part of a retirement plan, determine the ultimate purpose of the annuity, i.e., whether the annuity purchase is a transfer of assets for less than fair market value.

B. Policy

The following policy applies to annuities purchased before February 8, 2006. Determine if the annuity is a countable resource using the policy in M1140.260. If the expected return on the annuity is commensurate with a reasonable estimate of the beneficiary's life expectancy, the annuity is actuarially sound and its purchase is a transfer of assets for fair market value.

C. Procedures

1. Determine If Actuarially Sound

Determine if the annuity is actuarially sound. Use the Life Expectancy Table in M1450, Appendix 2:

a. Find the individual's age at the time the annuity was purchased in the "Age" column for the individual's gender ("Male" or "Female").

b. The corresponding number in the "Life Expectancy" column is the average number of years of expected life remaining for the individual.

c. Compare the life expectancy number to the life of the annuity (the period of time over which the annuity benefits will be paid).

d. When the average number of years of expected life remaining for the individual (the "life expectancy" number in the table) equals or exceeds the life of the annuity, the annuity is actuarially sound. When the annuity is actuarially sound, the purchase of the annuity is a compensated transfer for fair market value and does not affect eligibility.

e. When the average number of years of expected life remaining for the individual (the "life expectancy" number in the table) is less than the life of the annuity, the annuity is NOT actuarially sound. The annuity purchase is a transfer for less than fair market value. The transfer occurred at the time the annuity was purchased.

f. When the annuity is not actuarially sound, determine the uncompensated value and the penalty period (sections M1450.610 and M1450.620 below).

2. Example #2

EXAMPLE #2: A man at age 65 purchases a $10,000 annuity to be paid over the course of 10 years. His life expectancy according to the table is *15.52* years. Thus, the annuity is actuarially sound; the purchase of the annuity is a compensated transfer for fair market value and does not affect eligibility for LTC services payment.

3. Example #3

EXAMPLE #3: A man at age 80 purchases the same $10,000 annuity to be paid over the course of 10 years. His life expectancy according to the table is only *7.16* years. The annuity is not actuarially sound. The purchase of the annuity is a transfer for less than fair market value.

M1450.530 PURCHASE OF ANNUITY ON OR AFTER FEBRUARY 8, 2006

A. Introduction

The DRA established new policy for evaluating the purchase of an annuity as an asset transfer. The policy applies to annuities purchased on or after February 8, 2006. A significant change made under the DRA is that annuities purchased by either the institutionalized individual or the community spouse must be evaluated even after initial eligibility as an LTC recipient has been established. **The policy in this section applies to actions taken on applications, renewals and changes on or after July 1, 2006 for transfers made on or after February 8, 2006**.

B. Policy

All annuities purchased by an applicant/recipient or his spouse on or after February 8, 2006, must be declared on the Medicaid application or renewal form. In addition to determining if the annuity is a countable resource, the eligibility worker must evaluate the purchase of the annuity to determine if it is a compensated transfer.

The following rules apply to the purchase of an annuity:

1. Purchased by Institutionalized Individual or Community Spouse On/After Feb. 8, 2006

An annuity purchased by the institutionalized individual or the community spouse on or after February 8, 2006, will be treated as an uncompensated transfer unless:

- the state is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the institutionalized individual; or
- the state is named the remainder beneficiary in the second position after the community spouse or minor or disabled child. If the spouse or the representative of a minor or disabled child disposes of any remainder for less than fair market value, the state must be named in the first position.

2. Purchased by Institutionalized Individual On/After Feb. 8, 2006

An annuity purchased by the institutionalized individual on or after February 8, 2006, will be considered an uncompensated transfer unless:

a. the annuity is described in one of the following subsections of section 408 of the Internal Revenue Service (IRS) Code:

- individual retirement account,
- accounts established by employers and certain associations of employees,

- simple retirement accounts; or

a. the annuity is a simplified employee pension (within the meaning of section 408(k) of the IRS Code; or a Roth Individual Retirement Account (IRA); or

b. *the annuity is:*

- irrevocable and non-assignable;
- actuarially sound (see M1450.520 C.); and
- provides for equal payments with no deferral and no balloon payments.

3. Send Copy to DMAS

A copy of the annuity agreement must be sent to:

DMAS, Division of Policy and Research
Eligibility Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

4. Maintain Copy of Annuity

The copy must be maintained by DMAS until the terms of the annuity have expired. A copy of the annuity must also be maintained in agency's case record.

M1450.540 PURCHASE OF A PROMISSORY NOTE, LOAN, OR MORTGAGE ON OR AFTER FEBRUARY 8, 2006

A. Introduction

This policy applies to the purchase of a promissory note, loan, or mortgage on or after February 8, 2006. Subchapter S1140.300 contains explanations of promissory notes, loans, and mortgages.

B. Policy

Funds used to purchase a promissory note, loan, or mortgage on or after February 8, 2006, must be evaluated as an uncompensated transfer unless the note, loan, or mortgage:

- has a repayment term that is actuarially sound (see M1450.*520*),
- provides for payments to be made in equal amounts during the term of the loan with no deferral and no balloon payments, and
- prohibits the cancellation of the balance upon the death of the lender.

C. Uncompensated Amount

If the promissory note, loan, or mortgage does not meet the above criteria, the uncompensated amount is the outstanding balance as of the date of the individual's application for Medicaid.

Note: The countable value as a resource is the outstanding principal balance for the month in which a determination is being made.

M1450.545 TRANSFERS INVOLVING LIFE ESTATES

A. Introduction

This policy applies to the purchase of a life estate on or after February 8, 2006.

B. Policy

Funds used to purchase a life estate in another individual's home on or after February 8, 2006, must be evaluated as an uncompensated transfer unless the purchaser resides in the home for at least 12 consecutive months. If the purchaser resides in the home for less than 12 consecutive months, the entire purchase amount will be considered a transfer for less than fair market value.

For Medicaid purposes, the purchase of a life estate is said to have occurred when an individual acquires or retains a life estate as a result of a single purchase transaction or a series of financial and real estate transactions.

M1450.550 TRANSFERS INVOLVING TRUSTS

A. Introduction

A transfer of assets into or from a trust may be a transfer of assets for less than market value. See M1120.200 for trust resource policy, definitions pertaining to trusts, and for instructions for determining if the trust is a resource.

B. Revocable Trust

1. Transfer Into Revocable Trust

A transfer of assets **into** a revocable trust does not affect eligibility because the entire principal of a revocable trust is an available resource to the individual.

2. Payments From a Revocable Trust

Any payments from the revocable trust which are made to or for the benefit of the individual are counted as income to the individual and are not transfers for less than market value.

Any payments from the revocable trust's principal or income which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value.

3. Look-back Date

The look-back date is 60 months for assets transferred (payments made) **from** a revocable trust.

EXAMPLE #4: Mr. B established a revocable trust with a principal of $100,000 on March 1, 1994. He enters a nursing facility on November 15, 1997, and applies for Medicaid on February 15, 1998. The trustee has complete discretion in disbursing funds from the trust. Each month, the trustee disburses $100 to Mr. B and $500 to a property management firm for the upkeep of Mr. B's home. On June 14, 1994, the trustee gave $50,000 of the trust principal to Mr. B's brother.

The $100 and $500 payments are counted as income to Mr. B. Because the trust is revocable, the entire principal is a resource to Mr. B. Because the trustee gave $50,000 away, the countable value of the trust is the remaining $50,000. The transfer of the $50,000 to Mr. B's brother is a transfer for less than fair market value. The look-back date is February 15, 1993, which is 60 months prior to February 15, 1998, the date Mr. B was both in an institution and applied for Medicaid. The transfer occurred on June 14, 1994 which is after the look-back date. The uncompensated value is $50,000. The penalty

date is June 1, 1994, the first day of the month in which the transfer occurred. The penalty period is 19 months beginning June 1, 1994.

C. Irrevocable Trust

A transfer of funds **into** an irrevocable trust and a transfer of funds **from** an irrevocable trust MAY be asset transfers for less than fair market value, depending on whether the terms of the trust

- allow for payments to or for the benefit of the individual, OR
- do not allow for payments to or for the benefit of the individual.

1. When Payment to Individual Is Allowed

When the trust allows for circumstances under which payment can be made to or for the benefit of the individual from all or a portion of the trust,

1) the portion of the trust principal that could be paid to or for the benefit of the individual is a resource available to the individual;

2) income (produced by the trust principal), which could be paid to or for the benefit of the individual, is a resource available to the individual;

3) payments from the trust income or principal, which are made to or for the benefit of the individual, are counted as income to the individual;

4) payments from income or from the trust principal which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value.

a. Transfer Into Trust

A transfer of assets **into** an irrevocable trust that allows for payment to or for the benefit of the individual does NOT affect eligibility because the irrevocable trust is a resource to the individual.

b. Payments From Trust

Payments from income or from the trust principal which are made to or for the benefit of the individual are counted as income.

Payments from income or from the trust principal which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value.

The date the transfer occurs is the date that the payment to the individual was foreclosed (the date the payment was paid to another person not for the benefit of the individual).

c. Look-back Date When Payment to Individual Is Allowed

The look-back date is **36 months** for assets transferred from an irrevocable trust under which some payment can be made to or for the benefit of the individual.

EXAMPLE #5: Mr. C established an irrevocable trust with a principal of $100,000 on March 1, 1994. He enters a nursing facility on November 15, 1997, and applies for Medicaid on February 15, 1998. The trustee has discretion to disburse the entire principal of the trust and all income from the trust to anyone, including Mr. C, the grantor. Each month, the trustee

disburses $100 to Mr. C and $500 to a property management firm for the upkeep of Mr. C's home. On June 14, 1994, the trustee gave $50,000 of the trust principal to Mr. C's brother.

The $100 and $500 payments are counted as income to Mr. C. Because the trustee gave $50,000 away, the value of the trust is the remaining $50,000. The $50,000 principal is a resource to Mr. C since the trust allows circumstances under which payment of all the trust principal could be made to Mr. C. The transfer of the $50,000 to Mr. C's brother is a transfer for less than fair market value. The look-back date is February 15, 1995, which is 36 months prior to the baseline date February 15, 1998, the date Mr. C was both in an institution and applied for Medicaid. The transfer occurred on June 14, 1994 which is before the look-back date. No penalty due to this transfer can be imposed; the transfer does not affect eligibility for LTC services payment. Mr. C is not eligible for Medicaid because the $50,000 available trust resource exceeds the Medicaid resource limit.

2. When Payment to Individual Is NOT Allowed

When the trust **DOES NOT allow payment to or for the benefit of the individual** from all or a portion of the trust principal (or income on the trust principal), treat the trust as a transfer of assets for less than fair market value.

a. Transfer Into Trust

A transfer of assets **into** an irrevocable trust that does NOT allow payment to or for the benefit of the individual is a transfer of assets for less than fair market value that affects eligibility.

The date the transfer occurred is

- the date the trust was established.
- the date payment to the individual was foreclosed (the date the exculpatory clause came into effect that made the trust funds no longer payable to the individual), if later.

A transfer of additional funds into an irrevocable trust is a new asset transfer and must be evaluated separately from the asset transfer that established the trust. The date the new transfer occurred is the date the additional funds were placed in the irrevocable trust.

b. Payments From Trust

Payments from the trust cannot be made to or for the benefit of the individual, so any payments from the trust do not affect the individual's eligibility.

c. Look-back Date When Payment to Individual Not Allowed

When the trust states that payment cannot be made to the individual, the look-back date is 60 months before the baseline date.

EXAMPLE #6: Mr. D established an irrevocable trust with a principal of $100,000 on March 1, 1994. He enters a nursing facility on November 15, 1997, and applies for Medicaid on February 15, 1998. The trust does not allow the trustee to disburse any of the principal of the trust to or for the benefit of Mr. D. The trustee disburses $100 to Mr. D and $500 to a property management firm for the upkeep of Mr. D's home each month from the trust income. On June 14, 1994, the trustee gave $50,000 of the trust principal to Mr. D's brother. On July 2, 1996, Mr. D placed another $10,000 of his savings into the trust.

The $100 and $500 payments are counted as income to Mr. D. Because none of the principal can be disbursed to Mr. D, the entire value of the trust at the time the trust was established ($100,000 in 3-1-94) is a transfer of assets for less than fair market value. The look-back date is February 15, 1993, which is 60 months prior to the baseline date of February 15, 1998, the date Mr. D was both in an institution and applied for Medicaid. The transfer occurred on 3-1-94 which is after the look-back date. The uncompensated value is $100,000.

The 7-2-96 transfer of $10,000 into the trust is another asset transfer for less than fair market value that occurred on 7-2-96. The transfer occurred on 7-2-96 which is after the look-back date. The uncompensated value is $10,000.

D. Pooled Trusts

A pooled trust is a trust that can be established for a disabled individual under the authority of Section 1917(d)(4)(C) of the Social Security Act (see M1120.202). The placement of an individual's funds into a pooled trust when the individual is age 65 years or older must be evaluated as an uncompensated transfer, if the trust is structured such that the individual irrevocably gives up ownership of funds placed in the trusts.

A trust established for a disabled individual under age 65 years is exempt from the transfer of assets provisions. However, any funds placed in the trust after the individual turns 65 must be evaluated as an asset transfer.

M1450.560 INCOME TRANSFERS

A. Policy

Income is an asset. When an individual's income is given or assigned in some manner to another person, such gift or assignment may be a transfer of an asset for less than market value.

B. Procedures

Determine whether the individual has transferred lump sum payments actually received in a month. Such payments are counted as income in the month received for eligibility purposes, and are counted as resources in the following month if retained. Disposal of a lump sum payment before it can be counted as a resource could be an uncompensated asset transfer.

Attempt to determine whether amounts of regularly scheduled income or lump sum payments, which the individual would otherwise have received, have been transferred. Normally, such a transfer takes the form of transferring the right to receive income. For example, a private pension may be diverted to a trust and no longer be paid to the individual. Question the individual concerning sources of income, income levels in the past versus the present, direct questions about giving away income or assigning the right to receive income, to someone else, etc.

In determining whether income has been transferred, do not attempt to ascertain in detail the individual's spending habits during the look-back period. Absent a reason to believe otherwise, assume that the individual's income was legitimately spent on the normal costs of daily living.

When income or the right to income has been transferred, and none of the criteria in M1450.300 or M1450.400 are met, determine the uncompensated value of the transferred income (M1450.610) and determine a penalty period (M1450.620 or 630).

M1450.570 SERVICES CONTRACTS

A. Policy

Services contracts (i.e. personal care contract, care contracts, etc.) are typically entered into for the completion of tasks such as, but not limited to, grocery shopping, house keeping, financial management and cooking, that individuals no longer can perform for themselves. For purposes of Medicaid payment of LTC services, payments made under these types of contracts may be considered an uncompensated transfer of assets.

B. Procedures

When a services contract, sometimes referred to as a personal care contract, is presented as the basis for a transfer of assets, the eligibility worker must do the following:

1. Determine Institutionalization

Determine when the individual met the requirement for institutionalization.

2. Verify Contract Terms and Value of Services

Obtain a copy of the written contract, or written statements verifying the terms of the agreement by all parties. Determine when the agreement was entered into/signed, who entered into/signed the contract and if the contract is legally binding as defined by policy at M1450.003 H. The terms of the contract must include the types of services, *hourly* rate of payment and the number of hours for each service. *The hourly rate for the services must be the fair market value for such services at the time the services were provided*. The terms must be specific and verifiable. Verification of payments made and services provided must be obtained. Any payment for a service which does not have a fair market value is an uncompensated transfer.

3. Contract Services Must Be Received Before Admission to LTC

A contract for services may have been created prior to or after the individual's entrance into LTC. Once an individual begins receipt of Medicaid LTC services, the individual's personal and medical needs are considered to be met by the LTC provider. Payments to other individuals for services received after the individual enters LTC are considered an uncompensated transfer for Medicaid purposes.

4. Physician Statement Required

A statement must be provided by the individual's physician that indicates the types of services that were to be provided under the contract, and that these services were necessary to prevent the individual's entrance into LTC.

5. Contract Made By Individual or Authorized Representative

The contract must have been made by the applicant/recipient or his authorized representative.

6.	**Payments Prior To Contract Date**	Any payment(s) made prior to the date the contract was signed (if contract is written) or date the contract was agreed upon (if contract is a legally binding oral contract) by all parties is considered an uncompensated transfer.
7.	**Advance Lump Sum Payments Made To Contractor**	Certain contracts for services provide an advance lump sum payment to the person who is to perform the duties outlined in the contract. Any payment of funds for services that have not been performed is considered an uncompensated transfer of assets. The Medicaid applicant/recipient has not received adequate compensation, as he has yet to receive valuable consideration.
8.	**Determine Penalty Period**	If it is determined that an uncompensated transfer of assets occurred, follow policy in this subchapter to determine the penalty period.

M1450.600 *APPLYING A* PENALTY PERIOD

A. Introduction

When a transfer of assets was for less than fair market value, the individual is not eligible for Medicaid payment of LTC services for a specific period of time (penalty period) based on the uncompensated value of the transferred asset and the date the transfer occurred. However, if the individual meets all other Medicaid eligibility requirements, the individual is enrolled in Medicaid and is eligible for Medicaid payment of all other Medicaid-covered services.

The asset transfer precludes Medicaid payment for LTC services during the penalty period unless and until the individual receives adequate compensation in return for the transferred asset.

Penalty periods that are imposed cannot overlap or run concurrently. The total cumulative uncompensated value of the assets transferred is used to determine the length of the penalty period.

Once a penalty period begins it does not change or stop. The penalty period continues regardless of whether Medicaid eligibility continues, the institutionalized individual is discharged from LTC, or the individual changes from nursing facility care to community-based care. If the individual is re-admitted to LTC and the penalty period has not expired or ended, Medicaid payment for LTC services will continue to be denied for the remainder of the penalty period. **EXCEPTION:** The penalty period may be shortened if subsequent compensation is received (see M1450.640) or eliminated if an undue hardship is granted (see M1450.700).

B. Determination Procedures

Determine the uncompensated value using policy and procedures in M1450.610 below. Go to M1450. 630 to determine the penalty period.

If the individual subsequently receives compensation in return for the transferred asset, re-evaluate the penalty period using policy and procedures in M1450.640 below.

M1450.610 UNCOMPENSATED VALUE

A. Policy

The uncompensated value is the amount of an asset's fair market value (FMV) that was not or will not be received as a result of the asset transfer. FMV is based on criteria used in determining the value of assets in determining Medicaid eligibility.

The uncompensated value for **real property** at the time of transfer:

- is the difference between the asset's FMV and the Gross Amount Due to Seller, when the lien/other encumbrance against the asset is satisfied from the seller's proceeds, or
- the difference between the asset's equity value (FMV minus the lien) and the Gross Amount Due to Seller, when the lien is assumed by the buyer.

See M1450.610 H for the procedures for determining the uncompensated value of transferred real property.

Determine the uncompensated value of the transferred asset in this section and go to M1450.630 to determine the penalty period.

B. Term Life Insurance Purchase On or Before April 7, 1993

For term life insurance policies purchased on or before April 7, 1993, the purchase is a compensated transfer of assets and the purchase does not affect eligibility.

C. Term Life Insurance Purchase After April 7, 1993

For term life insurance policies purchased after April 7, 1993, the purchase is a transfer of assets for less than fair market value if the term insurance's face value is less than twice the sum of all premium(s) paid on the policy. The uncompensated value is the total premium(s) paid on the policy.

If more than one premium was paid on the policy, and the premiums were paid in different months, each premium paid on the policy is a separate transfer of assets for less than fair market value. A transfer occurred in the month each premium was paid.

EXAMPLE #7: Mr. C applied for Medicaid on November 2, 1996. On August 13, 1995, Mr. C. used $3,000 from his checking account to pay a $3,000 premium on a $5,000 face value term life insurance policy. On October 5, 1995, he used $2,000 from his checking account to pay up premiums on the same $5,000 face value term life insurance policy. Since the policy was purchased after April 7, 1993, and $5,000 (benefit payable on death) is not twice the $5,000 total premiums, the premium payments are transfers of assets for less than fair market value.

The uncompensated value of the first transfer on 8-13-95 is $3,000. The uncompensated value of the second transfer on 10-5-95 is $2,000. The penalty period for the first transfer is based on the $3,000 uncompensated value and the transfer date of August 1995. The penalty period for the second transfer is based on the $2,000 uncompensated value and the transfer date of October 1995.

D. Annuity Purchase

When the average number of years of expected life remaining for the individual (the “life expectancy” number in the table) *is less than* the life of the annuity, the annuity is NOT actuarially sound. The annuity purchase is a transfer for less than fair market value.

The transfer occurred at the time the annuity was purchased.

To determine the transferred asset's uncompensated value:

1. divide the face value of the annuity by the number of years in the life of the annuity.

2. the result is the yearly payout amount.

3. from the number of years in the life of the annuity, subtract the individual's life expectancy from table.

4. the result is the uncompensated payout years (number of the annuity's "payout" years that are uncompensated).

5. multiply the uncompensated payout years by the yearly payout amount.

6. the result is the uncompensated value of the assets transferred to purchase the annuity.

EXAMPLE #8: An 80-year old man uses $9,000 from his savings account on May 6, 1996, to purchase a $10,000 annuity to be paid over the course of 10 years. His life expectancy according to the table is only 6.98 years. The annuity is not actuarially sound. The purchase of the annuity is a transfer for less than fair market value.

The uncompensated value is determined:

$10,000 annuity value
÷ 10 years life of annuity
$1,000 yearly payout
10 years life of annuity
- 6.98 life expectancy
3.02 uncompensated payout years
x$1,000 yearly payout
$3,020 uncompensated value

The penalty period is based on the $3,020 uncompensated value and the transfer date of May 1996.

E. Funds From Revocable Trust

Any payments **from** a revocable trust's principal or income which are NOT made to or for the benefit of the individual are assets transferred for less than fair market value. The uncompensated value is the amount of the payment.

EXAMPLE #9: Mr. B established a revocable trust with a principal of $100,000 on March 1, 1994. Each month, the trustee disburses $100 to Mr. B and $500 to a property management firm for the upkeep of Mr. B's home. On June 14, 1994, the trustee gave $50,000 of the trust principal to Mr. B's brother.

The $100 and $500 payments are counted as income to Mr. B. The transfer of the $50,000 to Mr. B's brother is a transfer for less than fair market value. The uncompensated value is $50,000; the penalty period starts on June 1, 1994, the date the transfer occurred.

F. Irrevocable Trust

1. When Payment Is Allowed to Individual

When the irrevocable trust allows payments to the individual from all or a portion of the trust, any payments **from** the trust income or **from** the trust principal which are NOT made to or for the benefit of the individual are

assets transferred for less than fair market value. The uncompensated value is the amount of the payment.

EXAMPLE #10: Mr. C established an irrevocable trust with a principal of $100,000 on March 1, 1994. The trustee has discretion to disburse the entire principal of the trust and all income from the trust to anyone, including Mr. C, the grantor. All of the trust principal ($100,000) could be disbursed to Mr. C under the terms of the trust. Each month, the trustee disburses $100 to Mr. C and $500 to a property management firm for the upkeep of Mr. C's home. On June 14, 1994, the trustee gave $50,000 of the trust principal to Mr. C's brother.

The $100 and $500 payments are counted as income to Mr. C. The transfer of the $50,000 to Mr. C's brother is a transfer for less than fair market value. The transfer occurred in June 1994. The uncompensated value is $50,000.

2. When Payment Is Not Allowed to Individual

When the irrevocable trust does NOT allow payment to the individual from the trust, the transfer of funds into the trust is a transfer of assets for less than fair market value.

a. Trust Value

In determining the value of the trust which cannot be paid to the individual, do not subtract from the trust value any payments made for whatever purpose after the date the trust was established or, if later, the date payment to the individual was foreclosed. The value of the transferred amount is no less than its value on the date the trust is established or the date payment to the individual was foreclosed.

b. Uncompensated value

The uncompensated value is the amount of assets transferred into a trust which cannot be paid to the individual. If payment from the trust was foreclosed after the trust was established, the uncompensated value is the value of the trust as of the date payment was foreclosed.

c. Transfer Date

The date the transfer occurred is the date the trust was established, or, if later, the date payment to the individual was foreclosed.

d. Example #11

EXAMPLE #11: Mr. D established an irrevocable trust with a principal of $100,000 on March 1, 1994. The trust allowed the trustee to disburse any of the principal of the trust to or for the benefit of Mr. D until Mr. D is admitted to a nursing facility. Mr. D was admitted to a nursing facility on May 30, 1996. Each month from the trust income, the trustee disburses $100 to Mr. D and $500 to a property management firm for the upkeep of Mr. D's home. On June 14, 1996, the trustee gave $50,000 of the trust principal to Mr. D's brother. Mr. D applied for Medicaid on February 15, 1998.

The $100 and $500 payments are counted as income to Mr. D. Because none of the principal can be disbursed to Mr. D on or after the date he was admitted to the nursing facility, the value of the trust at the time payment was foreclosed ($100,000 on 5-30-96) is a transfer of assets for less than fair market value. The date the transfer occurred is May 30, 1996, the date payment to Mr. D was foreclosed. The look-back period is 60 months. The look-back date is February 15, 1993, which is 60 months prior to the baseline date of February 15, 1998, the date Mr. D was both in an institution and applied for Medicaid.

The uncompensated value is $100,000. The fact that $50,000 was paid out of the trust to Mr. D's brother after payment to Mr. D was foreclosed does not alter the uncompensated amount upon which the penalty is based because the value of the transferred asset can be no less than its value on the date payment from the trust was foreclosed.

Mr. D placed an additional $25,000 in the same trust on June 20, 1996. Under the terms of the trust, none of this $25,000 can be disbursed to him. This is a new transfer of assets for less than fair market value. The uncompensated value is $25,000; the transfer date is 6-20-96.

G. Income Transfers

1. Lump Sum Transfer

When a single lump sum, or single amounts of regularly paid income, is transferred for less than fair market value, the uncompensated value is the amount of the lump sum, less any compensation received. For example, an individual gives a $2,000 stock dividend check that is paid once a year to the individual, to another person in the month in which the individual received the check. No compensation was received. The uncompensated value is $2,000.

2. Stream of Income Transfer

When a stream of income (income received regularly) or the right to a stream of income is transferred, determine the total amount of income expected to be transferred during the individual's life, based on an actuarial projection of the individual's life expectancy. The uncompensated value is the amount of the projected income, less any compensation received. Use the Life Expectancy Table in M1450, Appendix 2.

3. Income Transfer Example

EXAMPLE #12: A man aged 65 years, assigns his right to a $500 monthly annuity payment to his brother. He receives no compensation in return. Based on the life expectancy tables for males, the uncompensated value of the transferred income is $*93,120*.

$ 500
x12 months
$6,000 yearly income
x*15.52* life expectancy from table
$*93,120* value
- 0 compensation
$*93,120* uncompensated value

H. Real Property Transfers

The uncompensated value of transferred real property is determined by evaluating the settlement document which outlines the monetary transactions between the individual who sells the property and the individual who buys the property. A copy of the Settlement Document is in **M1450, Appendix 3.**

The eligibility worker must obtain:

- documentation of the tax assessed value of the property at the time of the transfer; and
- a copy of the closing or settlement documents from the client or the financial institution.

1. Summary of Seller's Transactions

Review the summary of the seller's transactions:

- *Determine the Gross Amount Due to Seller.*
- *Is the Gross Amount Due to Seller less than the **tax assessed value**?*
  - *If **no**, the seller received adequate compensation for the property and there is **no** uncompensated transfer.*
  - *If **yes**, determine the uncompensated value of the asset transfer.*

2. Real Property Uncompensated Value Calculations

a. *When the lien is satisfied from the proceeds received by the seller, deduct the Gross Amount Due to Seller from the tax assessed value to determine the uncompensated amount of the asset transfer.*

b. *When the lien is assumed by the buyer, deduct the lien amount from the tax assessed value of the property, to determine the equity value. From the equity value deduct the Gross Amount Due to Seller for the property to determine the uncompensated amount of the asset transfer.*

c. *Determine the penalty period. The beginning of the penalty period depends upon whether the transfer took place prior to or on/after 2/08/2006.*

Note: *Any funds deducted from the Gross Amount Due to Seller that are paid to another individual, such as funds for repair of the property, are not considered usual and customary fees and must be evaluated as a separate asset transfer. If the transfer was uncompensated then the amount of this transfer may be added to any uncompensated value from the sale of property, as the transfer occurred at the same point in time.*

Example #13a: *Mrs. K. is receiving CBC services. The worker discovers that Mrs. K. has moved in with her daughter and has sold her home to her son. The tax assessed value of her home at the time of transfer was $200,000. The closing documents indicate that she sold her home for $125,000 (the gross amount due to seller). The closing costs were paid by Mrs. K. There was no lien against the property.*

The uncompensated value of the transferred real property is calculated as follows:

$200,000 tax assessed value
-125,000 Gross Amount Due to Seller
$ 75,000 uncompensated value

The penalty period is based on the uncompensated value of $75,000. The begin date of the penalty period depends on whether the transfer took place prior to or after February 8, 2006.

Example #13b: On October 20, Mr. B. was admitted to a nursing facility. He transferred his home in July of the same year, which was within the look-back period. His home was assessed at $100,000 in July. The mortgage against his home had a balance due of $16,000 in July.

In reviewing the settlement statement for the sale of the property, it is noted that the sale price of the home was $70,000 (gross amount due to seller), which was less than the tax assessed value of the home. The lien of $16,000 was satisfied at closing from the $70,000 sale price. The other fees deducted were usual and customary and were determined to have been paid by the buyer. Mr. B. received a $54,000 net settlement for the sale of his home.

The uncompensated value of the transferred real property is calculated as follows:

$100,000 tax assessed value
- 70,000 Gross Amount Due to Seller (includes the lien amount)
$ 30,000 uncompensated value

The penalty period is based on the uncompensated transfer value of $30,000. When the penalty period begins depends on whether the transfer took place prior to or after February 8, 2006.

Example #13c: The scenario is the same as in example 13b. However, the lien will be assumed by the purchaser rather than satisfied from the seller's gross settlement amount (Gross Amount Due to Seller). The equity value of the home is used to determine the uncompensated value in this case, because the seller was not responsible for satisfaction of the lien.

$100,000 tax assessed value
-16,000 lien amount
$ 84,000 equity value (EV)

$ 84,000 EV
- 70,000 Gross Amount Due to Seller
$ 14,000 uncompensated value

M1450.620 *RESERVED*

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M1450.630 PENALTY PERIOD *CALCULATION*

A. Policy

When a transfer of assets on or after February 8, 2006, affects eligibility, the penalty period begins when the individual would otherwise be eligible for Medicaid payment for LTC services if not for the penalty period. The penalty period includes the fractional portion of the month, rounded down to a day. Penalty periods for multiple transfers cannot overlap.

Individuals in a penalty period who meet all other Medicaid eligibility requirements may be eligible for Medicaid payment for all other Medicaid covered services.

B. Penalty Begin Date

For individuals not receiving LTC services at the time of transfer, the penalty period begins the first day of the month in which the individual would otherwise be eligible for Medicaid payment for LTC services, except for the imposition of a penalty period. This includes the application retroactive period for nursing facility patients who have been in the facility during the retroactive period.

For individuals who are receiving Medicaid payment for LTC services at the time of transfer, the penalty period begins the month following the month of transfer.

1. Medicaid LTC Not Received at Time of Transfer

If the individual is not receiving Medicaid-covered LTC services at the time of the asset transfer, the penalty period begins the first day of the month in which the individual would otherwise be eligible for Medicaid payment for LTC services but for the application of the penalty period, as long as the date does not fall into another period of ineligibility imposed for any reason.

2. Receiving Medicaid LTC Services at Time of Transfer

If the individual is receiving Medicaid LTC services at the time of the asset transfer, the penalty period begins the first day of the month following the month in which the asset transfer occurred. A referral to the DMAS Enrollee Audit Unit (RAU) must be made for the months in the penalty period during which the individual received Medicaid LTC services. See Chapter M17 for instructions on RAU referrals.

3. Penalty Periods Cannot Overlap

When multiple asset transfers result in multiple penalty periods, the penalty periods cannot overlap. One penalty period must be completed prior to the beginning of the next penalty period.

4. Nursing Facility

If the individual in a nursing facility meets all Medicaid eligibility requirements, he is eligible for Medicaid payment of all other covered services.

5. CBC, PACE, Hospice

If the individual has been screened and approved for or is receiving Medicaid CBC, PACE, or hospice services, he cannot be eligible for Medicaid in the 300% of SSI covered group or for the Medicaid payment of LTC services in any other covered group. The individual's Medicaid eligibility in other covered groups must be determined. His penalty period cannot be imposed unless and until he is (1) eligible for Medicaid in a covered group other than the 300% of SSI covered group, (2) he meets a spenddown and would otherwise be eligible for the Medicaid payment of LTC services, or (3) he is admitted to a nursing facility.

C. Penalty Period Calculation

The penalty period is the number of months, including any fractional portion of a month that an individual will be ineligible for the Medicaid payment of LTC services.

The period is calculated by taking the uncompensated value of the assets transferred on or after the look-back date, divided by the average monthly cost of nursing facility services to a private-pay patient in his locality at the time of the application for Medicaid. The remainder is divided by the daily rate (the monthly rate divided by 31).

When the uncompensated value of an asset transfer is less than the monthly nursing facility rate, go to step #4 in E below to calculate the partial month penalty period.

D. Average Monthly Nursing Facility Cost

Average Monthly Private Nursing Facility Cost*

Application Date	Northern Virginia	All Other Localities
10-1-96 to 9-30-97	$2,564	$2,564
10-1-97 to 12-31-99	$3,315	$2,585
01-01-00 to 12-31-00	$3,275	$2,596
01-01-01 to 12-31-01	$4,502	$3,376
01-01-02 to 12-31-03	$4,684	$3,517
01-01-04 to 9-30-07	$5,403	$4,060
10-1-07 to 12-31-10	$6,654	$4,954
01-01-11 and after	$7,734	$5,933

*Figures provided by Virginia Health Information.

See M1450, Appendix 1 for amounts prior to October 1, 1996.

E. Partial Month Transfer

The following example shows how to compute a penalty period for an uncompensated transfer that occurred on or after February 8, 2006 and involving a partial month.

Example #19: An individual makes an uncompensated asset transfer of $30,534 in April 2006, the same month he applies for Medicaid. The uncompensated value of $30,534 is divided by the average monthly rate of $4,060 and equals 7.52 months. The full 7-month penalty period runs from April 2006, the month of the transfer, through October 2006, with a partial penalty calculated for November 2006. The partial month penalty is calculated by dividing the partial month penalty amount ($2,114) by the daily rate. The calculations are as follows:

Step #1 $30,534.00 uncompensated value of transferred asset
÷ 4,060.00 avg. monthly nursing facility rate at time of application
= 7.52 penalty period (7 full months, plus a partial month)

Step #2 $ 4,060.00 avg. monthly nursing facility rate at time of application
X 7 seven-month penalty period
$28,420.00 penalty amount for seven full months

Step #3 $30,534.00 uncompensated value
- 28,420.00 penalty amount for seven full months
$ 2,114.00 partial month penalty amount

Step #4 $2,114.00 partial penalty amount
÷ 130.97 daily rate ($4,060 ÷ 31)
= 16.14 number of days for partial month penalty

For November 2006, the partial month penalty of 16 days would be added to the seven (7) month penalty period. The means that Medicaid would authorize payment for LTC services beginning November 17, 2006.

F. Penalty Period for a Couple When Both Are Eligible and Institutionalized

When an institutionalized individual is ineligible for Medicaid payment of long-term care services because of a transfer made by the spouse, and the spouse is or becomes institutionalized and eligible for Medicaid, the penalty period must be apportioned between the spouses. M1450.620 J. contains instructions for apportioning the penalty period.

M1450.640 SUBSEQUENT RECEIPT OF COMPENSATION

A. Policy

When all assets transferred are returned to the individual, no penalty for transferring assets can be assessed. When a penalty has been assessed and payment for services has been denied, a return of the assets requires a retroactive evaluation, including erasure of the penalty, back to the beginning of the penalty period.

However, such an evaluation does not necessarily mean that Medicaid payment for LTC services must be paid on behalf of the individual. Return of the assets in question to the individual leaves the individual with assets which must be evaluated in determining eligibility during the retroactive period. Counting those assets as available may result in the individual being ineligible (because of excess income or resources) at the time of evaluation as well as for a period of time after the assets are returned.

NOTE: To void imposition of a penalty, all of the assets in question or their fair market equivalent must be returned. For example, if the asset was sold by the individual who received it, the full market value of the asset must be returned to the transferor.

When only part of an asset or its equivalent value is returned, a penalty period can be modified but not eliminated. For example, if only half of the value of the asset is returned, the penalty period can be reduced to one-half.

B. Example #20 Full Compensation Received

Example #20 Mr. G., who is in a nursing facility, applied for Medicaid on November 24, 2004. On October 10, 2004, he transferred his non-home real property worth $30,000 to his son. The transfer did not meet any of the criteria in M1450.501, so a penalty period was imposed from October 1, 2004, through April 30, 2005.

On December 12, 2004, Mr. G.'s son paid medical bills for his father totaling $30,000. The agency re-evaluated the transfer and determined a penalty period was no longer appropriate since full compensation was received. Mr. G's eligibility for Medicaid payment of long-term care services was re-evaluated, beginning with October 1, 2004.

C. Example #21 Partial Compensation Received

Example #21: Ms. H. applied for Medicaid on November 2, 2004, after entering a nursing facility on March 15, 2004. On October 10, 2004, she transferred her non-home real property worth $40,000 to her son and received no compensation in return for the property. Ms. H's Medicaid application was approved, but she was ineligible for Medicaid payment of long-term care services for 9 months beginning October 1, 2004 and continuing through June 30, 2005.

On December 12, 2004, the agency verified that Ms. H's son paid her $20,000 for the property on December 8, 2004. The agency re-evaluated the transfer and determined a remaining uncompensated value of $20,000 and a penalty period of 4 months, beginning October 1, 2004, and continuing through January 31, 2005.

The $20,000 payment must be evaluated as a resource in determining Ms. H.'s Medicaid eligibility for January 2005.

M1450.700 CLAIM OF UNDUE HARDSHIP

A. Policy

The opportunity to claim an undue hardship must be given when the imposition of a penalty period affects Medicaid payment for LTC services. An undue hardship may exist when the imposition of a transfer of assets penalty period would deprive the individual of medical care such that the individual's health or life would be endangered or he would be deprived of food, clothing, shelter, or other necessities of life. An undue hardship may be granted when documentation is provided that shows:

- that the assets transferred cannot be recovered, and
- that the immediate adverse impact of the denial of Medicaid coverage for payment of LTC services due to the uncompensated transfer would result in the individual being removed from the institution or becoming unable to receive life-sustaining medical care, food, clothing, shelter or other necessities of life.

Applicants, recipients, or authorized representatives may request an undue hardship evaluation. Additionally, the Deficit Reduction Act of 2005 authorized nursing facilities to act on behalf of their patients, when necessary, to submit a request for undue hardship. The nursing facility must have written authorization from the recipient or his authorized representative in order to submit the claim of undue hardship.

A claim of undue hardship:

- *can be made for an individual who meets all Medicaid eligibility requirements and is subject to a penalty period.*
- *cannot be made on a denied or closed Medicaid case.*
- *cannot be used to dispute the value of a resource.*

B. Procedures

If the individual chooses to make a claim of an undue hardship, documentation regarding the transfer and the individual's circumstances

must be sent to the Department of Medical Assistance Services (DMAS) for an undue hardship determination **prior** to the eligibility worker taking action to impose a penalty period.

The individual has the burden of proof and must provide written evidence to clearly substantiate what was transferred, the circumstances surrounding the transfer, attempts to recover the asset or receive compensation, and the impact of the denial of Medicaid payment for LTC services.

1. Eligibility Worker

The eligibility worker must inform the individual of the undue hardship provisions and, if an undue hardship is claimed, send the claim and supporting documentation to DMAS for evaluation.

The eligibility worker must send a letter to the individual informing him of each asset transfer and the corresponding penalty period, as well as the right to claim an undue hardship. An Asset Transfer Hardship Claim Form, available on the VDSS local agency intranet at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi, must be included with the letter. The Asset Transfer Hardship Claim Form serves as the request for an undue hardship evaluation.

a. Undue Hardship Claimed - Required Documentation

When requesting an undue hardship, the individual must provide the following documentation:

- the reason(s) for the transfer;
- attempts made to recover the asset, including legal actions and the results of the attempts;
- notice of pending discharge from the facility or discharge from CBC services due to denial or cancellation of Medicaid payment for these services;
- physician's statement that inability to receive nursing facility or CBC services would result in the applicant/recipient's inability to obtain life-sustaining medical care;
- documentation that individual would not be able to obtain, food, clothing or shelter;
- list of all assets owned and verification of their value at the time of the transfer if the individual claims he did not transfer resources to become Medicaid eligible; and
- documents such as deeds or wills if ownership of real property is an issue.

b. 10 Days to Return Undue Hardship Claim

The individual must be given 10 calendar days to return the completed form and documentation to the local agency. *If the form and documentation are not returned within 10 calendar days, the penalty period must be imposed.*

c. Documentation for DMAS

If an undue hardship is claimed, the eligibility worker must send *to DMAS*:

- a copy of the undue hardship claim form
- a description of each transfer:
  - what was transferred
  - parties involved and relationship
  - uncompensated amount
  - date of transfer
- the penalty period(s)
- a brief summary of the applicant/recipient's current eligibility status and living arrangements (nursing facility or community), and
- other documentation provided by the applicant/recipient

Send the documentation to DMAS at the following address:

DMAS, Division of Policy and Research
Eligibility Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

A copy of all documentation submitted with the undue hardship claim must be retained in the case record.

d. When Applicant/Recipient Was Victim

If the applicant/recipient was a victim of an individual who is not the individual's attorney in fact, guardian, conservator or trustee and undue hardship is claimed, the **agency** must provide a statement documenting the facts and what actions were taken by the agency with regard to their findings. If the transfer was by a court-appointed guardian or conservator, documentation of any bond insurance that would cover the loss must be provided.

e. Undue Hardship Not Claimed or Not Granted by DMAS

If undue hardship is not claimed or if a penalty period must be imposed per DMAS, follow the procedures in M1450.800 through M1450.830 for notifying the individual and DMAS of the action. The individual must be

informed that a denial of a claim for undue hardship may be appealed in accordance with the provisions of 12 VAC 30-110. If the individual meets all other eligibility requirements, he is eligible for Medicaid payment of all covered services other than LTC.

2. DMAS DMAS will review the documentation provided with the undue hardship claim to determine if an undue hardship may be granted and send written notification to the eligibility worker. If additional *information* is needed to support *or clarify the documentation received with* the Undue Hardship claim, DMAS will notify the agency and provide a time frame for submitting the documentation. A copy of the decision must be retained in the individual's case record.

3. Subsequent Claims If DMAS is unable to *approve an* undue hardship *request because sufficient supporting documentation was not submitted, the claim must be denied. Once a claim is denied,* no further decision related to the same *asset transfer* will be made by DMAS, should the individual reapply for Medicaid coverage of LTC services.

M1450.800 AGENCY ACTION

A. Policy If an individual's asset transfer is not allowable by policy, the individual is not eligible for Medicaid payment of long-term care services. The individual, the service provider, and the Department of Medical Assistance Services (DMAS) must be notified of his/her ineligibility for *the* Medicaid payment of long-term care services, *as well as his eligibility or ineligibility for Medicaid per M1450.810 below.*

B. Procedures The procedures used for notifying the recipient, the provider and DMAS are in sections M1450.810, 820, and 830 below.

M1450.810 APPLICANT/RECIPIENT NOTICE

A. Policy Whenever an institutionalized individual is not eligible for Medicaid payment of long-term care services because of an asset transfer, the notice to the individual must contain the following:

1. Notice Includes Penalty Period The form which notifies him/her of Medicaid eligibility must include the penalty period during which Medicaid will not cover LTC services for the individual.

2. Individual In Facility - Eligible An individual in a nursing or other medical facility continues to meet the definition of an institutionalized person. If the individual meets all other Medicaid eligibility requirements, he is eligible for Medicaid in the 300% SSI covered group, except for payment for LTC services.

3. Individual Not in Facility - Not Eligible An individual outside a medical facility (i.e. living in the community) **does not** meet the definition of an institutionalized person if he is not receiving Medicaid covered CBC services, *PACE or hospice services*. Therefore, an individual for whom a penalty period is imposed cannot be eligible for Medicaid unless the individual is eligible for Medicaid outside the 300% SSI covered group.

B. Notice Contents

The Notice of Action on Medicaid sent to the individual must specify that:

- Medicaid will not pay for nursing facility or CBC waiver services for the months (state the begin and end dates of the penalty period) because of the uncompensated asset transfer(s) that occurred on (date/dates);
- the penalty period may be shortened if compensation is received.

The notice must also specify that either:

- the individual is eligible for Medicaid coverage of services other than nursing facility or waiver services beginning (the appropriate date); **or**
- the individual is ineligible for Medicaid in any covered group, citing M1450.810 A.3, above.

C. Advance Notice

When an institutionalized Medicaid recipient is found no longer eligible for Medicaid payment of long-term care services because of an asset transfer, the Advance Notice of Proposed Action must be sent to the individual at least 10 days before cancelling coverage of LTC services, and must specify that either:

- *The individual is eligible for Medicaid coverage of services other than nursing facility or waiver services beginning (the appropriate date); **or***
- *The individual is ineligible for Medicaid in any covered group, citing M1450.810 A.3, above.*
- Medicaid will not pay for long-term care services for the months (state the penalty period begin and end dates) because of the asset transfer(s) that occurred (date/dates).
- The penalty period may be shortened if compensation is received.

M1450.820 PROVIDER NOTICE

A. Introduction

Use the Medicaid LTC Communication Form (DMAS-225) to notify the provider of the individual's Medicaid eligibility and ineligibility for Medicaid payment of long-term care services.

B. Medicaid LTC Communication Form (DMAS-225)

The DMAS-225 should include:

- the individual's full name, Medicaid and Social Security numbers;
- the individual's birth date;
- the patient's Medicaid coverage begin date; and
- that the patient is not eligible for Medicaid payment of nursing facility/CBC waiver services for the months (state the penalty period begin and end dates) because of an asset transfer(s).

M1450.830 DMAS NOTICE

A. Introduction

The worker must notify DMAS that the recipient is not eligible for LTC services payment because of an asset transfer. DMAS must input the code in the MMIS that will deny payment of LTC services claims.

The worker notifies DMAS via a copy of the DMAS-225 sent to the provider.

B. Copy of DMAS-225

The copy of the DMAS-225 that is sent to DMAS must contain the following information, in addition to the information on the provider's copy of the DMAS-225:

- date(s) the asset transfer(s) occurred;
- the uncompensated value(s); and
- penalty period(s) (begin and end dates) and computation of that period(s).

C. Send DMAS Notice

The agency worker must send a copy of the DMAS-225 to:

Program Delivery Systems
Long-Term Care Unit
Department of Medical Assistance Services
600 E. Broad St., Suite 1300
Richmond, VA 23219.

The copy of the DMAS-225 must be signed and dated by the worker, and must show the worker number and the local agency's FIPS code.

Any information the agency receives about the individual's subsequent receipt of compensation which shortens the penalty period must be sent to the Long-Term Care Unit at the above address.

Average Monthly Private Nursing Facility Cost Prior to October 1, 1996

Application Date		Average Monthly Cost (All Localities)
7-1-1988 to 6-30-1989		$2,029
7-1-1989 to 12-31-1990		$2,180
1-1-1991 to 9-30-1993		$2,230
10-1-1993 to 9-30-1996		$2,554

LIFE EXPECTANCY TABLE

If the exact age is not on the chart, use the next lower age. For example, if an individual is age 47 at the time of the asset transfer, use the life expectancy that corresponds to age 40 on the chart.

AGE	*Life Expectancy MALE*	*Life Expectancy FEMALE*	AGE	*Life Expectancy MALE*	*Life Expectancy FEMALE*
0	*73.26*	*79.26*	74	*10.12*	*12.74*
10	*64.03*	*69.93*	75	*9.58*	*12.09*
20	*54.41*	*60.13*	76	*9.06*	*11.46*
30	*45.14*	*50.43*	77	*8.56*	*10.85*
40	*35.94*	*40.86*	78	*8.07*	*10.25*
50	*27.13*	*31.61*	79	*7.61*	*9.67*
60	*19.07*	*22.99*	80	*7.16*	*9.11*
61	*18.33*	*22.18*	81	*6.72*	*8.57*
62	*17.60*	*21.38*	82	*6.31*	*8.04*
63	*16.89*	*20.60*	83	*5.92*	*7.54*
64	*16.19*	*19.82*	84	*5.55*	*7.05*
65	*15.52*	*19.06*	85	*5.20*	*6.59*
66	*14.86*	*18.31*	86	*4.86*	*6.15*
67	*14.23*	*17.58*	87	*4.55*	*5.74*
68	*13.61*	*16.85*	88	*4.26*	*5.34*
69	*13.00*	*16.14*	89	*3.98*	*4.97*
70	*12.41*	*15.44*	90	*3.73*	*4.63*
71	*11.82*	*14.85*	95	*2.71*	*3.26*
72	*11.24*	*14.06*	100	*2.05*	*2.39*
73	*10.67*	*13.40*	110	*1.14*	*1.22*

Settlement Statement-

Form HUD-1 follows on pages 2 and 3 of this appendix. This form is frequently used as the settlement statement when closing a real estate transaction or transfer. Note that there is a specific section for the borrower and the seller. The Borrower is the individual(s) who is purchasing the property. The Seller is the owner of the property.

The Gross Amount Due to Seller for the property noted on line 420 of the first page of the statement represents the amount of funds being paid for purchase the property. This amount includes the funds which satisfy any outstanding liens against the property at the time of transfer, which are noted on lines 504 and 505 of the first page.

Usual and customary fees associated with real estate transactions are already indicated on the form, such as the lien amounts, any additional deductions must be added to the form. These types of deductions should be carefully examined by the eligibility worker, as they may represent a separate uncompensated transfer from the seller's portion of the proceeds from the sale of the property.

Any questions regarding this form and any deductions listed should be referred to the appropriate Medical Assistance Program Consultant.

A. Settlement Statement

U.S. Department of Housing and Urban Development

OMB Approval No. 2502-02 (expires 11/30/200

B. Type of Loan

1. ☐ FHA 2. ☐ FmHA 3. ☐ Conv. Unins. 4. ☐ VA 5. ☐ Conv. Ins.

6. File Number:	7. Loan Number:	8. Mortgage Insurance Case Number:

C. Note: This form is furnished to give you a statement of actual settlement costs. Amounts paid to and by the settlement agent are shown. Items marke "(p.o.c.)" were paid outside the closing; they are shown here for informational purposes and are not included in the totals.

D. Name & Address of Borrower:	E. Name & Address of Seller:	F. Name & Address of Lender:

Buyer

G. Property Location:	H. Settlement Agent:	
	Place of Settlement:	I. Settlement Date:

J. Summary of Borrower's Transaction		K. Summary of Seller's Transaction	
100. Gross Amount Due From Borrower		**400. Gross Amount Due To Seller**	
101. Contract sales price		401. Contract sales price	
102. Personal property		402. Personal property	
103. Settlement charges to borrower (line 1400)		403.	
104.		404.	
105.		405.	
Adjustments for items paid by seller in advance		**Adjustments for items paid by seller in advance**	
106. City/town taxes to		406. City/town taxes to	
107. County taxes to		407. County taxes to	
108. Assessments to		408. Assessments to	
109.		409.	
110.		410.	
111.		411.	
112.		412.	
120. Gross Amount Due From Borrower		**420. Gross Amount Due To Seller**	
200. Amounts Paid By Or In Behalf Of Borrower		**500. Reductions In Amount Due To Seller**	
201. Deposit or earnest money		501. Excess deposit (see instructions)	
202. Principal amount of new loan(s)		502. Settlement charges to seller (line 1400)	
203. Existing loan(s) taken subject to		503. Existing loan(s) taken subject to	
204.		504. Payoff of first mortgage loan	
205.		505. Payoff of second mortgage loan	
206.		506.	
207.		507.	
208.		508.	
209.		509.	
Adjustments for items unpaid by seller		**Adjustments for items unpaid by seller**	
210. City/town taxes to		510. City/town taxes to	
211. County taxes to		511. County taxes to	
212. Assessments to		512. Assessments to	
213.		513.	
214.		514.	
		515.	
		516.	
		517.	
		518.	
		519.	
220. Total Paid For Borrower		**520. Total Reduction Amount Due Seller**	
300. Cash At Settlement From/To Borrower		**600. Cash At Settlement To/From Seller**	
301. Gross Amount due from borrower (line 120)		601. Gross amount due to seller (line 420)	
302. Less amounts paid by/for borrower (line 220)	( )	602. Less reductions in amt. due seller (line 520)	( )
303. Cash ☐ **From** ☐ **To Borrower**		**603. Cash** ☐ **To** ☐ **From Seller**	

Gross Amount Due to Seller

Liens paid for by the seller.

Areas not pre-filled are where other transactions are listed.

Section 5 of the Real Estate Settlement Procedures Act (RESPA) requires the following: • HUD must develop a Special Information Booklet to help persons borrowing money to finance the purchase of residential real estate to better understand the nature and costs of real estate settlement services; • Each lender must provide the booklet to all applicants from whom it receives or for whom it prepares a written application to borrow money to finance the purchase of residential real estate; • Lenders must prepare and distribute with the Booklet a Good Faith Estimate of the settlement costs that the borrower is likely to incur in connection with the settlement. These disclosures are manadatory.

Section 4(a) of RESPA mandates that HUD develop and prescribe this standard form to be used at the time of loan settlement to provide full disclosure of all charges imposed upon the borrower and seller. These are third party disclosures that are designed to provide the borrower with pertinent information during the settlement process in order to be a better shopper.

The Public Reporting Burden for this collection of information is estimated to average one hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information.

This agency may not collect this information, and you are not required to complete this form, unless it displays a currently valid OMB control number.

The information requested does not lend itself to confidentiality.

Previous editions are obsolete

Page 1 of 2

form **HUD-1** (3/86) ref Handbook 4305.2

L. Settlement Charges

				Paid From Borrowers Funds at Settlement	Paid From Seller's Funds at Settlement
700. Total Sales/Broker's Commission based on price $		@	% =		
Division of Commission (line 700) as follows:					
701. $	to				
702. $	to				
703. Commission paid at Settlement					
704.					
800. Items Payable In Connection With Loan					
801. Loan Origination Fee	%				
802. Loan Discount	%				
803. Appraisal Fee	to				
804. Credit Report	to				
805. Lender's Inspection Fee					
806. Mortgage Insurance Application Fee to					
807. Assumption Fee					
808.					
809.					
810.					
811.					
900. Items Required By Lender To Be Paid In Advance					
901. Interest from to	@$	/day			
902. Mortgage Insurance Premium for		months to			
903. Hazard Insurance Premium for		years to			
904.		years to			
905.					
1000. Reserves Deposited With Lender					
1001. Hazard insurance	months @ $	per month			
1002. Mortgage insurance	months @ $	per month			
1003. City property taxes	months @ $	per month			
1004. County property taxes	months @ $	per month			
1005. Annual assessments	months @ $	per month			
1006.	months @ $	per month			
1007.	months @ $	per month			
1008.	months @ $	per month			
1100. Title Charges					
1101. Settlement or closing fee	to				
1102. Abstract or title search	to				
1103. Title examination	to				
1104. Title insurance binder	to				
1105. Document preparation	to				
1106. Notary fees	to				
1107. Attorney's fees	to				
(includes above items numbers:			)		
1108. Title insurance	to				
(includes above items numbers:			)		
1109. Lender's coverage	$				
1110. Owner's coverage	$				
1111.					
1112.					
1113.					
1200. Government Recording and Transfer Charges					
1201. Recording fees: Deed $	; Mortgage $	; Releases $			
1202. City/county tax/stamps: Deed $	; Mortgage $				
1203. State tax/stamps: Deed $	; Mortgage $				
1204.					
1205.					
1300. Additional Settlement Charges					
1301. Survey to					
1302. Pest inspection to					
1303.					
1304.					
1305.					
1400. Total Settlement Charges (enter on lines 103, Section J and 502, Section K)					

CHAPTER M14
LONG-TERM CARE
SUBCHAPTER 60

LTC FINANCIAL ELIGIBILITY

M1460 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	pages 3, 20, 21
TN #95	3/1/11	pages 3, 4, 35
TN #94	9/1/10	page 4a
TN #93	1/1/10	pages 28, 35
TN #91	5/15/09	pages 23, 24

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M1460.000 LTC FINANCIAL ELIGIBILITY

M1460.001 OVERVIEW

A. Introduction

This subchapter contains the Medicaid financial eligibility requirements for individuals receiving facility or Medicaid waiver long-term care (LTC) services, who are not married or who are married but do not have community spouses. **For married individuals with community spouses, go to subchapter M1480 to determine financial eligibility and patient pay.**

All individuals whose Medicaid eligibility has been determined PRIOR to entering LTC must have their financial eligibility redetermined, including asset transfer evaluation, home ownership and other resource evaluation. First, determine if the individual meets the Medicaid non-financial requirements including covered group in M1410.020. Then determine financial eligibility. Financial eligibility requirements for an individual differ depending on the individual's covered group, marital status and type of long-term care.

This subchapter contains policy and procedures for resources and income eligibility determination for institutionalized individuals. Patient pay (post-eligibility treatment of income) policy and procedures for unmarried individuals or married individuals without community spouses are in subchapter M1470.

B. Related Policies

- ABD resource rules in Chapter S11.
- ABD income rules in Chapter S08.
- Family and Children resource rules in Chapter M06.
- Family and Children income rules in Chapter M07.
- Married Institutionalized Individuals' Eligibility & Patient Pay rules in subchapter M1480.

M1460.100 DEFINITIONS

A. Purpose

This section provides definitions for terms used in this subchapter.

B. Definitions

1. 300% SSI Group

The 300% SSI group is the short name for the categorically needy non-money payment (CNNMP) covered groups of Aged, Blind & Disabled (ABD) and Families & Children (F&C) individuals who are institutionalized in medical facilities or Medicaid-covered waiver services, who have resources within the Medicaid resource limits and whose gross income is less than or equal to 300% of the SSI income limit for one person.

2. Budget Period

The budget period is the period of time during which an individual's income is calculated to determine eligibility.

3. Carry-over Expenses

Carry-over expenses are the balance due on medical, dental, and remedial care expenses incurred in the retroactive or prospective budget period prior to the current budget period which were not used in establishing eligibility and which may be deducted in a consecutive budget period(s) when there has been no break in spenddown eligibility.

4. Certification Period

The certification period is the period of time over which an application or redetermination is valid.

5. Current Payments

Current payments are payments made in the current spenddown budget period on expenses incurred before the current spenddown budget period which were not used in establishing eligibility in a previous spenddown budget period and when there has been a break in spenddown eligibility. The payment amount allowed is the actual payment amount paid to the provider and is deducted from the spenddown liability on the date the payment is actually made.

6. Income Determination Period

The income determination period is the budget period; for all LTC cases, the budget period is one month.

7. LTC Case

A case in which the Medicaid applicant or recipient is an institutionalized individual receiving long-term care services is an LTC case.

8. Lump Sum Payment

Income received on a "non-recurring basis" and/or income that is received once a year is a lump sum payment. All lump sum payments are income in the month of receipt and a resource in the following month(s), if retained.

Different types of lump sum payments must be treated differently. Refer to the ABD Income chapter S08 (for both ABD and F&C individuals) for policy specific to the type of lump sum payment that is being evaluated.

9. Medicaid Rate

The Medicaid rate is a monthly rate which is calculated:

- for a facility, by multiplying the Medicaid per diem (daily) rate by the number of days in the month. The per diem rate differs from one facility to another; confirmation of a facility's rate should be obtained by contacting the facility;

  NOTE: When projecting the facility's monthly Medicaid rate, the Medicaid per diem is multiplied by 31 days.

- for Medicaid CBC waiver services, by multiplying the provider's Medicaid hourly rate by the number of hours of service received by

- the patient in the month. Confirm the provider's hourly Medicaid rate and number of service hours by contacting the provider.

10. Old Bills

Old bills are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid application month and the application's retroactive period,
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

EXCEPTION: Bills paid by a state or local program and which meet the definition of "old bills" are treated as old bills even though they are not the individual's liability.

11. Projected Expenses

Expenses for services that have not yet been incurred but are reasonably expected to be incurred are projected expenses.

12. Spenddown Liability

The spenddown liability is the amount by which the individual's countable income exceeds the MNIL for the budget period.

M1460.150 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LTC

A. Applicability

The policy in this section applies to nursing facility and CBC/PACE patients, who meet the requirements for LTC on or after January 1, 2006. This includes individuals who filed reapplications after a break in Medicaid eligibility. It does **not apply** to Medicaid recipients who were approved for LTC prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

For Medicaid applicant*s* or enrollee*s* approved for LTC on or after July 1, 2006, *the amount of equity in the home at the time of the initial LTC determination and at each renewal must be evaluated.*

B. Policy

Individuals with equity value (tax assessed value minus encumbrances) in home property that exceeds the limit are NOT eligible for Medicaid payment of long-term care services unless the home is occupied by

- a spouse,
- a dependent child under age 21 years, or
- a blind or disabled child of any age.

Individuals with substantial home equity may be eligible for Medicaid payment of other covered services if they meet all the other Medicaid eligibility requirements.

1. Home Equity Limit

The home equity limit applied is based on the date of the application or request for LTC coverage. Effective January 1, 2011, the home equity limit is subject to change annually. The home equity limit is:

- Effective January 1, 2006 through December 31, 2010: $500,000
  Effective January 1, 2011: $506,000.

2. **Reverse Mortgages**	Reverse mortgages **do not** reduce equity value until payments are being received from the reverse mortgage.
3. **Home Equity Credit Lines**	A home equity line of credit **does not** reduce the equity value until credit line has been used or payments from the credit line have been received.
C. Verification Required	Verification of the equity value of the home is required.
D. Notice Requirement	If an individual is ineligible for Medicaid payment of LTC services because of substantial home equity exceeding *the limit*, the Notice of Action must state why he is ineligible for Medicaid payment of LTC. The notice must also indicate whether the applicant is eligible for other Medicaid covered services.
E. References	See section M1120.225 for more information about reverse mortgages.

M1460.160 LONG-TERM CARE PARTNERSHIP POLICIES

A. Introduction

A Long-term Care Partnership Policy (Partnership Policy) is a type of LTC insurance. Under section 6021(a)(1)(A) of the Deficit Reduction Act (DRA) of 2005 states were permitted to develop LTC partnerships. In addition to paying for assisted living or long-term care services, a Partnership Policy allows for additional assets to be disregarded in the Medicaid eligibility determination.

The value of assets disregarded in the Medicaid eligibility determination is equal to the dollar amount of benefits paid to or on behalf of the individual as of the month of application, even if additional benefits remain available under the terms of the policy.

The Partnership Policy disregard is not applicable to the resource assessment for married individuals with a community spouse. See M1480 for more information regarding resource assessments and Partnership Policies.

B. LTC Insurance Policy Issued Prior to 9/01/2007

LTC policies issued prior to 9/01/2007 are **not** Partnership Policies. See M1470.230 B.6, M1470.430 B.5 and M1470.820 D for more information regarding these types of insurance policies.

C. LTC Insurance Policy Issued on or After 9/01/2007

LTC policies issued on or after 9/01/2007 may or may not be Partnership Policies. For a policy to be considered a Partnership Policy, it must meet the following conditions:

- issued on or after 09/01/2007,
- contain a disclosure statement indicating that it meets the requirements under § 7702B(b) of the Internal Revenue Service Code of 1986, and

- provide inflation protection:

  - under 61 years of age, compound annual inflation protection,
  - 61 to 76 years of age, some level of inflation protection, or
  - 76 years or older, inflation protection may be offered, but is not required.

Obtain a copy of the Partnership Disclosure Notice and the LTC Partnership Certification Form (See M1460, Appendices 1 and 2) for verification of the requirements noted above. Also, verification of the amount of benefit paid to or on behalf of an individual as of the month of application must be obtained. This can be found on the Explanation of Benefits statement or by calling the insurance carrier.

Partnership Policies that are issued in other states may or may not meet Virginia's requirements. Please contact your Medicaid Consultant to verify reciprocity with Virginia.

Verifications and documentation regarding a Partnership Policy must be kept with other permanent verifications in the case record.

See M1470.820 for data entry procedures for MMIS.

M1460.200 DETERMINATION OF COVERED GROUP

A. Overview

An individual in LTC who meets the Medicaid non-financial eligibility requirements in M1410.010 must also meet the requirements of at least one covered group in order to be eligible for Medicaid and Medicaid payment of LTC services.

1. Covered Groups Eligible for Long Term Care Services

The covered groups whose benefit packages include long-term care services are the following groups:

a. All categorically needy (CN) covered groups.

b. All categorically needy non-money payment (CNNMP) covered groups.

c. ABD with income $\leq$ 80% FPL (ABD 80% FPL).

d. All medically indigent (MI) Families & Children (F&C) covered groups:

- pregnant women and newborns under age 1 year,
- children under age 19.

e. All medically needy (MN) covered groups; however, Medicaid will not pay for the following services for MN individuals:

- *services in an intermediate care facility for the mentally retarded* (ICF-MR),
- services *in an institution for the treatment of mental disease* (IMD),
- *Intellectual Disabilities/Mental Retardation (ID/*MR) Waiver services, and
- *Individual and Family Development Disability Support* (DD) Waiver services.

2. Applicants Who Do Not Receive Cash Assistance

a. Child Under Age 19

If the applicant is a child under age 19, first determine the child's eligibility as an MI child, using the covered group policy in M0320 and the financial eligibility policy in chapters M05 and M07. If not eligible as MI, determine the child's eligibility in the CNNMP 300% SSI group, using the covered group policy in subchapter M0320 and the financial eligibility policy and procedures in this subchapter.

If the child's resources or income exceed the limits for the 300% SSI group, determine the child's eligibility in an MN covered group (subchapter M0330).

NOTE: A child who is age 18, 19 or 20 meets an MN covered group if he is blind, disabled, pregnant, in foster care, adoption assistance, or institutionalized in a nursing facility. An individual age 21 or older, must meet the pregnant, aged, blind or disabled definition in order to meet an MN covered group.

b. Individual Age 19 or Older

If the applicant is an individual age 19 or older, determine the individual's eligibility in the ABD or F&C covered group depending on which definition the individual meets, using the financial eligibility policy and procedures in this subchapter.

For ABD individuals, determine the individual's eligibility in the 300% SSI covered group. If not eligible in the 300% SSI covered group, determine the individual's eligibility in the ABD 80% FPL covered group. If not eligible in the ABD 80% FPL covered group, determine the individual's eligibility in the MN (see M0330) and the limited benefit ABD MI (see M0320) covered groups.

For F&C individuals, first determine the individual's eligibility in the CNNMP 300% SSI group. If the individual's income exceeds the limits for 300% SSI covered group, determine the individual's eligibility in an MN covered group (see M0330).

B. Relation to Income Limits

Determination of the appropriate covered group must be made prior to determination of income because the income limits are determined by the covered group:

1. 300% SSI

The ABD income policy in chapter S08 is used to determine income for all individuals (ABD and F&C) in the 300% SSI group. The items found in "Countable Income for the 300% SSI Group," section M1460.611 ARE counted in determining income eligibility for long-term care. The income items listed in "What Is Not Income," section M1460.610 are not counted for the 300% SSI groups (ABD and F&C).

2. ABD 80% FPL

The ABD income policy in chapter S08 is used to determine countable income for the ABD 80% FPL covered group. The income items listed in "What Is Not Income," Section M1460.610 and in "Countable Income for the 300% SSI Group," Section M1460.611 are NOT counted as income in determining income eligibility for the ABD 80% FPL covered group.

3. ABD MN Groups

The ABD income policy in chapter S08 is used to determine countable income for the ABD MN covered groups. However, the income items listed in "What Is Not Income", Section M1460.610 and in "Countable Income for the 300% SSI Group", Section M1460.611 are NOT counted as income in determining income eligibility for ABD MN groups.

4. F&C MI and MN Groups

The F&C income policy in chapter M07 is used to determine countable income for individuals in F&C MI and MN covered groups. However, the income items listed in "What Is Not Income", section M1460.610 and "Countable Income for the 300% SSI Group", Section M1460.611 are NOT counted when determining income eligibility for F&C MI and MN groups.

C. Ongoing Recipient Enters LTC

1. Cash Assistance Recipients

Recipients who are already enrolled in Medicaid when they enter Medicaid long-term care and who receive cash assistance payments must have their eligibility reviewed. They already meet a covered group but they must also meet the asset transfer, resource and financial eligibility requirements in order for Medicaid to cover the cost of long-term care services.

2. Other Recipients

Recipients who do not receive cash assistance but who are already enrolled in Medicaid when they enter long-term care in a medical facility **must have their eligibility redetermined**. They must meet a covered group and they must meet the asset transfer, resource, and financial eligibility requirements in order for Medicaid to cover the LTC services cost.

Review the asset transfer policy in subchapter M1450 with the recipient if he has transferred assets. If the recipient is admitted to a nursing facility, or moves from his home to receive Medicaid CBC in another person's home, review asset transfer, home property and other resource requirements to determine if the individual remains eligible for Medicaid.

A married recipient who enters LTC must have resource and income eligibility redetermined using the rules in subchapter M1480, if his spouse is a community spouse.

D. Covered Groups

The financial eligibility rules for each covered group are contained in the following sections:

1. SSI Recipients

SSI recipients' financial eligibility requirements are in section M1460.201 below.

2. Other CN Groups

Other categorically needy groups are listed in section M1460.210 below.

3. CNNMP Groups

CNNMP groups are listed in section M1460.220 below

4. ABD 80% FPL

An ABD 80% FPL recipient's financial eligibility requirements are in section M1460.225 below.

5. MN Groups Medically needy (MN) groups are listed in section M1460.230 below.

6. MI Groups MI groups are listed in section M1460.240 below.

M1460.201 SSI RECIPIENTS

A. Introduction An SSI recipient in a nursing facility, or who receives Medicaid CBC waiver services, must meet the Medicaid nonfinancial, asset transfer and resource eligibility requirements to be eligible for Medicaid payment of LTC services. The SSI recipient's resource eligibility must be determined if he owns a real property resource; the receipt of SSI meets the Medicaid income eligibility requirements. *An SSI recipient is income-eligible for LTC as long as he is entitled to an SSI payment.* W*hen the SSA record indicates a payment code of "C01" but shows no payment amount due to a recovery of an overpayment, the individual is considered to be an SSI recipient.* The covered group eligibility requirements for SSI recipients are in section M0320.201.

1. Medicaid CBC An SSI recipient who receives Medicaid CBC waiver services in his community residence usually continues to receive SSI with no change. If a recipient moves to another person's home to receive Medicaid CBC, his SSI payment may be affected. When a Medicaid SSI recipient begins receiving Medicaid CBC waiver services, asset transfer and resource eligibility must be evaluated. As long as the individual receives SSI, he is categorically needy if he meets the Medicaid nonfinancial and resource eligibility rules.

2. Facility SSI recipients in nursing facilities are subject to the reduced SSI benefit rate of $30 for their personal needs. If they have other countable income that exceeds $30, their SSI will be canceled. SSI recipients may continue to receive their regular monthly SSI benefit for 3 months if they are considered temporarily institutionalized. Individuals who receive SSI after admission to a facility are categorically needy if they meet the Medicaid nonfinancial and resource eligibility rules.

B. Policy

1. Nonfinancial Evaluate the non-financial Medicaid eligibility rules in section M1410.020. An SSI recipient meets an ABD covered group.

2. Asset Transfer Determine if the recipient meets the asset transfer policy in subchapter M1450.

3. Resources

a. Determine Countable Resources

Determine if the SSI recipient has the following real property resource(s):

1) equity in non-exempt property contiguous to his home which exceeds $5,000 and none of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;

2) interest in undivided heir property and the equity value of *the individual's* share *that,* when added to all other countable resources, exceeds the appropriate Medicaid resource limit. (The interest in the

estate must be legally available. If a partition suit is necessary to sell the interest, costs of partition and attorneys' fees may be deducted as described in section M1120.215);

3) ownership (equity value) of *the individual's* former residence *when* the SSI recipient is in an institution for longer than 6 months. Determine if the former *residence* is excluded under policy in section M1130.100 D;

4) equity value in property owned jointly *by the SSI recipient and* another person *who is not the SSI recipient's spouse*, as tenants in common or joint tenants with the right of survivorship at common law. Determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property;

5) other real property; determine if any of the real property exclusions in sections M1130.100, M1130.140, S1130.150, or M1130.160 apply to the property.

When an SSI recipient has any of the real property listed in 1) through 5) *previously*, ALL of the recipient's resources must be verified, evaluated, and counted together to determine if the SSI recipient meets the Medicaid resource requirements. Calculate resources for an assistance unit of 1 person.

When an SSI recipient has no real property resource listed in 1) through 5) previously, do NOT evaluate the SSI recipient's resources. The SSI recipient meets the Medicaid resource requirements because he receives SSI and does not have a countable real property resource listed above.

b. Countable Resources Within Resource Limit

If countable resources are less than or equal to the $2,000 resource limit, go to item 4 below for income eligibility.

c. Countable Resources Exceed the Resource Limit

If current resources exceed the $2,000 resource limit, the individual is NOT eligible in the SSI recipient covered group, nor is he eligible in the 300% SSI group or the medically needy group. He may be eligible for limited Medicaid coverage as medically indigent (which has more liberal resource methods and standards), however, Medicaid will not pay for LTC services for an ABD medically indigent recipient.

4. Income

An SSI recipient in LTC is income-eligible for Medicaid as long as he receives an SSI payment. Verify receipt of the payment. If the SSI recipient meets the nonfinancial and resource eligibility rules for Medicaid, then he is eligible for Medicaid as categorically needy.

a. When an SSI recipient who has no other income enters a nursing facility, the SSI check is usually reduced to $30 for the month following the month of entry. The SSI payment is **NOT** counted as income when determining income eligibility or patient pay.

b. If the recipient is temporarily in the nursing facility, the SSI check is not reduced or canceled. Temporary institutionalization for SSI purposes means 90 days or less. The SSI payment is **NOT** counted as income when determining eligibility or patient pay.

C. Development

A partial review of the SSI recipient's Medicaid eligibility is required when the recipient is admitted to facility care or Medicaid CBC waiver services. The EW must determine that asset transfer and resource requirements are met, and that the recipient's SSI continues.

If eligible, determine patient pay; see subchapter M1470. If the individual is eligible but is in an asset transfer penalty period, follow the notification instructions in M1450. If not eligible, follow the eligibility notice requirements in M1410.300.

M1460.210 OTHER CATEGORICALLY NEEDY (CN) COVERED GROUPS

A. Description

Categorically needy (CN) individuals receive or are deemed to be receiving public assistance cash benefits.

B. ABD Groups

1. QSII (1619(b))

Qualified Severely Impaired Individuals (QSII) are former SSI recipients who are working but are still disabled, and are eligible under 1619(b) of the Social Security Act. To be eligible for Medicaid, they must have met the more restrictive resource requirements for Medicaid in the month before the month they qualified under 1619(b). See section M0320.105 for details about this covered group.

2. AG Recipients

An Auxiliary Grants (AG) recipient is eligible for Medicaid if he meets the assignment of rights to medical support and third party payments requirements and the asset transfer policy. See section M0320.202 for details about this covered group.

C. F&C Groups

1. Individuals Under 21

a. IV- E Foster Care Recipients

Children who are eligible for foster care payments under Title IV-E of the Social Security Act are eligible for Medicaid. See section M0320.305 for details about this covered group.

b. IV-E Adoption Assistance Recipients

Children who are eligible for adoption assistance under Title IV-E of the Social Security Act are eligible for Medicaid. See section M0320.305 for details about this covered group.

c. Individuals Under 21 in NF or ICF-MR

Individuals under age 21 who meet the resource and income requirements of the July 16, 1996, AFDC State Plan are eligible for Medicaid if they are in a nursing facility or intermediate care facility for the mentally retarded. See section M0320.307 for details about this covered group.

M1460.220 CNNMP 300% SSI COVERED GROUP

A. Description

These are ABD or F&C individuals in medical facilities or who receive Medicaid CBC waiver services, who meet the appropriate CNNMP resource requirements and resource limit and whose income is less than or equal to 300% of the SSI payment limit for an individual.

Individuals who have been screened and approved for Medicaid LTC services may be evaluated in this covered group. If the individual is treated as an institutionalized individual and eligibility is established prior to the begin date of services, the individual has 30 days from the date on the Notice of Action to begin services.

B. ABD Groups

Aged, blind or disabled individuals institutionalized in medical facilities, or who require institutionalization and are approved to receive Medicaid CBC waiver services are those who:

- meet the Medicaid ABD resource requirements; and
- have gross income, determined according to the ABD income requirements, that does not exceed 300% of the SSI individual payment limit.

See sections M0320.203 and 204 for details about these covered groups.

C. F&C Groups

Individuals who meet an F&C definition (children under age 19, foster care or adoption assistance children under age 21, parents or caretaker-relatives of dependent children, and pregnant women) in medical facilities, or who require institutionalization and who are approved to receive Medicaid home and community-based care (CBC) waiver services, are those who:

- meet the F&C CNNMP resource requirements if unmarried, (married individuals must meet the ABD resource requirement); and
- have gross income, determined according to the **ABD income** requirements, that does not exceed 300% of the SSI individual payment limit.

See sections M0320.309 and 310 for details about these covered groups.

M1460.225 ABD 80% FPL COVERED GROUP

A. Description

The ABD 80% FPL covered group includes aged, blind and disabled

individuals who have income less than or equal to 80% FPL and countable resources that do not exceed the SSI resource limits. See M0320.210 for details about this covered group.

B. Policy

1. Nonfinancial Evaluate the non-financial Medicaid eligibility rules in section M1410.020.

2. Asset Transfer Determine if the recipient meets the asset transfer policy in subchapter M1450.

3. Resources Determine countable resources using the policy in chapter S11 and Appendix 2 to chapter S11. The resource limit is $2,000.

The home property resource exclusion for individuals in the ABD 80% FPL covered group includes the home and ALL contiguous property as long as the individual lives in the home or, if absent, intends to return to the home (see Appendix 2 to chapter S11). When the ABD 80% FPL individual leaves his home property, obtain a signed statement from the individual as to:

- when and why he left the home;
- whether he intends to return; and
- if he does not intend to return, when that decision was made.

The 6-month home property resource exclusion for institutionalized individuals does NOT apply to this covered group.

4. Income Income is determined using the policy in chapter S08, and countable income must not exceed 80% FPL. Spenddown does not apply to this covered group.

M1460.230 MEDICALLY NEEDY COVERED GROUPS

A. Description The medically needy (MN) classification applies to those groups of aged, blind, disabled (ABD) individuals who do not meet the ABD CN or CNNMP resource or income requirements, but who meet the ABD MN resource and income requirements. The medically needy (MN) classification also applies to those groups of families and children (F&C) who do not meet the F&C CN or CNNMP resource or income requirements, but who meet the F&C MN resource and income requirements.

B. ABD Groups

1. Aged individuals age 65 years or older; see section M0330.201.

2. Blind individuals; see section M0330.202.

3. Disabled individuals; see section M0330.203.

4. Individuals who were Blind or Disabled MN recipients in December 1973, who continue to meet the MN eligibility requirements in the December 1973 plan, but do not meet the current blindness or disability criteria; see section M0330.204.

C. F&C Groups

1. Pregnant women; see section M0330.301.
2. Newborn children under age 1; see section M0330.302.
3. Children under age 18 years; see section M0330.303.
4. Individuals under age 21 in non-IV-E foster care, non-IV-E adoption assistance, or who are in nursing facilities or ICF-MRs; see section M0330.304.
5. Special medical needs non-IV-E adoption assistance children under age 21; see section M0330.305.

M1460.240 MEDICALLY INDIGENT COVERED GROUPS

A. Description

Medically Indigent (MI) covered groups are categorically needy and have income limits based on the federal poverty limit.

The MI ABD groups, except the ABD 80% FPL covered group, have limited Medicaid coverage. Limited Medicaid coverage does not include LTC services, except for the QMB who receives Medicare-covered days in a skilled nursing facility (SNF).

MI F&C groups have full coverage, including LTC services.

The ABD 80% FPL group receives full coverage, including LTC services.

B. ABD Groups

1. ABD 80% FPL

Aged, blind and disabled individuals who have income less than or equal to 80% of the FPL are eligible for full Medicaid coverage. See section M1460.225 for details about this covered group.

***2.* QMB**

The QMB covered group is not eligible for Medicaid payment of LTC services, except for the Medicare-covered days in a skilled nursing facility (SNF). A QMB is eligible for Medicaid LTC services only if he also meets another CN, CNNMP, or MN covered group. A QMB who also meets another Medicaid covered group is a "dual-eligible" QMB. Medicaid will cover LTC services for a dual-eligible QMB. See section M0320.206 for details about this covered group.

NOTE: Only QMBs can be "dually eligible".

***3.* SLMB, QI, and QDWI**

The SLMB, QI, and QDWI covered groups are **NOT** eligible for any Medicaid payment of LTC services. See sections M0320.207, 208 and 209 for details about these covered groups.

C. F&C Groups

1. Pregnant women and infants under 1 year whose income is equal to or less than 133% of the federal poverty level (FPL); see section M0320.301 for details about this covered group.

2. *MI Children Under Age 19* whose income is equal to or less than 133% of the FPL; see section M0320.*303* for details about this covered group.

M1460.300 ASSISTANCE UNIT

A. Policy

An institutionalized individual is an assistance unit of one person, considered living separately from his spouse and/or parent(s), beginning the month in which he meets the definition of "institutionalization" in section M1410.010.

EXCEPTION: A pregnant woman's assistance unit includes the number of unborn children with which she is pregnant.

B. Financial Eligibility

The financial eligibility rules in this section apply to **both ABD and F&C individuals.**

1. Resources

The resources of an institutionalized child's parent(s**)** are **NOT** deemed available to the institutionalized child. The resources of an institutionalized individual's spouse are deemed available to the institutionalized individual in the initial eligibility determination (see subchapter M1480).

2. Income

The income of an institutionalized individual's spouse or parent(s) is **NOT** deemed available to the institutionalized individual.

For income eligibility, married institutionalized individuals are considered separated, not living together, and only that income which is voluntarily contributed to the institutionalized spouse by the separated spouse is considered available to the institutionalized spouse.

Institutionalized children are considered separated from, not living with, their parents and only that income which is voluntarily contributed to the child is considered available to the child.

M1460.400 STEPS FOR DETERMINING FINANCIAL ELIGIBILITY

A. Is person an SSI recipient?

Yes: Go to M1460.201 (determine ABD CN resources; if within limit, is eligible as SSI). If resources exceed the limit, does recipient also meet F&C MI covered group?

Yes: eligible as F&C MI; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay. (Remember to review asset transfer to evaluate whether Medicaid payment may be made for LTC services).

No: ineligible for Medicaid; STOP. Go to section M1460.660 for notice procedures.

No: Does person receive IV-E cash assistance?

Yes: eligible as CN; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay. (Remember to review asset transfer to evaluate whether Medicaid payment may be made for LTC services).

No: Go to B below.

B. Covered Group

Is person already enrolled in Medicaid in a covered group eligible for LTC services?

Yes: Go to E "Resources" below.

No: Is person F&C?

Yes: Determine if he meets F&C MI group first (section M1460.240) go to D "Income" below.

No: Go to C below.

C. Is person ABD?

Yes: Go to D "Income" below.

No: Is person in Hospice?

Yes: Determine as Hospice; see section M0320.205.

No: ineligible for Medicaid, does not meet a covered group; STOP. Go to section M1460.660 for notice procedures.

D. Income (*See* M1460.600)

1. Person is F&C MI

Determine countable income using chapter M07.

Compare income to appropriate F&C MI income limit.

Is income within F&C MI limit?

Yes: eligible as F&C MI, STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

No: not eligible as F&C MI, go to item 2 below.

2. Person Is Not F&C MI

(1) Is person ABD *and (2) does person meet the definition of institutionalization in M1410.010?*

Yes: Determine if gross income is less than or equal to the 300% SSI income limit using chapter S08 and section M1460.600 below to determine gross income.

Is gross income less than or equal to 300% SSI income limit?

Yes: Go to section E "Resources" below.

No: Go to section M1460.410 "Steps for Determining MN Eligibility" below.

No: Does person meet the F&C 300% SSI or Hospice covered group (*does person meet the definition of institutionalization in M1410.010)?*

Yes: Go to item 3 "Determine 300% SSI income" *below.*

No: Go to section M1460.410 "Steps for Determining MN Eligibility."

3. Determine if Gross Income is Less Than or Equal to 300% SSI

Determine if gross monthly income is less than or equal to the 300% SSI income limit using chapter S08 and section M1460.600 below for **ABD and F&C** individuals.

Is gross income less than or equal to 300% SSI income limit?

Yes: go to section E "Resources" below.

No: go to section M1460.410 "Steps for Determining MN Eligibility" below.

E. Resources (See M1460.500)

1. Determine CN/CNNMP Resources

a. ABD groups

1) Unmarried Individual or Married Individual with no Community Spouse

a) 300% SSI group: Determine ABD countable resources using chapter S11.

Compare to ABD CN/CNNMP resource limit = $2,000 for 1 person. If the individual is not eligible due to excess resources, evaluate eligibility in the ABD 80% FPL covered group. See item b) below.

b) ABD 80% FPL group: Using chapter S08 and M1460.600, determine if countable income is within the ABD 80% FPL income limit contained in M0810.002.A.5. If countable income is less than or equal to 80% FPL, determine countable resources using chapter S11 and Appendix 2 to chapter S11. **NOTE:** the 6-month home exclusion does not apply to this covered group.

Compare to ABD CN/CNNMP resource limit = $2,000 for 1 person.

2) Married Individual with Community Spouse

Determine ABD countable resources using chapter S11 and subchapter M1480.

Compare to ABD CN/CNNMP resource limit = $2000 for 1 person

b. F&C groups

1) Unmarried Individual or Married Individual with no Community Spouse

- Determine F&C CN/CNNMP countable resources using chapter M06 for the unmarried institutionalized individual.
- Compare to F&C CN/CNNMP resource limit = $1,000.

2) Married Individual with Community Spouse

- Determine ABD countable resources, Chapter S11, M1480.
- Compare to ABD CN/CNNMP resource limit = $2000 for 1 person.

2. Are resources within CN/CNNMP limit?

Yes: *eligible in the covered group whose income limit is met; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.*

No: go to *item* 3 below.

3. Does person meet an MN covered group?

Yes: go to section M1460.410 "Steps for Determining MN Eligibility," below.

No: person is not eligible for Medicaid because of excess resources; STOP. Go to section M1460.660 for notice procedures.

M1460.410 STEPS FOR DETERMINING MN ELIGIBILITY

A. Does person meet an MN covered group?

Yes: go to B below "Determine MN Resources."

No: person is not eligible for Medicaid because his gross income exceeds 300% of SSI and he does not meet a medically needy covered group; STOP, unless he has Medicare Part A. If he has Medicare Part A, determine eligibility for ABD MI, *except for the ABD 80% FPL group*. LTC services will not be covered. If he does not have Medicare Part A, go to section M1460.660 for notice procedures.

B. Determine MN Resources

1. ABD Groups

Determine ABD countable resources, Chapter S11.

Compare to ABD MN resource limit = $2,000 for 1 person.

2. F&C Groups

a. Unmarried Individual or Married Individual with No Community Spouse

Determine F&C MN countable resources, Chapter M06.

Compare to F&C MN resource limit = $2,000 for 1 person.

b. Married Individual with Community Spouse

Determine ABD countable resources, Chapter S11, M1480.

Compare to ABD MN resource limit=$2000

3. Are resources within MN limit?

Yes: go to C "Determine MN Income" below.

No: person not eligible for Medicaid due to excess resources; STOP. Go to section M1460.660 for notice procedures.

C. Determine MN Income

1. ABD groups

Determine ABD MN countable income, Chapter S08.

Compare to MN income limit for 1 person in individual's home locality - where the individual last resided in Virginia outside of an institution (use Group III MN limit if individual was admitted to Virginia facility from out-of-state).

2. F&C groups

Determine F&C MN income, Chapter M07.

Compare to MN income limit for 1 person in individual's home locality - where the individual last resided in Virginia outside of an institution (use Group III MN limit if individual was admitted to Virginia facility from out-of-state).

3. Is Income Less Than or Equal to MN Income Limit?

NOTE: A person who has gross income exceeding the 300% SSI limit will **always** have countable income that exceeds the MN limit.

Yes: eligible as MN; STOP. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

No: Spenddown; excess amount is "spenddown liability." Go to 4. below for facility patients, 5. below for CBC recipients.

4. Spenddown--Facility Patients

a. Spenddown Liability Less Than or Equal to Facility Medicaid Rate

If the spenddown liability is less than or equal to the facility's Medicaid rate, determine spenddown eligibility by projecting facility costs at the Medicaid rate for the month. Spenddown balance after deducting projected costs at the Medicaid rate should be zero or less.

The patient is eligible as MN for the whole month. Use Type 1 to enroll. Go to section M1460.660 for enrollment and subchapter M1470 for patient pay.

b. Spenddown Liability More Than Facility Medicaid Rate

When the spenddown liability is **more than** the facility Medicaid rate, determine spenddown eligibility AFTER the month has passed, on a daily basis (do not project expenses) by chronologically deducting old bills and carry-over expenses, then deducting the facility daily cost at the **private** daily rate and other medical expenses as they were incurred.

If the spenddown is met on any date within the month, the patient is eligible effective the first day of the month in which the spenddown was met. Eligibility ends the last day of the month.

Each month must be evaluated separately. These patients will always be enrolled after the month being evaluated has passed. Use eligibility Type 4 to enroll.

5. Spenddown--CBC Patients

Do not project CBC waiver services costs. Eligibility is evaluated on a monthly basis. Determine spenddown eligibility AFTER the month has passed, by deducting old bills and carry-over expenses first, then (on a daily basis) chronologically deducting the daily CBC cost at the **private** daily rate and other medical expenses **as they are incurred.** If the spenddown balance is met on a date within the month, the patient is eligible effective the first day of the month in which the spenddown was met. Eligibility ends the last day of the month.

Each month must be evaluated separately. These patients will always be enrolled after the month being evaluated has passed. Use eligibility Type 4 to enroll.

M1460.500 RESOURCE DETERMINATION

A. Introduction

The following sections describe the resource eligibility rules that are applicable to individuals in long-term care.

B. Resource Limits

1. ABD Groups

ALL aged, blind and disabled (ABD) covered groups = $2,000 per individual.

2. F&C Groups

F&C 300% SSI and Hospice groups = $1,000, regardless of the number of individuals in the assistance unit.

MN groups = $2,000 for an individual. $3,000 for 2 persons (pregnant woman with 1 unborn child; add $100 for each additional unborn child).

There are no resource requirements for any other F&C covered group.

C. Budget Period

The budget period for determining long-term care resource eligibility is always one month.

M1460.510 DETERMINING COUNTABLE RESOURCES

A. Married Individual

1. With A Community Spouse

See **subchapter M1480** for the rules to determine the **institutionalized individual's resource eligibility** when he is married and his spouse is a community spouse (the spouse is not in a medical institution or nursing facility).

a. Community Spouse Not Receiving Medicaid CBC Waiver Services

When both husband and wife have applied for Medicaid and one is institutionalized, and the community spouse does NOT receive Medicaid CBC waiver services, the community spouse's eligibility is processed as a noninstitutionalized individual.

NOTE: Follow resource determination rules found in chapter S11 for ABD covered groups, and in chapter M06 for F&C covered groups. The community spouse's resource eligibility is determined as a couple in the month the other spouse becomes institutionalized, and as an unmarried individual for the following months.

b. Community Spouse Receives Medicaid CBC Waiver Services

When both husband and wife have applied for Medicaid and one is institutionalized in a medical facility, and the community spouse receives Medicaid CBC waiver services, the community spouse's eligibility is processed as a married institutionalized Medicaid CBC recipient in the initial month of Medicaid CBC and afterwards, using the policy and procedures in subchapter M1480.

2. Both Spouses In A Medical Facility (No Community Spouse)

When the institutionalized individual's spouse is NOT a community spouse (the spouse is in a medical institution or nursing facility), the policy and procedures in subchapter M1460 that apply to an **unmarried individual** apply to the institutionalized individual effective the month of institutionalization and apply to the individual's spouse if the spouse also applies for Medicaid. Do not use subchapter M1480 because the individual is not an "institutionalized spouse" as defined in M1480.

When both husband and wife are institutionalized in a facility, the policy and procedures in subchapter M1460 that apply to **unmarried** individuals apply to each spouse in the initial month of institutionalization and afterwards.

3. Both Spouses Receive Medicaid CBC

When both spouses have applied for Medicaid and both receive Medicaid CBC waiver services, each spouse must be evaluated using policy and procedures in subchapter M1480**.**

B. Unmarried Individual

1. ABD Covered Groups

An institutionalized individual is an assistance unit of 1 person, considered living separately from his family. No resources are deemed available from the individual's spouse. To determine the ABD resource eligibility of an unmarried individual, or married individual with no community spouse, use the ABD Resource policy and procedures found in chapter S11 and in section M1460.500.

For the ABD 80% FPL covered group, use the ABD resource policy and procedures in chapter S11 and Appendix 2 to chapter S11.

The maximum allowable resource limit for an ABD individual is $2,000.

NOTE: If the individual's resources exceed the resource limit, and the individual has Medicare Part A, evaluate for eligibility as QMB, SLMB, QI-1 or QI-2 (limited coverage) which have a higher resource limit.

2. F&C Covered Groups

An institutionalized individual is an assistance unit of 1 person, considered living separately from his family. No resources are deemed available from a child's parent(s).

NOTE: A pregnant woman's assistance unit includes the number of unborn children with which she is pregnant.

Use the resource policy and procedures in chapter M06 for the resource determination.

M1460.520 RETROACTIVE RESOURCE DETERMINATION

A. Policy

When an applicant reports that he received a medical service within the retroactive period, evaluate Medicaid eligibility for that period.

Evaluate resource eligibility for each month using resources available during that month.

B. Reduction of Resources

An individual cannot retroactively reduce resources. If countable resources exceeded the resource limit **throughout** a retroactive month, the individual is **not** eligible for that month. However, if an applicant reduces excess resources **within** a retroactive month, he may be eligible in the month in which the value of his resources is reduced to or below the Medicaid resource limit.

In order to reduce resources, liquid resources such as bank accounts and prepaid burial accounts must actually have been expended. Non-liquid resources must have been liquidated and the money expended.

M1460.530 HOME OWNERSHIP (*NOT APPLICABLE TO ABD 80% FPL GROUP)*

A. Policy

The policy in this section does not apply to the ABD 80% FPL group. See Appendix 2 to chapter S11 for home ownership resource policy for the ABD 80% FPL group.

The institutionalized individual's former home in which he has an ownership interest, and which he occupied as his residence before becoming institutionalized, is not a countable resource for the first six months **following** admission to a medical facility or nursing facility. The former home is excluded indefinitely when it is occupied by a spouse, minor child, aged or disabled adult child, or an aged or disabled parent.

B. Definitions for This Section

1. Dependent

A dependent child or parent is one who may be claimed as a dependent for tax purposes under the Internal Revenue Service's Code by either the institutionalized individual or his spouse.

2. Institutionalization

a. Definition

Institutionalization means receipt of 30 consecutive days of :

- care in a medical facility (such as a nursing facility), or
- Medicaid waiver services (such as community-based care); or
- a combination of the two.

The definition of institutionalization is also met when an individual has a signed hospice election that has been in effect for 30 consecutive days.

The 30 consecutive days requirement is expected to be met if the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC) services *(see M1410.010).*

NOTE: For purposes of this definition, continuity is broken by 30 or more consecutive days *of*:

- absence from a medical institution, or
- non-receipt of Medicaid waiver services.

EXCEPTION: When an individual is readmitted in less than 30 days due to a different diagnosis or a change in condition unforeseen at the time of discharge, a new 6-month home exclusion will begin if it was medically documented that the discharge occurred because facility services were no longer required and a physician documents that the change in circumstances could not be anticipated.

b. When Institutionalization Begins

Institutionalization begins the date of admission to a nursing facility or Medicaid waiver services when the pre-admission screening committee provides verbal or written confirmation of its approval for the individual's receipt of long-term care (LTC) services, or when the individual has been in the nursing facility for at least 30 consecutive days.

Institutionalization begins the date of admission to a hospital (acute care) when the individual has actually been a patient in the hospital for 30 consecutive days or more. For example, an individual was admitted to the general hospital on March 5. He applied for Medicaid on March 6. On April 3, he was still a patient in the general hospital. He was in the hospital for 30 consecutive days on April 3; his institutionalization began on the date he was admitted to the hospital, March 5. His eligibility for March is determined as an institutionalized individual, in the covered group of individuals in medical institutions with income less than or equal to 300% of SSI.

*The date of discharge from a medical institution into the community (and not receiving CBC waiver services) or death is **NOT** included in the 30 days.*

3. Home Property

The home property is defined based on the individual's covered group, except when the individual is married with as community spouse. When the individual is married with a community spouse, **go to subchapter M1480.**

a. ABD Groups

The home property definition in section M1130.100 applies to ABD covered groups. An individual's home is property that serves as his or her principal place of residence. A home shall mean the house and lot used as the principal residence and all contiguous property, as long as the value of the land, exclusive of the lot occupied by the house, does not exceed $5,000. If the individual has property contiguous to his home, the value of the non-home contiguous property over $5,000 is a countable resource, unless it can be excluded for another reason listed in subchapter S1130.

b. F&C Groups

The home property definition in section M0630.115 applies to F&C covered groups. Home property is the home used as the principal residence and all contiguous property. Contiguous property is the land, and improvements on that land, which adjoins the home and which is not separated by land owned by others.

4. Former Home

The patient's former home (including a mobile home) is his primary residence:

- which he owns, and
- which he occupied as his residence prior to admission to an LTC facility, or prior to moving out to receive Medicaid CBC waiver services in another person's home.

C. Exclude Former Home Indefinitely

The former home property can be excluded indefinitely when one of the following conditions is met:

1. Occupied By Spouse or Minor Child

The former home is occupied by the individual's spouse, minor dependent child under age 18, or dependent child under age 19 if attending school or vocational training.

2. Occupied By Disabled Adult Child or Disabled Parent

The former home is occupied by the individual's parent or adult child who:

- is age 65 years or older (is presumed to be disabled because of age),
- or, if under age 65 years, *has been determined to be* disabled according to the Medicaid disability definition;
- lived in the home with the recipient for at least one year prior to the recipient's institutionalization; and
- is dependent upon the recipient for his shelter needs.

3. ABD Groups--Home Exclusion Does Not Apply To Contiguous Property

For unmarried individuals and married individuals with no community spouses, the home exclusion for ABD covered groups applies to the home (dwelling) and the plot of land on which the home is located, and to the property contiguous to the home that comes under the home exclusion by using one of the two different calculations in section M1130.100. The home exclusion DOES NOT apply to the property contiguous to the home that does **not** come under the home definition in section M1130.100 A.2.

If the ABD individual owns property contiguous to his home, the value of the non-home contiguous property is a countable resource, regardless of whether the home is occupied by a dependent relative, unless the contiguous property can be excluded for another reason listed in subchapter S1130.

D. 6-Months Home Exclusion

The home is excluded as a primary residence during temporary absences for visits or to obtain medical treatment. The former home property is excluded as a resource for 6 months, beginning with the month **following** the month institutionalization begins.

1. ABD Groups--Exclusion Does Not Apply To Contiguous Property

The 6-month home exclusion for ABD covered groups applies to the home (dwelling) and the plot of land on which the home is located, and to the property contiguous to the home that comes under the home exclusion by using one of the two different calculations in section M1130.100. The 6-month home exclusion DOES NOT apply to the property contiguous to the home that does **not** come under the home definition in section M1130.100 A.2.

Therefore, if the ABD individual owns property contiguous to his home, the value of the non-home contiguous property is a countable resource, regardless of the individual's temporary absence, unless the contiguous property can be excluded for another reason in subchapter S1130.

2. Facility Admission

The former home property is excluded for 6 full months beginning with the month **following** the month of institutionalization in a medical facility. The property is no longer "home property" after 6 months of absence due to institutionalization. An individual who has been receiving Medicaid CBC waiver services in his own home and who then enters a nursing facility receives the six months former home exclusion starting with the month following the month of admission to the facility.

Individuals re-admitted to a medical facility 30 days or more after discharge will have the six-months former home exclusion start over again.

EXAMPLE #1: Mr. G is an unmarried aged individual who has been receiving Medicaid CBC waiver services in his home since February 2, 1997. He was admitted to a nursing facility on June 20, 1998. He owns his home, which has no contiguous property. His former home property is excluded for 6 months after admission, beginning July 1, 1998 and ending December 31, 1998

3. Medicaid CBC Waiver Services Admission

A Medicaid CBC waiver services recipient who is living away from the home established as his primary place of residence, in order to receive medical care, is entitled to the six months' home exclusion. The six months will start with the month **following** the month in which he left his home.

An individual who is discharged from a nursing facility to go home and receive Medicaid CBC waiver services is considered as living on the home property. The home property, as defined by the appropriate manual section, is excluded while the individual lives there.

EXAMPLE #2: Mr. B is an unmarried aged individual living in his home. He was admitted to Medicaid CBC waiver services on January 20, 1999, the day he moved into his daughter's home. He owns his home, which has no contiguous property. His former home property is excluded for 6 months after the month in which he moved to his daughter's home. The 6-months exclusion begins February 1, 1999 and ends July 31, 1999.

E. After Six Months

At the end of six months of continuous absence due to institutionalization, the former home property must be counted as an available resource if owned by the recipient, unless it can be excluded for another reason.

1. Exclude Indefinitely

The former home property (residence) can be excluded indefinitely when one of the conditions in section M1460.530 C. above is met.

2. Exclude Under Resource Rules

If the former residence is not excluded because it is not occupied by an individual who meets the requirements in section M1460.530 C. above, determine if it can be excluded under the resource rules applicable to the individual's covered group.

a. ABD Covered Groups

1) Reasonable but Unsuccessful Efforts to Sell (section M1130.140).

2) Indians' Interest in Trust or Restricted Lands (section S1130.150).

3) Other Real Property (section M1130.160).

4) Property Essential to Self-support (sections S1130.500 through S1130.510).

b. F&C Covered Groups

1) Excluded Resources (section M0630.100).

2) Reasonable Effort To Sell (CN, CNNMP) (section M0630.105).

3) Reasonable Effort To Sell For the Medically Needy (section M0630.110).

F. Home No Longer Excluded

If the individual's home property is no longer excluded and the individual has excess resources, cancel Medicaid because of excess resources when the individual does not have Medicare Part A. If the individual has Medicare Part A, evaluate the individual's eligibility as ABD MI, which has more liberal resource requirements and limits.

1. Individual Has Medicare Part A

When the individual has Medicare Part A:

a. compare income with the ABD MI limits; if the income is below one of the ABD MI income limits, then

b. evaluate the resources using ABD MI policy as found in Chapter S11, Appendix 2.

c. If eligible as ABD MI only, Medicaid will not pay for nursing facility or CBC waiver services costs. Do the following:

- prepare and send an Advance Notice of Proposed Action to the recipient;
- cancel the recipient's coverage in the MMIS, then reinstate the recipient to ABD MI limited coverage;
- send a *Medicaid LTC Communication Form (DMAS-225)* to the provider, stating that the recipient is no longer eligible for full Medicaid coverage because of excess resources, but is eligible for limited ABD MI coverage; beginning (specify the date following the cancel date of the recipient's full coverage), Medicaid will not pay for the individual's care.

d. If NOT eligible as ABD MI because of resources and/or income, cancel the recipient's Medicaid. Do the following:

- prepare and send an "Advance Notice of Proposed Action" to the recipient;
- cancel the recipient's Medicaid coverage in the MMIS because of excess resources or income;

- send a *DMAS-225* to the provider, stating that the recipient's Medicaid will be canceled because of excess resources (and/or income) and the effective date of cancellation.

2. Individual Does Not Have Medicare Part A

When the individual DOES NOT have Medicare Part A:

a. cancel the recipient's Medicaid coverage in the MMIS because of excess resources;

b. prepare and send an Advance Notice of Proposed Action to the recipient;

c. send a *DMAS-225* to the provider, stating that the recipient's Medicaid will be canceled because of excess resources, and the effective date of cancellation.

M1460.540 SUSPENSION PROCEDURES

A. Policy

This section applies ONLY to Medicaid recipients:

- who are enrolled in ongoing Medicaid coverage and
- whose patient pay exceeds the Medicaid rate.

B. Procedures

If a Medicaid recipient's patient pay exceeds the Medicaid rate and his resources go over the Medicaid resource limit, take the following actions:

1. For Recipients Who Have Medicare Part A

a. Resources Less Than or Equal to ABD MI Resource Limit

If the recipient's resources are less than or equal to the higher ABD MI resource limit, **determine** if the recipient's income is less than or equal to the QMB, SLMB, or QI income limit.

1) When the recipient's income is less than or equal to the QMB, SLMB, or QI income limit:

a) prepare and send an advance notice to reduce the recipient's Medicaid coverage from full benefits to limited benefits (specify the appropriate QMB, SLMB, or QI coverage). Write a note on the notice telling the recipient that:

- the limited (QMB, SLMB, or QI) benefits will NOT pay for long-term care services, and
- if he verifies that his resources are less than or equal to the $2,000 resource limit, he should request reinstatement of full Medicaid benefits.

b) **cancel** the recipient's full coverage line in the MMIS effective the last day of the month in which the 10-day advance notice period expires, using cancel reason "07". Reinstate the recipient's coverage with the begin date as the first day of the month following the cancellation effective date, using the appropriate QMB, SLMB or QI PD.

2) When the recipient's income exceeds the QMB, SLMB and QI income limits, follow the procedures in 2 below (the procedures for recipients who do not have Medicare Part A).

b. Resources Exceed ABD MI Resource Limit

If resources are greater than the ABD MI resource limit, follow the procedures in item 2 below (the procedures for recipients who do not have Medicare Part A).

2. For Recipients Who Do NOT Have Medicare Part A

a. Prepare and Send Advance Notice

Prepare and send an advance notice to cancel the recipient's Medicaid eligibility. Specify the effective date, which is the last day of the month in which the 10-day advance notice period expires. Write a note on the notice telling the recipient that if he verifies that his resources are less than or equal to the $2,000 resource limit before the specified date (specify the date which is 3 months from the cancel effective date), he should request reinstatement of Medicaid eligibility.

b. Cancel Medicaid Eligibility

Cancel the recipient's eligibility in the MMIS effective the last day of the month in which the 10-day advance notice period expires.

c. Suspend Case Administratively

Suspend the case administratively for a maximum of 3 months; do not close the case statistically. The suspension effective date is the effective date of the Medicaid cancellation in the MMIS. While suspended, the case remains open for a maximum of 3 months.

If, by the end of 3 months from the suspension effective date, the individual provides verification that his resources have been reduced to or below the resource limit, document the reduction in resources in the individual's case record. Reinstate his Medicaid eligibility in the MMIS effective the first day of the month in which his resources are less than or equal to the resource limit.

If the individual does NOT provide verification within 3 months of the suspension effective date that his resources have been reduced to or below the resource limit, close the case administratively and statistically. Do not take any action on his enrollment in the MMIS, because his eligibility has already been canceled. The individual will have to file a new Medicaid application.

M1460.600 INCOME DETERMINATION

A. Introduction

This section provides the income requirements specific to determinations of eligibility for Medicaid participation in payment of long-term care services.

B. F&C Medically Indigent

If an institutionalized individual meets an F&C Medically Indigent covered group, determine if his income is within the appropriate F&C Medically Indigent income limit. The institutionalized individual is an assistance unit of one person; no income is deemed from responsible relatives. Use the policy and procedures in chapter M07 to determine countable income.

C. *300% SSI Income Limit Group*

For purposes of this section, we refer to the ABD covered group and the F&C covered group of "individuals in medical facilities who have income less than or equal to 300% of the SSI individual payment limit" and "individuals receiving Medicaid waiver services who have income less than or equal to 300% of the SSI individual payment limit" as one covered group. We refer to this one group as "institutionalized individuals who have income within 300% of SSI" or the "300% SSI group."

1. Assistance Unit

The institutionalized individual is an assistance unit of one person; no income is deemed from responsible relatives.

2. Income Limit

The income limit for ABD and F&C individuals in the 300% SSI group is 300% of the SSI individual payment limit (see M0810.002 A. 3.).

3. Countable Income

Income sources listed in section M1460.610 are NOT considered income.

Income sources listed in section M1460.611 ARE counted as income.

All other income is counted. The individual's gross income is counted; no exclusions are deducted.

To determine an income type or source and to determine how to count the income, use the policy and procedures in chapter S08 for all individuals (both ABD and F&C) in this covered group.

Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.

D. *ABD 80% FPL Group*

If an individual is aged, blind or disabled, determine if his income is less than or equal to 80% of the FPL. See M0810.002.A.5 for the ABD 80% FPL income limits. Use the policy in chapter S08 to determine countable income.

E. MN Income - All MN Covered Groups

The medically needy (MN) individual income limits are listed in Appendix 5 to subchapter M0710 and in section M0810.002.A.4.

1. ABD MN Covered Groups

Evaluate MN resource and income eligibility for ABD individuals who have resources and/or income over the 300% SSI income limit.

The income sources listed in sections M1460.610 "What is Not Income" and M1460.611 "Countable Income for the 300% SSI Group" are NOT counted. Countable income is determined by the income policy in chapter S08; applicable exclusions are deducted from gross income to calculate the individual's countable income.

The income actually received in the retroactive period is considered for retroactive eligibility. The income expected to be received within the application month is considered when determining eligibility in that month. The income expected to be received within a month is counted in that month for ongoing eligibility.

2. F&C MN Covered Groups

Evaluate MN resource and income eligibility for F&C individuals who have resources and/or income over the 300% SSI income limit.

Countable income is determined by the income policy in chapter M07, using a monthly budget period; applicable exclusions are deducted from gross income to calculate the individual's countable income. In addition, the income sources listed in sections M1460.610 "What is Not Income" and M1460.611 "Countable Income for the 300% SSI Group" are NOT counted.

Anticipated income is projected for the month for which eligibility is being determined. This calculation is based upon the income received in the prior month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount to be received.

***F.* Expected Contributions From Legally Responsible Relatives**

An expected contribution from a legally responsible relative is not counted as available unless it is actually contributed to the institutionalized individual.

M1460.610 WHAT IS NOT INCOME

A. Introduction

This section contains a list of items that are not considered as income when determining income eligibility for institutionalized individuals in medical facilities or Medicaid CBC waiver services.

NOTE: The income items in C. below ARE COUNTED as income only when determining F&C medically needy eligibility.

B. What Is Not Income - All Covered Groups

Do not consider the types of items in this subsection as income **when determining eligibility or patient pay for all covered groups.**

1. Federal/State Government Payments & Programs

Benefits provided under the following federal and state government program payments are not income:

a. Supplemental Security Income (SSI) payments.
b. Auxiliary grants (AG) payments.
c. Temporary Assistance to Needy Families (TANF) payments.
d. *Supplemental Nutrition Assistance Program (SNAP) (formerly* Food Stamps*)*.
e. Women, Infants and Children (WIC) coupons.
f. IV-E and Non IV-E Foster Care payments [ref. 1612(b)(10)].
g. IV-E and Non IV-E Adoption Assistance payments.
h. Food and Meal programs with government involvement:

- school breakfasts,
- school lunches,
- milk programs.

2. Medical or Social Services

(S0815.050) Cash or in-kind items received from governmental medical or social services programs, unless it is remuneration for work or activities performed as a participant in a sheltered workshop or an incentive payment to encourage individuals to use specific facilities or to participate in specific medical or social services programs, is not income. For example, Title XX, Title IV-B, Child Welfare Services, Title V, Maternal and Child Health Services, services under the Rehabilitation Act of 1973 are cash or in-kind medical or social services received from a government program and are NOT income.

NOTE: Education in public schools, vocational training and government income maintenance programs such as VA are NOT social services programs. The provision of food, shelter, laundry, or recreation is not a social service.

3. Non-government Medical or Social Services

(S0815.050 F1) Cash received from **non-governmental** medical or social services programs, such as Red Cross or Salvation Army, for medical or social services already received by individuals and approved by the organizations is not income.

4. Personal Services

(S0815.150) Personal services performed for an individual is not income, e.g., mowing the lawn, doing housecleaning, going to the grocery store, babysitting are not counted as income to the individual who receives the personal service.

5. Conversion of a Resource

(S0815.200) Receipts from the sale, exchange, or replacement of a resource are not income; they are a conversion of a resource from one form of resource to another form of resource.

6. Income Tax Refund

(S0815.270) Any amount refunded on income taxes already paid is not income.

7. Credit Life/Disability Payments

(S0815.300) Payments made under a credit life or credit disability insurance policy on behalf of an individual are not income.

8. Loan Proceeds

(S0815.350) Proceeds of a bona fide loan are not income to the borrower because of the borrower's obligation to repay.

9. Third Party Payments

a. Payments made by another individual

(S0815.400) Payment of an individual's bills (including Medicare supplementary medical insurance or other medical insurance premiums) by a third party directly to the supplier is not income.

Payments made directly to the service provider by another person for the individual's private room or "sitter" in a medical facility are **not** income to the individual. Refer all cases of Medicaid eligible recipients who have a "sitter" to DMAS, Division of Long-term Care, for DMAS review to assure that DMAS is not paying the facility for services provided by the sitter.

EXCEPTION: For F&C covered groups **except** the 300% SSI group: If the person paying the bill(s) is the child's absent father and the Division of Child Support Enforcement (DCSE) has not established an obligation for the absent parent, the amount(s) paid by the absent parent for the child is counted as income.

b. Long-term care (LTC) insurance payments

Institutionalized individuals who have LTC insurance coverage must have the LTC insurance coverage information entered into the recipient's TPL file on MMIS. The insurance policy type is "H" and the coverage type is "N."

If the patient receives the payment from the insurance company, it is not counted as income. The patient should assign it to the provider. If the patient cannot do this, or the policy prohibits assignment, the payment should be given directly to the provider facility. The provider should report the payment as a third party payment on its claim form. If the patient received the payment and cannot give it to the provider for some reason, then the patient should send the insurance payment to the DMAS Fiscal Division, Accounts Receivable, 600 E. Broad Street, Suite 1300, Richmond, Virginia 23219.

10. Replacement Income

(S0815.450) If an individual's income is lost, stolen, or destroyed and the individual receives a replacement, the replacement is not income if the original payment was counted in determining the individual's Medicaid eligibility.

11. Erroneous Payments

(S0815.460) A payment is not income when the individual is aware that he is not due the money and returns the check uncashed or otherwise refunds all of the erroneously received money.

12. Weatherization Assistance

(S0815.500) Weatherization assistance (e.g., insulation, storm doors, and windows, etc.) is not income.

13. Certain Employer Payments

(S0815.600) The following payments by an employer are not income UNLESS the funds for them are deducted from the employee's salary:

a. funds the employer uses to purchase qualified benefits under a "cafeteria" plan;

b. employer contribution to a health insurance or retirement plan;

c. the employer's share of FICA taxes or unemployment compensation taxes in all cases;

d. the employer's share of FICA taxes or unemployment compensation taxes paid by the employer on wages for domestic service in the private home of the employer or for agricultural labor only, to the extent that the employee does not reimburse the employer.

14. Payments to Victims of Nazi Persecution

Any payments made to individuals because of their status as victims of Nazi persecution are not income [P.L.103-286 and 1902(r)(1)].

15. Advance Payments That will Be Reimbursed

Advance payments made by a person other than the patient which are expected to be reimbursed once Medicaid is approved, and payments made by outside sources to hold the facility bed while the patient is hospitalized, are **not counted as income** in determining eligibility or patient pay.

There are instances when the family of a prospective Medicaid patient, or other interested party(ies), makes an advance payment on the cost of facility care prior to or during the Medicaid application process to assure the Patient's admission and continued care. The individual may have been promised that the advance payment will be refunded if Medicaid eligibility is established. Any monies contributed toward the cost of patient care pending a Medicaid eligibility determination must be reimbursed to the patient or the contributing party by the facility once Medicaid eligibility is established.

16. Medical Expense Reimbursement

Medical expense reimbursement from either VA or an insurance policy is not income. Medical expense reimbursements are resources.

The income in items 17 through 23 below are not income by other federal statutes or law:

17. Energy Assistance

Energy Assistance through Block Grants (Virginia's Fuel Assistance payments) is excluded [P.L. 93-644].

18. Radiation Exposure Trust Fund

Radiation Exposure Compensation Trust Fund payments are excluded [P.L. 101-426].

19. Agent Orange Agent Orange Payments are excluded [P. L. 101-239].

20. Native American Funds The following funds for Native Americans are excluded:

a. Alaska Native Claims Settlement Act (cash payments not to exceed $2,000) [P.L. 100-241]

b. Maine Claims Settlement Act [P.L. 96-420]

c. Blackfeet and Gros Ventre [P.L. 92-254]

d. Grand River Band of Ottawa [P.L. 94-540]

e. Red Lake Band of Chippewa [P.L. 98-123]

f. Assiniboine Tribe of Fort Peck Montana [ref. P.L. 98-124]

g. Assiniboine Tribe of Port Belknap [ref. P.L. 98-124]

h. Shoshone and Arapaho Tribes of Wind River Reservation of Wyoming [ref. P.L. 98-64].

21. Indian Trust or Restricted Land Payments

Income from individual interests in Indian Trust or Restricted Lands up to $2,000 per year in payments is excluded [ref. P.L. 103-66].

22. Walker v. Bayer Settlement Payments

The following payments from the settlement of the Walker v. Bayer Corp., et.al., lawsuit (sometimes called the "Hemophilia Litigation Settlement") are excluded as income: [ref. P.L.105-33].

a. payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corp., et.al., or

b. payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement of Walker v. Bayer Corp., et.al., and that is signed by all affected parties on or before the later of

- December 31, 1997, or
- the date that is 270 days after the date on which such release is first sent to the persons to whom the payment is to be made.

The **interest** received on these excluded funds is NOT excluded and must be counted as income in the month received.

23. Home Produce

Home produce consumed by the individual or his household is excluded as income. Proceeds from the sale of home produce ARE counted as earned or unearned income [ref. 1612(b)(8)].

C. What Is NOT Income For All Covered Groups EXCEPT F&C MN

The items below are NOT income when determining eligibility for all covered groups EXCEPT for the F&C MN covered groups. Count these income sources in the F&C medically needy income determination, **but NOT in the patient pay calculation.**

1. Specific VA Payments

The following VA payments are NOT income for all covered groups EXCEPT the F&C MN covered groups:

a. Payments for Aid and Attendance or housebound allowances. Refer to section M1470.100 for counting Aid and Attendance payments as income in the patient pay calculation.

NOTE: This applies to all LTC recipients, including those patients who reside in *state* veterans' care centers.

b. Payments for unusual medical expenses.

c. Payments made as part of a VA program of vocational rehabilitation.

d. VA clothing allowance.

e. Any pension paid to a nursing facility patient who is

- a veteran with no dependents, or
- a veteran's surviving spouse who has no child.

NOTE: Refer to section M1470.100 for counting VA pension payments as income for post-eligibility determinations. This applies to all LTC recipients who reside in *state* veterans' care centers.

f. Any portion of a VA educational benefit which is a withdrawal of the veteran's own contribution is a conversion of a resource and is not income.

2. VA Augmented Benefits

An absent dependent's portion of an augmented VA benefit received by the individual on or after 11-17-94 is NOT income to the individual when determining his eligibility in any covered group EXCEPT an F&C MN covered group.

VA Augmented benefits are COUNTED as income when determining eligibility in the F&C MN covered groups.

3. Return of Money

(S0815.250) A rebate, refund, or other return of money that an individual has already paid is NOT income to the individual when determining his eligibility in any covered group EXCEPT an F&C MN covered group. The key idea is a return of the individual's own money. Some "rebates" do not fit this category, such as a cooperative operating as a jointly owned business pays a "rebate" as a return on a member's investment; this "rebate" is unearned income similar to a dividend.

4. Death Benefits

Death benefits **equal** to cost of last illness and burial are NOT income in all covered groups EXCEPT the F&C MN covered groups.

Any amount of the death benefit that **exceeds** the costs of last illness and burial **is counted as income** for eligibility and patient pay **in all covered groups**.

5. Austrian Social Insurance

Austrian Social Insurance payments that meet the requirements in S0830.715 are NOT income in all covered groups EXCEPT the F&C MN covered groups.

6. Native American Funds

a. Seneca Nation Settlement Act [ref. P.L. 101-503]

b. Yakima Indian Nation [ref. P.L. 99-433]

c. Papago Tribe of Arizona [ref. P.L. 97-408]

d. Shawnee Indians [ref. P.L. 97-372]

e. Miami Tribe of Oklahoma and Indiana [ref. P.L. 97-376]

f. Clallam Tribe [ref. P.L. 97-402]

g. Pembina Chippewa [ref. P.L. 97-403]

h. Confederated Tribes of Warm Springs Reservation [ref. P.L. 97-436].

M1460.611 COUNTABLE INCOME FOR THE 3OO% SSI GROUP

A. Applicability

This section contains a list of income sources and amounts of income that are COUNTED when determining income eligibility for the 300% SSI group, but may be excluded when determining income eligibility for the other covered groups.

B. Items Under 1612(b) and Footnote 57 (counted also as patient pay income)

Count the following income sources in this subsection when determining eligibility for the **300% SSI income limit group**.

DO NOT COUNT the income sources in this section when determining the income eligibility in **all other Medicaid covered groups.**

1. ACTION Program

Action Program. This is the federal domestic volunteer agency which provides programs such as the Special and Demonstration Volunteer Programs. This includes the following programs: [Refer to P.L. 93-113]

- Retired Senior Volunteer Program (RSVP)
- Foster Grandparent Program
- Senior Companion Program
- University Year for Action
- VISTA
- Special and Demonstration Volunteer Programs.

2. BIA Student Assistance

Bureau of Indian Affairs Student Assistance [ref. P.L. 89-329].

3. Disaster Assistance

Presidentially declared disaster assistance. This includes assistance from federal programs and agencies, joint federal and state programs, state or local government programs, and private organizations such as the Red Cross [1612(b) (11)].

4. EITC

Earned income tax credit payments [1612(b) (19)].

5. Federal Relocation

Federal Relocation Assistance [ref. P.L. 91-646].

6. Infrequent or Irregular Income

Any infrequent/irregular income. See Chapter S08 for the ABD policy. See Chapter M07 for the F&C policy.

7. Native Americans' Funds

Funds for Native Americans, including funds from:

- Indian Tribal Judgment Funds Use or Distribution Act [ref. P.L. 93-134]
- ·Indian Tribes Submarginal Land Act [ref. P.L. 94-114].

8. Specific Restitution

Japanese-American and Aleutian Restitution payments [ref. P.L. 100-383].

9. Grants, Scholarships, Fellowships

Any portion of a grant, scholarship or fellowship that is for the cost of tuition and fees at any educational institution, including those for vocational or technical training [1612(b)(7)].

10. Student Loans & Grants

The following student loans or grants:

a. National Defense Student Loans [ref. P.L. 89-329].
b. Pell Grants [ref. P.L. 89-329].
c. Supplemental Education Opportunity Grants (SEOG) [ref. P.L. 89-329].
d. State Student Incentive Grants [ref. P.L. 89-329].

C. Count for 300% SSI Group; (counted as patient pay income)

Count the income sources in this subsection when determining eligibility and patient pay for the **300% SSI group AND all F&C covered groups**.

Do not count the income sources in this section when determining the Income eligibility of the **ABD MN** covered groups.

1. Interest on Disaster Assistance

Interest income on disaster assistance within first nine months of receipt of the payment [1612(b) (12)].

2. Tax Refund

Tax refund on food or real property.

3. Assistance Payments

State or local assistance payments that are based on need [1612(b) (6)].

4. Energy Assistance

Support or maintenance assistance which is based on need and which is furnished in kind by a nonprofit agency, or furnished by supplier of home heating oil or gas, by an entity providing home energy, or by a municipal utility providing home energy [1612(b)(13)]. Energy assistance that is provided by a source other than the "Block Grants" (Virginia's Fuel Program) [1612(b) (13)].

5. Housing Assistance

Housing assistance (including Farmer's Home Assistance payments) under the U.S. Housing Act of 1937, the National Housing Act, section 101 of the Housing and Urban Development Act of 1965, title V of the Housing Act of 1949, or section 202(h) of the Housing Act of 1959 [1612(b) (14)] *paid directly to the applicant/recipient. Do not count housing assistance payments that are not paid directly to the applicant/recipient.*

6. Domestic Travel Tickets Gifts of domestic travel tickets [1612(b)(15)].

7. Victim's Compensation Victim's compensation provided by a state.

8. Tech-related Assistance Tech-Related Assistance for Individuals with Disabilities [ref. P.L. 100-407].

9. $20 General Exclusion $20 a month general income exclusion for the unit.

EXCEPTION: Certain veterans (VA) benefits are not subject to the $20 income exclusion. Refer to subchapter S0830 for complete explanation of which VA payments are entitled to the $20 general exclusion.

10. PASS Income Any unearned income used to fulfill an SSI approved plan to achieve self-support (PASS). See item 12 below for earned income used to fulfill a PASS [1612(b) (4)(A) & (B)].

11. Earned Income Exclusions The following earned income exclusions are not deducted for the 300% SSI group:

a. In 2010 and *2011*, up to $1,640 per month, but not more than $6,600 in a calendar year, of the earned income of a blind or disabled student child

b. Any portion of the $20 monthly general income exclusion which has not been excluded from unearned income in that same month [1612(b) (2)(A)].

c. $65 of earned income in a month [1612(b) (4)(C)].

d. IRWE - earned income of disabled individuals used to pay impairment-related work expenses [1612(b) (4)(B)].

e. One-half of remaining earned income in a month [1612(b) (4)(C)].

f. BWE - Earned income of blind individuals used to meet work expenses [1612(b) (4)(A)].

g. Earned income used to fulfill an SSI approved plan to achieve self-support (PASS) [1612(b) (4)(A) & (B)].

12. Child Support Child support payments received from an absent parent for a blind or Disabled child [1612(b) (9)].

13. **Native American Funds**

The following Native American funds (only exclude for ABD MN groups):

a. Puyallup Tribe [ref. P.L. 101-41]
b. White Earth Reservational Land Settlement [ref. P.L. 99-264]
c. Chippewas of Mississippi [ref. P.L. 99-377]
d. Saginaw Chippewas of Michigan [ref. P.L. 99-346]
e. Shoalwater Bay Indian Tribe [ref. P.L. 98-432]
f. Wyandotte Tribe [ref. P.L. 98-602]
g. Chippewas of Lake Superior [ref. P.L. 99-146]
h. Cow Creek Band of Umpqua [ref. P.L. 100-139]
i. Coushatta Tribe of Louisiana [ref. P.L. 100-411]
j. Wisconsin Band of Potowatomi [ref. P.L. 100-581]
k. Seminole Indians [ref. P.L. 101-277]
l. receipts from land distributed to:

- Pueblo of Santa Ana [ref. P.L. 95-498]
- Pueblo of Zia [ref. P.L. 95-499].

14. **State/Local Relocation**

State or local relocation assistance [1612(b) (18)].

15. **USC Title 37 Section 310**

Special pay received pursuant to section 310 of title 37, United States Code [1612(b)(20)].

NOTE: For additional F&C medically needy (MN) income exclusions, go to Chapter M07. For additional ABD medically needy (MN) income exclusions, go to Chapter S08.

M1460.620 RESERVED

M1460.640 INCOME DETERMINATION PROCESS FOR STAYS LESS THAN 30 DAYS

A. Policy - Individual in An Institution for Less Than 30 Days

This subsection is applicable ONLY if it is known that the time spent in the institution has been, or will be, less than 30 days. If the individual is institutionalized for less than 30 days, Medicaid eligibility is determined as a non-institutionalized individual because the definition of "institutionalization" is not met. If there is no break between a hospital stay and admission to a nursing facility or Medicaid CBC waiver services, the hospital days count toward the 30 days in the "institutionalization" definition.

B. Recipient

If a Medicaid recipient is admitted to a medical institution for less than 30 days, go to subchapter M1470 for patient pay policy and procedures.

C. Applicant

If the individual is NOT a Medicaid recipient and applies for Medicaid determine the individual's income eligibility as a non-institutionalized individual. Go to Chapter M07 for F&C or S08 for ABD to determine the individual's income eligibility.

M1460.650 RETROACTIVE INCOME DETERMINATION

A. Policy

The retroactive period is the three months immediately prior to the Application month. The three-month retroactive period cannot include a portion of a prior Medicaid medically needy spenddown budget period in which eligibility was established.

1. Institutionalized Individual

For the retroactive months in which the individual was institutionalized *in a medical facility,* determine income eligibility on a monthly basis using the policy and procedures in this subchapter (M1460). *An individual who lived outside of a medical institution during the retroactive period must have retroactive Medicaid eligibility determined as a non-institutionalized individual.*
A spenddown must be established for any month(s) during which excess income existed. Go to M1460.700 for spenddown policies and procedures for medically needy institutionalized individuals.

2. Individual Not Institutionalized

For the retroactive months in which the individual was NOT institutionalized, determine income eligibility for the ABD groups using the ABD policy and procedures in chapter S08. Determine income eligibility for the F&C groups using policy and procedures in chapter M07. A spenddown must be established for any month(s) during which excess income existed. See Chapter M13 for spenddown policies and procedures.

3. Retroactive Entitlement

If an applicant meets all eligibility requirements, he is entitled to Medicaid coverage for the month(s) in which all eligibility factors were met.

B. Countable Income

Countable income is that income which was actually received in the retroactive month(s). Count the income received in the months in which the individual meets all other Medicaid eligibility requirements.

If the individual was CNNMP in the retroactive month, the countable income is compared to the appropriate income limit for the retroactive month. **Medicaid income eligibility is determined on a monthly basis for the MN institutionalized individual.**

C. Entitlement

Retroactive coverage cannot begin earlier than the first day of the third month prior to the application month. When an applicant reports that he received a medical service within the retroactive period, entitlement for Medicaid will begin with the first day of the third month prior to the application month, provided all eligibility factors were met in all three months. If the institutionalized applicant had excess income in the retroactive period, entitlement may begin the first day of the month in which the retroactive spenddown was met.

For additional information, refer to section M1510.101.

D. Retroactive Income Determination Example

EXAMPLE #3: A disabled institutionalized individual applies for Medicaid on June 5 and requests retroactive coverage for unpaid medical bills that he incurred in March, April, and May. His disability onset date was April 10. He was institutionalized on April 10. The retroactive period is March, April and

May. He is not eligible for March because he did not meet a covered group in March. The income he received in April and May is counted monthly because he was institutionalized in each month. He is resource eligible for all three months.

His April income is calculated and compared to the monthly 300% SSI income limit. It exceeds that limit. His May income is calculated and compared to the monthly 300% SSI income limit; it is within the limit. Therefore, he is placed on a one-month retroactive spenddown for April, and is enrolled in the 300% SSI covered group for May.

M1460.660 NOTICES & ENROLLMENT PROCEDURES FOR CATEGORICALLY NEEDY AND MEDICALLY INDIGENT

A. Eligible--CN, CNNMP & F&C MI

Enroll the recipient with the appropriate CN, CNNMP or F&C MI *aid category (AC)* as follows:

1. CN

a. Supplemental Security Income (SSI) recipients EXCEPT AG recipients, regardless of living arrangements.
***0*11** Aged
***0*31** Blind
***0*51** Disabled

b. All Auxiliary Grant (AG) recipients, including those who receive SSI.
***0*12** Aged
***0*32** Blind
***0*52** Disabled

c. IV-E foster care (AFDC-FC) or IV-E adoption assistance (AFDC-AA) child who is IV-E eligible.
***0*74**

2. CNNMP

a. Individuals not receiving SSI or TANF because of an eligibility condition specifically prohibited by Medicaid (e.g., stepparent's income deemed available); protected individuals such as former SSI, AG, or AFDC recipients; 12-month Extended and Transitional Medicaid recipients.
***0*21** Aged
***0*41** Blind
***0*61** Disabled
***0*81** Low Income Families With Children (LIFC)
***0*83** LIFC--Unemployed/underemployed parent deprivation

b. Child age *19 or 20* in intermediate care facility or ICF-MR, *not determined blind or disabled.*
***0*82**

c. Non-IV-E (state/local) Adoption Assistance child & Special Medical Needs Adoption Assistance child under age 21.
***0*72**

d. Child under age 21, responsibility of Juvenile Justice Department.
***0*75**

e. Non-IV-E (state/local) foster care child under age 21
***0*76**

***3.* ABD 80% FPL**

ABD individuals with income less than or equal to 80% FPL
***0*29** Aged
***0*39** Blind
***0*49** Disabled

***4.* F&C MI**

a. Pregnant woman w/income less than or equal to the 133% FPL
***0*91**

b. Child under age 6 w/income less than or equal to the **100% FPL**
***0*91**

c. Child under age 6, income greater than the **100% *FPL* b**ut less than or equal to the **133% FPL**
***0*90**

d. Child age 6 to 19
- **insured or uninsured** w/income less than or equal to the **100% FPL;**
- **insured** w/income greater than 100% and less than or equal to the **133% FPL**
***0*92**

e. **Uninsured** child age 6 to 19 w/income greater than 100% FPL and less than or equal to the **133% FPL**
094

***5.* Complete & Send Notice**

Complete a "Notice of Action on Medicaid *and FAMIS* to notify the individual of his Medicaid eligibility and coverage begin date. Go to subchapter M1470 to determine the individual's patient pay.

B. Eligible--300% SSI Group

If the individual's gross income is less than or equal to the 300% SSI income limit, determine patient pay according to the policy and procedures found in Subchapter M1470.

1. Individual Has Medicare Part A

If the individual has Medicare Part A, determine if his income is within the QMB income limit. Calculate the individual's countable income for QMB according to Chapter S08, and compare to the QMB limit. If the individual's gross income is less than or equal to the QMB limit, enroll the recipient with the appropriate CNNMP *AC*:

- ***0*22** Aged
- ***0*42** Blind
- ***0*62** Disabled.

If the income is over the QMB limit, enroll the recipient with the appropriate CNNMP *AC*:

- ***0*20** Aged
- ***0*40** Blind
- ***0*60** Disabled.

2. Individual Does Not Have Medicare Part A

If the individual does NOT have Medicare Part A, enroll the **ABD** *patient* with the appropriate CNNMP aid category:

- ***0*20** Aged
- ***0*40** Blind
- ***0*60** Disabled.

Enroll the **F&C** *patient* with the appropriate CNNMP *AC*:

***0*60** *Institutionalized F&C individual who does not meet the "Individuals Under Age 21 in an ICF or ICF/MR" covered group, who has not been determined blind or disabled and does not have Medicare*

***0*82** Institutionalized child under age 21 *in an ICF or ICF-MR who has not been determined blind or disabled.*

NOTE: *Children under age 19 who are eligible in the MI Child Under Age 19" covered group should be enrolled in the appropriate MI AC.*

3. Complete & Send Notice

Complete and send a "Notice of Action on Medicaid" to the individual notifying him of his Medicaid eligibility and coverage begin date. Go to subchapter M1470 to determine the individual's patient pay.

B. Income Exceeds 300% SSI Limit

If income exceeds the 300% SSI limit, evaluate as MN. If the individual meets an MN covered group, re-calculate countable income for MN.

Subtract the income exclusions listed in sections M1460.610 and 611 that apply to the individual's MN covered group. Go to section M1460.700 below.

If the individual does NOT meet an MN covered group, he is not eligible for Medicaid; go to subsection C. below.

C. Ineligible--Notice

Complete and send a "Notice of Action on Medicaid and FAMIS" to the individual notifying him that he is not eligible for Medicaid and of his appeal rights.

M1460.700 MEDICALLY NEEDY INCOME & SPENDDOWN

A. Policy

Institutionalized individuals whose income exceeds the 300% SSI income limit must be placed on a monthly medically needy (MN) spenddown if they meet a medically needy (MN) covered group and have countable resources that are less than or equal to the MN resource limit. Countable income for the medically needy (MN) is different than countable income for the 300% SSI covered group. Recalculate income using medically needy income principles.

For individuals who were within a spenddown budget period prior to the month in which they become institutionalized, prorate and shorten the spenddown budget period for the months prior to admission to long-term care services.

Income for all LTC recipients is determined on a monthly basis. Upon receipt of long term care services, the spenddown budget period is one month. A separate monthly spenddown budget period is established for each month of receipt of LTC services.

A spenddown case is considered denied; however, the application is valid for a certification period of 12 months from the last application or redetermination.

B. Spenddown Procedures

The spenddown procedures for facility patients differ from the spenddown procedures for CBC patients. The expected monthly cost of the facility care is projected at the beginning of the month. The cost of CBC is NOT projected and must be deducted daily as incurred. Specific instructions for determining MN income eligibility for facility and CBC patients are provided in the following sections:

- M1460.710 Spenddown For Facility Patients
- M1460.720 Facility Spenddown Enrollment Procedures
- M1460.740 Spenddown For Patients Receiving CBC
- M1460.750 MN CBC Spenddown Enrollment Procedures.

M1460.710 SPENDDOWN FOR FACILITY PATIENTS

A. Policy

Facility patients in the MN classification fall into two distinct subgroups for the purpose of spenddown eligibility determination. These subgroups are:

1. individuals with a spenddown liability less than or equal to the monthly Medicaid rate for the facility.

2. individuals with a spenddown liability greater than the monthly Medicaid rate for the facility.

Entitlement and enrollment procedures depend on whether the individual's spenddown liability is less than, equal to or greater than the facility's Medicaid rate.

Applications for individuals who are placed on spenddown are valid for a 12 month period and the cases are subject to annual redetermination.

B. Determine the Spenddown Liability

Calculate the individual's monthly MN income:

1.ABD MN Group

a. Start with the gross monthly income for the ABD MN income determination found in section M1460.600 E. 1.

b. Subtract the applicable ABD MN income exclusions. The result is the MN countable income.

c. Subtract the monthly MN income limit for 1 person in the individual's home locality from the MN monthly countable income. The remainder is the ABD individual's spenddown liability.

2. F&C MN Groups

a. Start with the gross monthly income for the F&C MN income determination found in section M1460.600 E. 2.

b. If the unit has earned income, subtract the F&C earned income exclusions in M0720.500 except for the 30 + 1/3 exclusion which is not applicable to this group.

If the Unit has child support income, subtract the $50 child support exclusion. See section M0730.400.

c. The remainder is the MN monthly countable income.

d. Subtract the monthly MN income limit appropriate to the individual's home locality from the MN monthly countable income. The remainder is the F&C individual's spenddown liability.

C. Determine the Facility's Projected Medicaid Rate

The facility's projected Medicaid rate is the Medicaid per diem multiplied by 31 days. For the month of entry, use the actual number of days that care was received or is projected to be received in the facility.

D. Compare

Compare the individual's spenddown liability to the facility's Medicaid rate.

E. SD Liability Is Less Than or Equal To Medicaid Rate

If the spenddown liability is less than or equal to the facility's Medicaid rate, the individual is income eligible as medically needy for the full month. Individuals with a spenddown liability less than or equal to the Medicaid rate will meet their spenddown based on the Medicaid rate alone. The Medicaid rate is projected and compared to the spenddown liability. Because the spenddown liability is less than the monthly Medicaid rate, eligibility begins the first day of the month.

Go to section M1460.720 below for enrollment procedures.

F. SD Liability Is Greater Than Medicaid Rate

If the spenddown liability is greater than the facility's Medicaid rate, the individual is NOT income eligible as MN. The individual must incur medical expenses, including old bills, carry-over expenses and the facility's cost of care at the private rate, that equal or exceed the spenddown liability for the month. These determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred.

To determine spenddown eligibility for a medically needy individual whose spenddown liability is greater than the Medicaid rate, go to G. below.

G. Facility Spenddown Determination Procedures

To determine spenddown eligibility for a medically needy institutionalized individual whose spenddown liability is greater than the Medicaid rate, take the following actions:

1. Calculate Private Cost of Care

Multiply the facility's **private** per diem rate by the number of days the individual was actually in the facility in the month. Do not count any days the individual was in a hospital during the month.

The result is the private cost of care for the month.

2. Compare to Spenddown Liability

Compare the private cost of care to the individual's spenddown liability for the month.

a. Private Cost of Care Greater Than or Equal To Spenddown Liability

If the private cost of care is **greater than or equal to** the individual's spenddown liability, the individual meets the spenddown in the month because of the private cost of care. He is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the individual in Medicaid with the begin date of the first of the month, the end date the last day of the month, eligibility Type 4. Go to section M1460.720 below for enrollment procedures. Determine patient pay according to subchapter M1470.

b. Private Cost of Care Less Than Spenddown Liability

If the private cost of care is less than the individual's spenddown liability, **determine spenddown on a day-by-day basis** in the month by deducting allowable incurred expenses from the spenddown liability.

From the spenddown liability, deduct old bills, carry-over expenses and incurred medical/remedial care expenses per subchapter M1340. When the monthly spenddown liability is reduced to $0, eligibility is established. Eligibility can be established only AFTER the expenses are actually incurred.

If the spenddown is met any time during the month, the individual is eligible for full month coverage. Enroll the individual in Medicaid with the begin date of the first of the month, the end date the last day of the month, eligibility Type 4. Go to section M1460.720 below for enrollment procedures. Determine patient pay according to subchapter M1470.

5. Example - Cost of Care Less Than Spenddown Liability, No Prior Spenddown

EXAMPLE #4: Mr. Not lives in Group III and applied for Medicaid on April 21 as a disabled individual. He is in a nursing facility and was admitted on April 1. The MDU determined that he is disabled. He has not previously been on spenddown. He has a $8,400 hospital bill and a $1,500 physician's bill for October 10 to October 20 (total $9,900) on which he still owes a total of $9,000. He has a $578 outpatient hospital bill for November 3. He has no health insurance. His income is $1,800 per month disability benefit from a private company. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His resources are within the Medicaid limit in April (application month).

He is not eligible as CNNMP because his $1,800 gross income exceeds the 300% SSI income limit. The facility's Medicaid rate is $45 per day. His MN income eligibility is calculated:

$1,800	disability benefit
- 20	general income exclusion
$1,780	MN countable income
- 325	MNIL for 1 month for 1 person in Group III
$1,455	spenddown liability

The Medicaid rate for the admission month is calculated as follows:

$ 45	Medicaid per diem
x 30	days
$1,350	projected facility Medicaid rate

The $1,455 spenddown liability is greater than the Medicaid rate of $1,350. Because his spenddown liability is greater than the Medicaid rate, his April application is denied and he is placed on a spenddown.

On May 1 his authorized representative requests re-evaluation of his April spenddown eligibility. Mr. Not was in the facility for the entire month of April. The facility's private rate is calculated:

$ 48	private per diem
x 30	days in April
$1,440	facility private rate

The facility cost of care at the private rate, $1,440, is less than Mr. Not's spenddown liability of $1,455. His spenddown eligibility must be determined on a daily basis. Because he was not previously on spenddown, his verified old bills are deducted first from the spenddown liability. He owes the hospital $8,000 and the physician $1,000, total $9,000, as of April 1(the first day of the budget period). His eligibility is calculated:

$1,455	spenddown liability
- 9,000	old bills owed 4-1
0	spenddown balance on 4-1

Because the spenddown was met on April 1, Mr. Not is entitled to medically needy Medicaid for the period 4-1 through 4-30, eligibility Type 4. The old bills' balance, or $7,545 ($9,000- 1,455= $7,545) not used to establish eligibility can be used in subsequent months to reduce the spenddown liability.

6. Example - On Prior Spenddown, Cost of Care Less Than Spenddown Liability

EXAMPLE #5: Ms. Was lives in Group I and applied for Medicaid on May 6, 2001, as disabled. She is in a nursing facility and was admitted on May 1, 2001. She had applied for Medicaid previously and was on a spenddown from December 1, 1999 through May 31, 2000, which she met on May 2, 2000. She did not re-apply until May 2001. She verifies that she has an unpaid $2,300 hospital bill and a $1,500 physician's bill for September 10 to September 12, 2000 (total = $3,800) on which she pays $50 a month. She also has a retroactive incurred expense - a $678 outpatient hospital bill for services dated February 13, 2001. She has no health insurance and is not eligible for Medicare.

She was not institutionalized in the retroactive period. Her income in the retroactive spenddown budget period was $1,600 per month CSA disability. The retroactive spenddown budget period is February, March and April; the income limit is $650.

Her retroactive spenddown liability is $4,090.

$1,600	CSA disability
- 20	general income exclusion
1,580	countable income
x 3	months
4,740	countable income for retroactive spenddown budget period
- 650	MNIL for retroactive spenddown budget period
$4,090	retroactive spenddown liability

Her May 2001 application is a re-application. The September 2000 medical expenses are old bills based on her May 2001 re-application because they were incurred prior to the re-application's retroactive period, were not incurred during a prior spenddown budget period in which eligibility was established. These old bills, totaling $3,800, are deducted from the retroactive spenddown liability. Her retroactive spenddown eligibility is calculated:

$4,090	retroactive spenddown liability
- 3,800	September 2000 old bills (hospital & physician bills)
290	spenddown balance on February 2, 2001
- 678	February 13, 2001 outpatient expense
0	spenddown balance on February 13, 2001

The retroactive spenddown was met on February 13, 2001. Ms. Was is enrolled in retroactive Medicaid for the period February 13, 2001 through April 30, 2001. .

Her income starting May 1, 2001 increased. Her Civil Service Annuity is $1,620 per month and she began to receive Social Security of $300 per month; total income is $1,920 per month. Because this exceeds the CNNMP 300% SSI income limit, her medically needy income eligibility is calculated as follows:

$1,920.00	total monthly income
- 20.00	general income exclusion
1,900.00	countable income
- 216.67	MNIL for 1 month for 1 person in Group I
$1,683.33	spenddown liability

The facility's Medicaid per diem rate is $45. The projected Medicaid rate for the month is calculated as follows:

$ 45	Medicaid per diem
x 31	days
$1,395	projected facility Medicaid rate

The $1,683.33 spenddown liability is greater than the Medicaid rate of $1,395. Because her spenddown liability is greater than the Medicaid rate, her May application is denied and she is placed on a monthly spenddown for the certification period of May 1, 2001 through April 30, 2002.

On June 3, her authorized representative requests re-evaluation of her spenddown for May. She was in the facility for 31 days in May. The private cost of care for May is calculated:

$ 53	private per diem cost
x 31	days in May
$1,643	private cost of care

The private cost of care, $1,643, is less than her spenddown liability of $1,683.33. Therefore, her spenddown eligibility in May must be determined on a daily basis. The prospective budget period is May 1 through May 31, 2001. Since all of her September 2000 incurred medical expenses were used to meet her retroactive spenddown, they cannot be deducted from her current spenddown, even though she still owes money on those expenses and makes payments on them. The only incurred medical expenses which can be deducted are the medical expenses she incurred in May. In addition to the facility care, she incurred a doctor's expense on May 30 of $100. Her spenddown eligibility for May is determined:

$1,683.33	spenddown liability
- 1,590.00	30 days @ $53 per day (5-1 through 5-30)
- 100.00	noncovered doctor's expense 5-30-2001
0	spenddown balance on 5-30-2001

Because the spenddown was met on May 30, Ms. Was is entitled to Medicaid coverage beginning May 1, 2001 and ending May 31, 2001, eligibility Type 4.

M1460.720 FACILITY SPENDDOWN ENROLLMENT PROCEDURES

A. Program Designation

1. Individual Does Not Have Medicare Part A

If the individual does Not have Medicare Part A, use the appropriate MN PD:

- Aged = **18**
- Blind = **38**
- Disabled = **58**
- Child Under 21 in ICF/ICF-MR = **98**
- Child Under 18 = **88**
- Juvenile Justice Child = **85**
- Foster Care/ Adoption Assistance Child = **86**
- Pregnant Woman = **97**

2. Individual Has Medicare Part A

If the individual has Medicare Part A, compare the individual's monthly MN countable income to the QMB monthly income limit for 1 person (see section M0810.002 for the current QMB limit):

a. When income is less than or equal to the QMB limit, enroll using the following PD's:

- Aged = **28**
- Blind = **48**
- Disabled = **68**

b. When income is greater than the QMB limit, enroll using the following PDs:

- Aged = **18**
- Blind = **38**
- Disabled = **58**

B. Patient Pay

Determine patient pay according to subchapter M1470.

C. Notices & Re-applications

1. Spenddown Liability Less Than or Equal to Medicaid Rate

When the individual's spenddown liability is less than or equal to the 31-day Medicaid rate for the facility, the individual has ongoing eligibility for the 12-month certification period. The individual must file a redetermination after the 12-month certification period ends.

2. Spenddown Liability Greater Than Medicaid Rate

When the individual's spenddown liability exceeds the facility's Medicaid rate and the spenddown is met, the individual does **NOT** have ongoing eligibility. Therefore, the individual will need to submit monthly reports of actual expenses and changes in income and resources so that spenddown eligibility can be determined each month. This report, "Medical Expense Record - Medicaid" (form # 032-03-023) is found in subchapter M1330, Appendix 1. Instructions for use and completion are also in subchapter M1330, Appendix 1.

The notification to the applicant (and his representative) approving the application with spenddown must include a copy of the "Medical Expense Record - Medicaid" for the individual to use to provide verification of the expenses used to meet the spenddown.

a. When Spenddown Liability is Met

When expenses have been incurred, the individual must submit the "Medical Expense Record - Medicaid" with bills or receipts for medical services either paid or incurred, and evidence of third party payment or denial of payment if applicable. Entitlement begins the first day of the month in which the spenddown is met, and ends on the last day of the month; the individual is enrolled in eligibility Type 4.

Appropriate notice of action must be sent to the applicant every time spenddown eligibility is evaluated. After eligibility is established, the usual reporting and notification processes apply. The individual must provide verification of income and resources for any month for which bills are presented.

b. Certification Period

The certification period is 12 months; therefore, a new application is not required each month. However, the applicant must file a redetermination for Medicaid when the 12-month certification period ends. If the redetermination is not filed, the individual's Medicaid must be canceled, the case must be closed and the individual will have to file a new application.

M1460.740 SPENDDOWN FOR PATIENTS RECEIVING CBC

A. Policy

An individual meets the definition of "institutionalized" when he is screened and approved for Medicaid waiver services and the services are being provided. An individual who has been screened and approved for Medicaid waiver services and whose income exceeds the CNNMP 300% SSI income limit is not eligible for Medicaid until he meets the monthly spenddown liability. These determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred. The private cost of his home-based medical care is deducted as a noncovered medical expense.

For an individual on spenddown **before** starting Medicaid CBC waiver services, the spenddown budget period and the spenddown liability are prorated and recalculated to include the months prior to the receipt of Medicaid CBC services. A separate monthly spenddown budget period is calculated for each month of receipt of Medicaid CBC services.

A medically needy (MN) CBC patient must incur medical expenses, including old bills, carry-over expenses and the cost of CBC at the private rate, that equal or exceed the spenddown liability for the month. From the spenddown liability, deduct old bills, carry-over expenses and incurred medical/remedial care expenses per section M1340.210. When the monthly spenddown liability is reduced to $0, eligibility is established. Eligibility can be established only AFTER the expenses are actually incurred. Do not project CBC expenses. The eligibility begin date is the first day of the month in which the spenddown was met and the end date is the last day of the month.

B. CBC Spenddown Eligibility Procedures

To determine spenddown eligibility for a CBC institutionalized individual, take the following actions:

1. Calculate Private Cost of Care

Multiply the CBC provider's (or providers' if the individual has multiple CBC providers) **private** hourly rate by the number of hours of service the individual actually received from the provider in the month.

The result is the private cost of care for the month.

2. Compare to Spenddown Liability

Compare the private cost of care to the individual's spenddown liability for the month.

3. Private Cost of Care Greater Than or Equal To Spenddown Liability

If the private cost of care is **greater than or equal to** the individual's spenddown liability, the individual meets the spenddown in the month because of the private cost of care. He is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the individual in Medicaid with the begin date of the first of the month, the end date the last day of the month, eligibility Type 4. Go to section M1460.750 below for enrollment procedures. Determine patient pay according to subchapter M1470.

4. Private Cost of Care Less Than Spenddown Liability

If the private cost of care is less than the individual's spenddown liability, **determine spenddown on a day-by-day basis** in the month by deducting allowable incurred expenses from the spenddown liability. Refer to section M1340.210 to determine allowable deductions from the individual's spenddown liability.

If the spenddown is met any time in the month, the individual is eligible for full-month Medicaid coverage beginning the first day of the month in which the spenddown was met and ending the last day of the month, eligibility Type 4.

5. Example - Private Cost of Care Less Than Spenddown Liability, No Prior Spenddown

EXAMPLE #6: Mr. May lives in Group III and applied for Medicaid on April 21, 2000, as a disabled individual. He was screened and approved for the E&D waiver on April 10, 2000. The MDU determined that he is disabled. He has no health insurance. His income is $1,800 per month disability benefit from a private company. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His resources are within the Medicaid limit in April 2000 (application month).

He is not eligible as CNNMP because his $1,800 gross income exceeds the 300% SSI income limit. His MN income is calculated:

$1,800	disability benefit
- 20	general income exclusion
$1,780	MN countable income
- 325	MNIL for 1 month for 1 person in Group III
$1,455	spenddown liability

His CBC costs cannot be projected. Eligibility can be established only after the expenses are actually incurred. He received 20 days of CBC services in April.

His April application is denied and he is placed on a monthly spenddown for the certification period of 4-1-2000 through 3-31-2001.

$ 8	per hour private rate
x 6	hours per day, 7 days a week
$ 48	private per diem cost
x 20	days in April
$ 960	private cost of care

The private cost of care, $960, is less than Mr. May's spenddown liability of $1,455. His Medicaid eligibility was not established in April.

6. Example - On Prior Spenddown, Private Cost of Care More Than Spenddown Liability

EXAMPLE #7: Ms. Gray lives in Group I and applied for Medicaid on May 6, 2000, as disabled. She was screened and approved for Medicaid E&D waiver services on May 2, 2000; the services started on May 4, 2000. She is not married and has no dependents. She had applied for Medicaid previously and was on a spenddown from December 1, 1998 through May 31, 1999, which she met on May 2, 1999. She did not re-apply until May 2000. She verifies that she has an unpaid $2,300 hospital bill and a $1,500 physician's bill for September 10 to September 12, 1999 (total = $3,800) on which she pays $50 a month. She also has an incurred expense in the retroactive period - a $678 outpatient hospital bill for services dated February

13, 2000. She has no health insurance and is not eligible for Medicare.

She was not institutionalized in the retroactive period. Her income in the retroactive spenddown budget period was $1,600 per month Civil Service Annuity (CSA) disability. The retroactive spenddown budget period is February, March and April, 2000; the income limit is $650.

Mrs. Gray's retroactive spenddown liability is $4,090:

$1,600	CSA disability
- 20	general income exclusion
1,580	countable income
x 3	months
4,740	countable income for retroactive spenddown budget period
- 650	MNIL for retroactive spenddown budget period
$4,090	retroactive spenddown liability

There was a break between spenddown budget periods (June, July, August, September, October, November and December 1999 and January 2000). The September 1999 medical expenses are old bills based on her May 2000 re-application because they were incurred prior to the re-application's retroactive period and were not incurred during a prior spenddown budget period in which eligibility was established. These old bills, totaling $3,800, are deducted from the retroactive spenddown liability. Her retroactive spenddown eligibility is calculated:

$4,090	retroactive spenddown liability
- 3,800	September 1999 old bills (hospital & physician bills)
290	spenddown balance on February 1, 2000
- 678	February 13, 2000 outpatient expense
0	spenddown balance on February 13, 2000 ($388 carry-over balance)

A balance of $388 ($678-290) on the 2-13-2000 outpatient expense remains and can be used as a carry-over expense for the first prospective budget period.

The retroactive spenddown was met on 2-13-2000. Ms. Gray is enrolled in retroactive Medicaid for the period 2-13-2000 through 4-30-2000.

Her income starting May 1, 2000 increased. Her Civil Service Annuity is $1,620 per month and she began to receive Social Security of $300 per month; total income is $1,920 per month. Because this exceeds the CNNMP 300% SSI income limit, her medically needy income eligibility is calculated as follows:

$1,920.00	total monthly income
- 20.00	general income exclusion
1,900.00	countable income
- 216.67	MNIL for 1 month for 1 person in Group I
$1,683.33	spenddown liability
- 388.00	carry-over expense from retroactive period
$1,295.33	spenddown liability balance

Her May application is denied and she is placed on a monthly spenddown for the certification period of May 1, 2000 through April 30, 2001.

On June 3, she submits verification of expenses for May. In May, she received CBC services from one provider for 28 days, 6 hours per day, 7 days per week, at the private hourly rate of $10. The private cost of care for May is calculated:

$ 10	per hour private rate
x 6	hours per day, 7 days a week
$ 60	private per diem cost
x 28	days received services in May
$1,680	private cost of care

The private cost of care, $1,680, is more than her spenddown liability of $1,295.33. Therefore, she is eligible for the period 5-1-2000 through 5-31-2000.

M1460.750 MN CBC ENROLLMENT PROCEDURES

A. Entitlement After Spenddown Met

When a medically needy CBC waiver services patient meets the spenddown, the begin date of eligibility is the first day of the month in which the spenddown is met. There must be a chronological record of costs used to meet the spenddown to substantiate that eligibility was established. Eligibility ends on the last day of the month in which the spenddown liability was met.

B. Procedures

1. Coverage Dates

Coverage begin date is the first day of the month in which the spenddown was met; end date is the last day of the month.

2. Program Designation

a. If individual does NOT have Medicare Part A:

- Aged = **18**
- Blind = **38**
- Disabled = **58**
- Child Under 21 in ICF/ICF-MR = **98**
- Child Under Age 18 = **88**
- Juvenile Justice Child = **85**
- Foster Care/Adoption Assistance Child = **86**

- Pregnant Woman = **97**

b. If individual has Medicare Part A:

Compare the individual's monthly MN countable income to the QMB monthly income limit for 1 person (see section M0810.002 for the current QMB limit):

1) When income is less than or equal to the QMB limit, enroll using the following PDs:

   - Aged = **28**
   - Blind = **48**
   - Disabled = **68**

2) When income is greater than the QMB limit, enroll using the following PDs:

   - Aged = **18**
   - Blind = **38**
   - Disabled = **58.**

3. Patient Pay

Determine patient pay according to subchapter M1470.

4. Notices & Re-applications

The individual is entitled to Medicaid from the first day of the month in which the spenddown was met, until the end of the month. Individuals on spenddowns who are receiving Medicaid CBC waiver services must have their eligibility re-evaluated monthly. The individual must file an annual redetermination.

After eligibility is established, the usual reporting and notification processes apply. Send the Notice of Action on Medicaid and the Notice of Obligation for LTC Costs for the month(s) during which the individual establishes Medicaid eligibility.

Form 200-B
(eff. 9/07)

Partnership Disclosure Notice

[Company Name]
[Company Address]

[Policyholder/Certificateholder] Name:
[Policy/Certificate] Number/Identifier:
Effective Date:

Important Information Regarding Your Policy's [Certificate's]
Long-Term Care Insurance Partnership Status

NOTE: Please keep this Notice with Your Long-Term Care Insurance Policy

Partnership Policy [Certificate] Status. Your long-term care insurance policy [certificate] is intended to qualify as a Partnership Policy [Certificate] under the Virginia Long-Term Care Partnership Program as of your Policy's [Certificate's] effective date.

The long-term care insurance policy [certificate] recently purchased and enclosed qualifies for the Virginia Long-Term Care Insurance Partnership Program. Insurance companies voluntarily agree to participate in the Partnership Program by offering long-term care insurance coverage that meets certain State and Federal requirements. Long-term care insurance policies [certificates] that qualify as Partnership Policies [Certificates] may protect your assets through a feature known as "Asset Disregard" under Virginia's Medicaid program.

Asset Disregard means that an amount of the policyholder's [certificateholder's] assets equal to the amount of long-term care insurance benefits received under a qualified Partnership Policy [Certificate] will be disregarded for the purpose of determining the insured's eligibility for Medicaid. This generally allows a person to keep assets equal to the insurance benefits received under a qualified Partnership Policy [Certificate] without affecting the person's eligibility for Medicaid. All other Medicaid eligibility criteria will apply and special rules may apply to persons whose home equity exceeds $500,000. **In addition, the purchase of this Partnership Policy does not automatically qualify you for Medicaid.**

What Could Disqualify Your Policy [Certificate] as a Partnership Policy. If you make any changes to your policy [certificate], such changes could affect whether your policy [certificate] continues to be a Partnership Policy. ***Before you make any changes, you should consult with [carrier name] to determine the effect of a proposed change.*** In addition, if you move to a state that does not maintain a Partnership Program or does not recognize your policy [certificate] as a Partnership Policy [Certificate], you would not receive beneficial treatment of your policy [certificate] under the Medicaid program of that state. The information contained in this Notice is based on current Virginia and Federal laws. These laws may be subject to change. Any change in law could reduce or eliminate the beneficial treatment of your policy [certificate] under Virginia's Medicaid program.

Additional Information. If you have questions regarding your insurance policy [certificate], please contact [carrier name]. If you have questions regarding current laws governing Medicaid eligibility, you should contact the Virginia Department of Medical Assistance Services.

Form 200-C
(eff. 9/07)

LONG-TERM CARE PARTNERSHIP
CERTIFICATION FORM

Note: This Form must be completed and submitted with each long-term care policy or certificate form for which the insurer is seeking Partnership qualification. A separate form must be completed for each policy form and a specimen copy of the form, including all riders and endorsements, must be attached. A long-term care policy or certificate form may not be issued in Virginia as a partnership policy or certificate unless and until this form has been submitted to and approved by the Bureau of Insurance.

Under § 1917(b)(5)(B)(iii) of the Social Security Act (42 U.S.C. 1396p(b)(5)(B)(iii)) and in accordance with the 14 VAC 5-200-205 D, the insurer hereby submits information relating to policy or certificate form _____ (form number) to substantiate that the form includes all required consumer protection requirements set forth in § 1917(b)(5)(A) of the Social Security Act (42 U.S.C. 1396p(b)(5)(A)) and that it includes certain specified provisions of the Long-Term Care Insurance Model Regulation and Long-Term Care Insurance Model Act promulgated by the National Association of Insurance Commissioners (adopted as of October 2000) (referred to herein as the "2000 Model Regulation" and "2000 Model Act," respectively).

Part I:

Name of Insurer _____

Company NAIC # _____

Address _____

_____

_____

Telephone _____

Company Contact Name _____

Title _____

Telephone _____

E-Mail _____

CHAPTER M14
LONG-TERM CARE
SUBCHAPTER 70

PATIENT PAY — POST-ELIGIBILITY TREATMENT OF INCOME

M1470 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	pages 3, 4, 7-9, 19, 22-24, 43
TN #95	3/1/11	pages 9, 19, 20, 23
TN #94	9/1/10	Table of Contents pages 1, 1a, 3, 3a, 11, 12, pages 19, 20, 24, 28, 31
TN #93	1/1/10	pages 9, 13, 19-20, 23, 43, 44
TN #91	5/15/09	Table of Contents pages 1-56 Appendix 1

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M1470.000 PATIENT PAY-POST-ELIGIBILITY TREATMENT OF INCOME

M1470.001 OVERVIEW

A. Introduction

"Patient pay" is the amount of the LTC patient's income which must be paid as his share of the LTC services cost. This subchapter provides basic rules regarding the post-eligibility determination of the amount of the LTC patient's income which must be paid toward the cost of his care.

B. Policy

The state's Medicaid program must reduce its payment to the LTC provider by the amount of the eligible patient's monthly income, after allowable deductions. Patient pay is calculated after an individual has been determined eligible for Medicaid and for Medicaid LTC services. A Medicaid recipient who is admitted to a nursing facility, ICF-MR or Medicaid waiver services for less than 30 days must have a patient pay determined for the month(s) in which the recipient is in the facility or waiver services**.** The provider collects the patient pay from the patient or his authorized representative. Patient pay information is pulled from the Medicaid Management Information System (MMIS) to the Automated Response System (ARS) and the MediCall Systems for provider verification of patient pay. These systems report the amount of patient pay and the date of service to the provider responsible for collecting patient pay.

C. MMIS Patient Pay Process

The patient pay calculation is completed in MMIS. Refer to the MMIS User's Guide for DSS for information regarding data entry into MMIS. MMIS allows the patient pay to be calculated for up to three months to capture changes in allowances due to the Medicare buy-in, etc. For ongoing enrollees whose patient pay is being entered in MMIS for the first time, or for new enrollees whose patient pay will not change after the first month, it is not necessary to complete the patient pay calculation beyond the first month. The patient pay must be updated in MMIS whenever the patient pay changes, but at least once every 12 months.

The MMIS Allowance and Medically Needy Workbook is available to facilitate the calculation of certain allowances that must be computed outside of MMIS and to calculate patient pay for Medically Needy determinations. The workbook is available at: http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm.

D. Patient Notification

The patient or the authorized representative is notified of the patient pay amount on the Notice of Obligation for Long-term Care Costs. MMIS will generate and send the Notice of Obligation for LTC Costs. M1470, Appendix 1 contains a sample Notice of Obligation for LTC Costs generated by MMIS.

The provider is the only entity with the authority to take action when residents do not pay their patient pay amount. If a resident, or his authorized representative is negligent in paying his patient pay amount to the provider, the provider will provide written documentation regarding the requirement to pay the patient pay amount to the resident or authorized representative and follow the provider's collection procedures to collect the funds. The provider will report the resident's negligence in paying the patient pay amount to the LDSS.

The provider's failure to collect the patient pay, or the patient's failure to pay the patient pay, does not *itself* affect the patient's Medicaid eligibility. However, the

EW must review the patient's resources each month to determine if the resources are within the Medicaid limit.

If the individual resides in a nursing facility and the above attempts to collect the patient pay amount are unsuccessful, DMAS has advised that the facility may take one of the following options:

1. Facility Option #1

The facility will notify the LDSS no later than 120 days from the due date of the payment. The facility will include in this notification a copy of the third collection statement, a written notification of the situation, documentation of contacts made with the resident or authorized representative, and the reasons why payment has not been made.

The LDSS will take the following steps:

- *Upon receipt of the written notice from the facility, the local DSS will review the case to determine if the individual's resources are within Medicaid eligibility limits or if a transfer of assets has occurred.*

- *If the individual alleges that he does not receive sufficient income to pay his patient pay, the eligibility worker will review the patient pay amount and make any necessary adjustments.*

2. Facility Option #2

Discharge or transfer the resident, including transferring the resident within the facility, except as prohibited by the Virginia State Plan for Medical Assistance Services.

Prior to discharge or transfer, the facility must provide reasonable and appropriate notice of the required patient pay, and the resident or authorized representative must be given at least 30 days written notice prior to the discharge or transfer, which shall include appeal rights. If the resident or authorized representative does not agree with this action, he may submit an appeal request to DMAS. The individual will be allowed to continue residing in the facility during the appeal process.

M1470.100 AVAILABLE INCOME FOR PATIENT PAY

A. Gross Income

Gross monthly income is considered available for patient pay. Gross monthly income is the same income used to determine an individual's eligibility in the 300% SSI income group. It includes types and amounts of income which are excluded when determining medically needy eligibility.

1. 300% SSI Group

If the individual is eligible in the 300% SSI group, to determine patient pay start with the gross monthly income calculated for eligibility. Then add and deduct any amounts that are listed in subsection C. below.

2. Groups Other Than 300% SSI Group

If the individual is eligible in a covered group other than the 300% SSI group, determine the individual's patient pay income using subsections B. and C. below.

B. Income Counted For Patient Pay

All countable sources of income for the 300% SSI group listed in section M1460.611 are considered income in determining patient pay. Any other income NOT specified in C. below is counted as income for patient pay.

1. Aid & Attendance and VA Pension Payments

Count the total VA Aid & Attendance payments and/or VA pension payments in excess of $90.00 per month as income for patient pay when the patient is:

- a veteran who does not have a spouse or dependent child, or
- a deceased veteran's surviving spouse who does not have a dependent child.

Do not count any VA Aid & Attendance payments and/or VA pension payments when the patient is:

- a veteran who has a spouse or dependent child, or
- a deceased veteran's surviving spouse who has a dependent child.

NOTE: This applies to all LTC recipients, including patients who reside in a Veterans Care Center.

2. *Non-Refundable* Advance Payments To LTC Providers

Advance payments and pre-payments paid by a recipient to the LTC provider that will not be refunded are counted as income for patient pay. *M1470.1100 contains instructions for calculating the patient pay when an advance payment has been made to reduce resources within a month.*

C. Income Excluded For Patient Pay

Income *from sources* listed in subchapter M1460.610 "What is Not Income" is not counted when determining patient pay, **EXCEPT** for the VA Aid & Attendance and VA pension payments to veterans which are counted in the patient pay calculation (see B. above). *Additional* types of income excluded from patient pay are listed below.

1. SSI *& AG* Payments

All SSI *and Auxiliary Grants (AG)* payments are excluded from income when determining patient pay.

2. Certain Interest Income

a. Interest or dividends accrued on excluded funds which are set aside for burial are not income for patient pay.

b. Interest income when the total interest accrued on all interest-bearing accounts is less than or equal to $10 monthly is not income for patient pay. Interest income that is not accrued monthly must be converted to a monthly amount to make the determination of whether it is excluded.

- Verify interest income at application and each scheduled redetermination.

- If average interest income per month exceeds $10.00 and is received less often than monthly, it must be treated as a lump sum payment for patient pay purposes. Refer to Section M1470.1000 of this subchapter for procedures and instructions.

3. Repayments

Amounts withheld from monthly benefit payments to repay prior overpayments ***are*** income for patient pay *unless the exception in S0830.110 is met.* The patient or his representative should be advised to appeal the withholding *with the benefit source.*

4. CBC Additional Care

Additional care purchased outside of a CBC recipient's plan of care is not counted as income available for patient pay if it is purchased by someone other than the recipient. This additional care may be purchased from any source including the agency providing the CBC.

5. Refundable Payments to LTC Facilities

The family of a prospective Medicaid patient or other interested party may make an advance payment on the cost of facility care prior to or during the Medicaid application process to assure the patient's admission and continued care. The individual may have been promised that the advance payment will be refunded if Medicaid eligibility is established.

Advance payments made by a person other than the patient and which are expected to be reimbursed once Medicaid is approved, as well as payments made by outside sources to hold the facility bed while the patient is hospitalized, are **not counted as income** in determining eligibility or patient pay.

The facility must reimburse any payment contributed toward the cost of patient care pending a Medicaid eligibility determination once Medicaid eligibility is established.

6. Survivor's Benefit Plan Deductions from Military Pensions

Any portion of a military retiree's pension that is withheld as a contribution to participate in the Survivor's Benefit Plan (SBP) is not income for patient pay. To participate in SBP in conjunction with their retirement, military members must elect to receive reduced retirement pay for their lifetime so that a percentage of their retirement pay can continue to be paid to their survivors following their death. Once SBP is elected, retirees cannot discontinue the deductions from their pensions.

M1470.200 FACILITY PATIENTS - ALLOWABLE DEDUCTIONS FROM INCOME

A. Introduction

Sections M1470.210 through 240 are the only allowable deductions from a facility patient's gross monthly income when calculating patient pay in the month of entry and subsequent months when the patient does not have a community spouse.

If the individual is married and his spouse is in a nursing facility, then there is no community spouse and each spouse is treated as an unmarried individual for patient pay purposes. When the patient is an institutionalized spouse with a community spouse, as defined in subchapter M1480, go to subchapter M1480 to determine the institutionalized spouse's patient pay.

2. Dependent Child Allowance See section M1470.220 "Dependent Child Allowance."

3. Noncovered Medical Expenses See section M1470.230 "Facility - Noncovered Medical Expenses."

4. Home Maintenance Deduction See section M1470.240 "Facility - Home Maintenance Deduction."

C. Appeal Rights The patient or his representative has the right to appeal the patient pay determination, the amounts used in the calculation and denial of any request for adjustment. If a recipient or his representative appeals the patient pay, the EW or Medicaid Technician who made the decision prepares the appeal summary and attends the hearing.

M1470.210 FACILITY PERSONAL NEEDS ALLOWANCE

A. Policy The personal needs allowance is calculated according to the instructions in this section for the month of entry and subsequent months. The amount of the personal needs allowance depends on whether or not:

- the patient has a guardian or conservator who charges a fee; or
- the patient has earnings from employment that is part of the treatment plan.

The personal needs allowance is the sum of the basic personal allowance plus the guardianship fee and/or special earnings allowance, if applicable.

1. Basic Personal Allowance Deduct $40 per individual, effective July 1, 2007. The basic personal allowance for prior months is $30.

2. Guardianship Fee Deduct an amount up to 5% of the patient's gross monthly income (including amounts not counted as income and excluded income) for guardianship fees, if the patient has a legally appointed guardian or conservator AND the guardian or conservator charges a fee. The guardianship filing fees CANNOT be deducted from the individual's income. Document how it was determined that the guardian/conservator charges a fee and the amount of the fee.

No deduction is allowed if the patient's guardian is affiliated with a public agency or organization that receives funding for guardianship services.

No deduction is allowed for representative payee or "power of attorney" fees or expenses.

3. Special Earnings Allowance Working patients are allowed a higher personal needs allowance if they meet the following criteria. These patients will be identified by the facility. The patient must regularly participate in vocational activity which is a planned habilitation program and is carried out as a therapeutic work program, such as:

- sheltered workshops
- vocational training
- pre-vocational training.

2. Dependent Child Allowance See section M1470.220 "Dependent Child Allowance."

3. Noncovered Medical Expenses See section M1470.230 "Facility - Noncovered Medical Expenses."

4. Home Maintenance Deduction See section M1470.240 "Facility - Home Maintenance Deduction."

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A. Policy The personal needs allowance is calculated according to the instructions in this section for the month of entry and subsequent months. The amount of the personal needs allowance depends on whether or not:

- the patient has a guardian or conservator who charges a fee; or
- the patient has earnings from employment that is part of the treatment plan.

The personal needs allowance is the sum of the basic personal allowance plus the guardianship fee and/or special earnings allowance, if applicable.

1. Basic Personal Allowance Deduct $40 per individual, effective July 1, 2007. The *basic* personal allowance for prior months is $30.

2. Guardianship Fee Deduct an amount up to 5% of the patient's gross monthly income (including amounts not counted as income and excluded income) for guardianship fees, if the patient has a legally appointed guardian or conservator AND the guardian or conservator charges a fee. The guardianship filing fees CANNOT be deducted from the individual's income. Document how it was determined that the guardian/conservator charges a fee and the amount of the fee.

No deduction is allowed for representative payee or "power of attorney" fees or expenses.

3. Special Earnings Allowance Working patients are allowed a higher personal needs allowance if they meet the following criteria. These patients will be identified by the facility. The patient must regularly participate in vocational activity which is a planned habilitation program and is carried out as a therapeutic work program, such as:

- sheltered workshops
- vocational training
- pre-vocational training.

Deduct a special earnings allowance if the patient participates in a work program as part of treatment. The special earnings allowance is deducted from earned income only. Subtract:

- the first $75 of gross monthly earnings, PLUS
- ½ the remaining gross earnings,
- up to a maximum of $190 per month.

The special earnings allowance cannot exceed $190 per month.

4.* Example - *Calculation of Personal Needs Allowance

A patient in the nursing facility is employed as a telephone salesperson as part of his plan of care in the facility. He has a legally appointed guardian who charges a 2% fee. His only income is gross earnings of $875 per month. *The patient receives deductions for the basic allowance, the guardianship fee, and the special earning allowance.*

His special earnings allowance is calculated first:

$875	gross earned income
- 75	first $75 per month
800	remainder
÷ 2	
400	½ remainder
+ 75	first $75 per month
$475	which is > $190

His personal needs allowance is computed as follows:

$ 40.00	basic allowance
+190.00	special earnings allowance
+ 17.50	guardian fee (2% of $875)
$247.50	personal needs allowance

M1470.220 DEPENDENT CHILD ALLOWANCE

A. Unmarried Individual or Married Individual With No Community Spouse

An unmarried individual, or married individual without a community spouse, who has a minor dependent child(ren) under age 21 in the community, can have a dependent child allowance**.** When the individual verifies that he/she has a dependent child(ren) in the community:

- Calculate the difference between the appropriate monthly medically needy income limit (MNIL) for the child's locality for the number of minor dependent children in the home, and the child(ren)'s gross monthly income. If the child lives outside of Virginia, use the Group III MNIL.

- The result is the dependent child allowance. If the result is greater than $0, deduct it from the patient's monthly income as the dependent child allowance. If the result is $0 or less, there is NO dependent child allowance.

The dependent child allowance *cannot be given when* the dependent child(ren)'s gross monthly income exceeds the monthly MNIL for the number of children in the child(ren)'s locality, if money is not made available or he does not accept the monthly income allowance.

Do NOT deduct any allowance for other family member(s).

1. Example--One Dependent Child (Based on July 2008 figures)

Mrs. K is a married individual who is now residing in a nursing facility. Her spouse is in another medical facility. Their dependent child lives with her sister in a Group II locality. The child receives a $95.00 of Social Security income per month.

The allowance for the dependent child is calculated as follows:

$ 265.39	MN limit for 1 (Group II)
- 95.00	child's SSA income
$ 170.39	dependent child's allowance

NOTE: If Mrs. K's institutionalized spouse is eligible for Medicaid, an allowance for their child may also be deducted from his income in determining his patient pay. However, the income the child receives from Mrs. K will be counted in the child's gross income when determining any allowance from Mr. K.

2. Example--Two Dependent Children (Based on July 2008 figures)

Mr. H is a single individual with gross monthly income of $920, living in a nursing facility. He is divorced and has two children under age 21 who live with his ex-wife in Group I. His two children each receive $75 of monthly Social Security income.

The allowance for the dependent children is calculated as follows:

$ 337.92	MN limit for 2 (Group I)
- 150.00	children's total monthly SSA income
$ 187.92	dependent children's allowance

M1470.230 FACILITY - NONCOVERED MEDICAL EXPENSES

A. Policy

Amounts for incurred medical and dental expenses not covered by Medicaid or another third party are deducted from the patient's gross monthly income when determining patient pay.

B. Health Insurance Premiums

1. *Private or Commercial Insurance*

Payments for medical/health insurance, *including dental insurance*, which meet the definition of a health benefit plan are deducted from patient pay when:

- the premium amount is deducted from the patient's benefit check;
- the premium is paid from the patient's own funds; OR
- the premium is paid by a relative (other than a spouse or parent for minor child) when that relative receives a benefit payment (income) which includes a benefit amount for the patient.

The amount deducted is the amount of the **monthly** premium. If the patient pays the premium less often than monthly, such as quarterly, prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct in the patient pay calculation.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

Health benefit plan does not mean accident only, credit, or disability insurance; long-term care insurance; vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance (14VAC5-234-30).

Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the patient pay.

Membership fees for an organization that sponsors or provides the health insurance are not part of the premium and are not deductible.

2. Medicare Part A and/or B Premiums

Medicare Part B premiums and/or Medicare Part A premiums are paid by Medicaid for eligible individuals. The premiums are paid by Medicaid via the "buy-in" and are not usually deducted from patient pay. However, Medicaid does not start paying the premiums immediately for all eligible patients, so the Medicare premium(s) must be deducted from patient pay in those months for which Medicaid does not pay the premium.

For CNNMP and MN recipients, the Medicare buy-in is effective **2 months after the begin date** of Medicaid coverage. If the begin date of coverage is other than the first day of a month, the buy-in is effective the first of the month in which the 60th day occurs. Part B premiums (and Part A premiums if the recipient must pay the Part A premium) must be deducted from patient pay in the month(s) in which the buy-in is not effective.

Deduct the Medicare premium(s) for the first two months of coverage for the following recipients:

- CNNMP individuals who are not dually eligible QMB,
- MN recipients who are not dually eligible QMB.

The Medicaid Medicare buy-in does NOT pay for Medicare premiums in closed periods of coverage for LTC patients who are on spenddown and whose eligibility is for a closed period. Deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from patient pay in the month(s) in which the buy-in is NOT effective.

For cash assistance and QMB (either just QMB or dually-eligible) enrollees, the buy-in is effective with the begin date of Medicaid coverage. Therefore, do

NOT deduct Medicare premiums in the patient pay determination for months in the retroactive and ongoing coverage periods.

Do not deduct Medicare premiums in retroactive and ongoing coverage periods for the following recipients:

- SSI recipients,
- AG recipients,
- ABD 80% FPL recipients,
- IV-E cash assistance recipients,
- QMB eligible recipients (either dually-eligible or just QMB).

The Medicaid Medicare buy-in pays for Medicare premiums in retroactive coverage and closed periods of coverage EXCEPT for LTC patients who are on spenddown. DO NOT deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from the patient pay in the month(s) in which the buy-in is effective for LTC patients who are NOT on spenddowns.

3. Example--Dual Eligible QMB

Mrs. Q has Medicare coverage and SSA income of $580 per month. Her Medicare premiums are deducted from her SSA check. She was admitted to the nursing facility on September 9. Her daughter filed a Medicaid application for her on September 10.

Mrs. Q is eligible in the CNNMP 300% SSI group in September and is eligible as QMB. Her Medicare premiums are not deducted for September because they will be paid by Medicaid.

4. Example--Not Dual Eligible QMB

Mr. A was admitted to a nursing facility on March 5. He applied for Medicaid on June 2. His monthly income is $1,295, and his Medicare Part B premium is deducted from his SSA check. He is determined to be eligible in the CNNMP 300% SSI covered group effective March 1.

His patient pay for March (the month of entry) includes a deduction for the Medicare premium. Because he is not QMB eligible, the buy-in is effective in May, the second month following the month in which his ongoing Medicaid coverage began. The cost of his Medicare Part B premium is deducted from his patient pay for the months of March and April, as his buy-in will be in effect beginning with the month of May.

If the buy-in is delayed for any reason, the individual will be reimbursed by SSA for premiums deducted after the second month.

5. *Medicare Advantage (Part C) Premiums*

Medicare Advantage plans, also referred to as Medicare Part C, are voluntary managed-care Medicare plans. In addition to Medicare Part B premiums, some individuals may pay an extra Medicare Advantage premium. The Medicaid Medicare buy-in is initiated for individuals with Medicare Advantage ; however, the buy-in covers only the allowable Medicare Part A and/or B premiums. The individual is responsible for any additional Medicare Advantage monthly premium. The Medicare Advantage monthly premium remains the individual's responsibility and is an allowable deduction from patient pay.

6. **Medicare Part D Premiums**

The federal government sets a yearly "benchmark" premium for Medicare Part D Prescription Drug Plans (PDP). An individual who is eligible for Medicare and Medicaid is entitled to premium-free enrollment in a Medicare Part D basic prescription drug plan (PDP) with a "benchmark" premium. However, the individual may elect enrollment in a basic plan with a premium above the benchmark or in an enhanced plan, which offers additional benefits.

Individuals who enroll in a higher-premium basic plan or an enhanced plan are responsible for that portion of the premium attributable above the benchmark rate. When a full-benefit Medicaid enrollee is enrolled in a higher-premium PDP, the portion of the premium that remains the individual's responsibility is an allowable deduction from patient pay.

The benchmark Medicare Part D premium for Virginia for 2011 is $33.25.

7. **LTC Insurance**

a. Deduct LTC premium in admission month only

When an individual has an LTC insurance policy, the individual stops paying premiums beginning the month after he is admitted to LTC. The premium paid for the policy in the admission month can be deducted from the admission month's patient pay only. The LTC insurance premium is not deducted from patient pay for the months following the admission month.

b. LTC insurance benefits

LTC insurance benefits are treated as TPL. If the individual receives the payment from the insurance company, the payment is not income for patient pay or eligibility determinations. The individual should assign it to the nursing facility. If the individual cannot do this, or the policy prohibits assignment, the LTC insurance payment should be given directly to the nursing facility. The facility should report the payment as a third party payment on its claim form.

If the provider is unable to accept payment directly from the individual, the individual must send the insurance payment to:

DMAS Fiscal Division, Accounts Receivable
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

C. Non-covered Medical/Dental Services

Deductions for the cost of a patient's medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay. Some deductions for noncovered services must be approved by DMAS before they can be subtracted from the patient's income.

Services that are covered by Medicaid in the facility's per diem rate cannot be deducted from patient pay as a noncovered service. See M1470.230 C.3 for examples of services that are included in the facility per diem rate.

1. Zero Patient Pay Procedures

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal needs allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, deny the request.

Notify the patient or the patient' authorized representative *of the denial of the request* using the Notice *of Action.*

If a noncovered service is already being deducted, leaving no patient pay, and a new deduction for another noncovered service has been approved, notify the patient or his authorized representative that the deduction for the new noncovered service will be made after the first noncovered service deductions are completed.

2. Allowable Non-covered Expenses

When a patient has income available for patient pay, the following can be deducted as noncovered expenses:

a. Old Bills

"Old bills" are deducted from patient pay as noncovered expenses. "Old bills" are unpaid medical, dental, or remedial care expenses which:

- were incurred prior to the Medicaid application's retroactive period, or during the retroactive period if the individual was not eligible for Medicaid in the retroactive period or the service was not a Medicaid-covered service;
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met; **and**
- remain a liability to the individual.
- **"Old bills" do not require approval from DMAS in order to be deducted in the patient pay calculation even when the amount of the "old bill" exceeds $500.**

b. Medically Necessary Covered Services Provided By A Non-participating Provider

Medically necessary medical and dental services that are covered by Medicaid, but that the enrollee received from a provider who does not participate in Virginia Medicaid, are deducted from patient pay as non-covered services.

c. Covered Services Outside of Medicaid's Scope

Medically necessary medical and dental services exceeding Medicaid's amount, duration, or scope can be deducted from patient pay.

d. Other Allowable Noncovered Services

1) The following medically necessary medical and dental services that are NOT covered by Medicaid can be deducted from patient pay by the local department of social services without DMAS approval when the cost does NOT exceed $500. **If the service is not identified in the list below and/or the cost of the service exceeds $500, send the request**

and the documentation to DMAS for approval (see M1470.230 C.5). DMAS will advise the eligibility worker if the adjustment is allowable and the amount that is to be allowed.

- routine dental care, necessary dentures and denture repair for recipients 21 years of age and older. **Pre-approval for dental services that exceed $500 must be obtained from DMAS prior to receipt of the service;**

- routine eye exams, eyeglasses and eyeglass repair;

- hearing aids (when medically necessary), hearing aid batteries and hearing aid repair;

- batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period;

- chiropractor services, except for Medicare recipients (Medicare covers chiropractor services and Medicaid covers the Medicare deductible and coinsurance amounts);

- dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician;

- **transportation to medical, dental or remedial services not covered by Medicaid.**

2) Services received by a Medicaid enrollee during a period of limited Medicaid eligibility (e.g., LTC services not covered because of a property transfer) can be deducted in the patient pay calculation by the local agency without DMAS approval even when the amount of the service exceeds $500.

e. Medicare Part D

Individuals who:

- qualify for Medicare Part D,
- are NOT enrolled in a Medicare PDP, and
- are NOT Medicaid eligible at the time of admission to a nursing facility,

will be fully responsible for their drug costs until Medicaid eligibility is determined and the Medicare Part D PDP enrollment process is completed. The individual remains responsible for any drugs purchased prior to the effective date of the PDP enrollment; Medicaid cannot pay for these drugs. The cost of drugs purchased before the PDP begin date can be deducted from patient pay.

Medicaid-enrolled nursing facility patients who are enrolled in a Medicare Part D PDP are **not** responsible for the payment of deductibles or co-pays, nor will

they be subject to a coverage gap in their Part D benefits. Do NOT deduct from patient pay any Medicare PDP deductibles, co-pays or coverage gap costs *beyond the month of admission into the nursing facility.*

If a full-benefit Medicaid/Medicare recipient was subject to PDP co-pays prior to his admission to a nursing facility, he may continue to be assessed co-pays until the PDP is notified of his admission to the nursing facility. *Deduct PDP co-pays incurred during the month of admission to the nursing facility only.*

If an individual is enrolled in Part D and is in a nursing facility but was not eligible for Medicaid at the time of admission to the nursing facility, he may continue to be charged co-pays or deductibles until the PDP is notified of his eligibility as a full-benefit Medicaid enrollee. *Deduct PDP co-pays incurred during first month of Medicaid eligibility in the nursing facility only.*

3. Services NOT Allowed

Types of services that CANNOT be deducted from patient pay include:

a. medical supplies and equipment that are part of the routine facility care and are included in the Medicaid per diem, such as:

- diabetic and blood/urine testing strips,
- bandages and wound dressings,
- standard wheelchairs,
- air or egg-crate mattresses,
- IV treatment,
- splints,
- certain prescription drugs (placebos).

b. TED stockings (billed separately as durable medical supplies),
c. acupuncture treatment,
d. massage therapy,
e. personal care items, such as special soaps and shampoos,
f. ancillary services, such as physical therapy, speech therapy and occupational therapy provided by the facility or under arrangements made by the facility.

4. Documentation Required

a. Requests For Adjustments From A Patient or Authorized Representative

Request the following documentation from the patient or his representative:

- a copy of the bill;
- if applicable, the amount owed that was not covered by the patient's insurance;
- proof that the service was medically necessary. Proof may be the prescription, doctor's referral or a statement from the patient's doctor or dentist.

The local agency can make the adjustment for services identified in subsection C. 2. b. through d.1), above providing the cost of the service does not exceed $500. If the cost of the service is not identified in subsection C. 2. b. through d. 1), or exceeds $500, send the documentation to DMAS to obtain approval and the allowable amount of the adjustment (reimbursement is limited to the prevailing Medicaid or Medicare rate).

b. Requests For Adjustments From LTC Providers

If the request for an adjustment to patient pay to deduct one of the above expenses is made by a nursing facility, ICF-MR, long-stay hospital, or *Department of Behavioral Health and Developmental Services (DBHDS)* facility, the request must be accompanied by:

1) the recipient's correct Medicaid ID number;

2) the current physician's order for the non-covered service (not required for replacement of hearing aid batteries or eyeglass frames or for repair of hearing aids or eyeglasses);

3) actual cost information;

4) documentation that the recipient continues to need the equipment for which repair, replacement, or battery is requested; and

5) a statement of denial or non-coverage by other insurance. The denial may be from the insurance carrier or may be a written statement from the facility that the insurance company was contacted and the item/service is not covered.

If the request from a facility does not include all the above documentation, return the request to the facility asking for the required documentation.

When the cost of the service cannot be authorized by the local department of social services and/or exceeds $500, send the request and the documentation to DMAS to obtain approval for the adjustment and the allowable amount of the adjustment (reimbursement is limited to the prevailing Medicaid or Medicare rate). DMAS must be notified of the name and address of the recipient's spouse, POA or guardian so that proper notification of the decision can be given.

5. Procedures

a. DMAS Approval Required

Requests for adjustments to patient pay for services not included in subsection C.2. b. through d.1) above, or for any service which exceeds $500, must be submitted by the provider to the DSS worker. The DSS worker sends the request and documentation to:

Health Care Compliance Program Analyst
Division of Program Operations, Customer Service Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Do not send requests for adjustments to DMAS when the patient has no available income for patient pay. Refer to M1470.230 C.5.c for notification procedures to be followed by the local worker.

When a request for an adjustment is approved or denied by DMAS, the local DSS worker will receive a copy of the letter sent to the recipient by DMAS:

1) If approved, adjust the patient pay using the MMIS Patient Pay process.

2) If the adjustment request is denied, DMAS prepares the notification.

b. DMAS Approval Not Required

Determine if the expense is deducted from patient pay using the following sequential steps:

1) Upon receipt of the requested documentation, determine the amount of the bill that is a valid deduction. Do not deduct more than the available income that remains after the personal needs, dependent child allowance(s), and health insurance premiums are deducted.

   If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service is requested, deduct the new noncovered services after the first noncovered service deductions have been completed.

2) Subtract the deduction for the month following the month the change is reported. If the deduction exceeds the available income, the remaining balance can be carried over to the following month(s).

c. Notice Procedures

Upon the final decision to allow the deduction, use the MMIS Patient Pay process to adjust the patient pay. MMIS will generate and send the Notice of Obligation for LTC Costs.

M1470.240 FACILITY - HOME MAINTENANCE DEDUCTION

A. Policy

A single institutionalized individual can be allowed a deduction for the cost of maintaining a home for not more than six months, if a physician has certified he or she is likely to return home within that period.

Home maintenance means that the individual has the responsibility to pay shelter costs on his former place of residence in Virginia, such as rent, mortgage, utilities, taxes, room and board, or a*ssisted living facility (ALF*) payments, and that the home, apartment, room or bed is being held for the individual's return to his former residence in Virginia. *Individuals who have no responsibility to pay shelter costs are not permitted a home maintenance deduction. If responsibility for shelter costs is questionable, documentation must be requested and provided.*

EXEPTION: *For an individual admitted to a* nursing facility from an ALF, deduct a home maintenance allowance *for* the month of entry *even if the admission to the nursing facility is not temporary.*

Only one spouse of an institutionalized married couple (both spouses are in a medical facility) is allowed the deduction to maintain a home for up to six months, if a physician certifies that he is likely to return home within that period.

B. Temporary Care

Temporary care is defined as not exceeding 6 months of institutionalization, beginning the **month** of admission to the medical facility. A physician's written statement, including a DMAS-96, that the individual is expected to return to his home within 6 months of admission is required to certify temporary care. When the temporary care period ends, the home maintenance deduction must be discontinued.

C. Amount Deducted

The home maintenance deduction is the MN income limit for one person in the individual's locality of residence. See Appendix 5 to subchapter M0710 or section M0810.002 A. 4 for the MN income limits.

M1470.300 FACILITY PATIENTS

A. Overview

This section provides policy and procedures for calculating patient pay for the facility patient.

B. Policy and Procedures

Policy and procedures for determining patient pay in the most common admission situations are contained in the following sections:

- Facility Admission From A Community Living Arrangement (M1470.310)
- Medicaid CBC Recipient Entering A Facility (M1470.320)
- Facility Admission From Another Facility (M1470.340)

M1470.310 FACILITY ADMISSION FROM A COMMUNITY LIVING ARRANGEMENT

A. Policy

The policy in this section describes the procedures for calculating patient pay for the month of admission and ongoing months for all persons admitted to an LTC facility except:

- persons who received Medicaid CBC in the community during the admission month;
- persons who were admitted from another facility;
- persons admitted to a facility from a state institution.

B. Procedures

To determine patient pay for the admission month, use the procedures in this subsection.

1. All Covered Groups Except MN Spenddown

For an individual admitted to a facility (except an individual who meets a spenddown), take the following steps in the order presented, *to the extent that income remains:*

a. Count all income received in the admission month *(M1470.100).*

b. Deduct a personal needs allowance:

- $40.00 basic personal needs;
- additional amount for guardianship fees, if appropriate;
- additional amount for special earnings allowance, if working.

c. Deduct a dependent child allowance, if appropriate (M1470.220).

d. Deduct the Medicare premium withheld if the applicant is a Medicare recipient and was not receiving Medicaid prior to admission (see M1470.230).

e. Deduct other health insurance premiums, deductibles or co-insurance charges, if appropriate (M1470.230).

f. Deduct other allowable noncovered medical expenses, if appropriate (M1470.230).

g. Deduct the home maintenance (MNIL) deduction **if appropriate**, if a doctor has certified that the individual is likely to return home within a six-month period (see M1470.240). For recipients who are admitted for a stay that has been for less than 30 days, a physician certification of length of stay is NOT required.

h. Any remainder is the patient pay for the month(s).

2. MN Spenddown Individual in Facility for Less than 30 Days

For a medically needy individual on a spenddown who is in a facility for less than 30 days, see section M1470.350 B. for procedures.

3. MN Spenddown Individual In Facility For More Than 30 Days

For an institutionalized medically needy individual, see Section M1470.600 for procedures.

M1470.*320* PATIENT PAY FOR FACILITY STAY OF LESS THAN 30 DAYS

A. All Covered Groups Except MN Spenddown

To determine patient pay for a non-institutionalized individual admitted to a facility for less than 30 days (except an individual who meets a spenddown), use the procedures in subsection M1470.310 B.1 for the admission month and for the subsequent month when the facility stay continues into the month after admission.

B. Non-Institutionalized Individuals on MN Spenddown

A non-institutionalized MN individual who is on a spenddown is not eligible for Medicaid until the spenddown is met. Non-institutionalized MN individuals on a three-month retroactive or six-month ongoing spenddown.

1. Individual Who Meets the Spenddown

For a non-institutionalized MN individual who meets the spenddown on a date that is within the dates of facility service, take the following steps to determine patient pay:

a. Add together the number of days in the facility stay that are NOT covered by Medicaid. Multiply the result by the facility's private pay daily rate.

b. Determine the remaining balance of the spenddown prior to applying the bill that caused the spenddown to be met.

c. Add the amount in a. above to the figure obtained in b. above. The total is the individual's patient pay for the part of the facility stay that occurs in the spenddown coverage period.

d. Enter patient pay into MMIS.

2.* Example – *Spenddown Met

Mr. B, an unmarried 70 year-old individual living in a Group II locality, filed an initial application for Medicaid on October 5, 1999. He had excess income and was placed on a spenddown of $2000 for the period October 1, 1999 through March 31, 2000. On October 8, 1999, he was admitted to a nursing facility for temporary care that is expected to be less than 30 days.

On November 10, 1999, his authorized representative asks for his spenddown to be re-evaluated due to his admission to the nursing facility. The representative also submits medical bills incurred before October 8, 1999, that the worker determines leave a spenddown balance of $500 as of October 8, 1999. The nursing facility charges him $120 per day; the Medicaid per diem is $85. His spenddown is determined:

$2000	spenddown liability October 1, 1999-March 31, 2000
- 1500	old bills incurred prior to October 1, 1999
500	spenddown balance on October 1, 1999
- 50	doctor's charge on October 5, 1999 (after TPL pays)
- 120	private pay rate on October 8, 1999
330	spenddown balance beginning October 9, 1999
- 120	private pay rate on October 9,1999
210	spenddown balance beginning October 10, 1999
- 120	private pay rate on October 10, 1999
90	spenddown balance beginning October 11, 1999
- 120	private pay rate on October 11, 1999
$ 0	spenddown met on October 11, 1999

Mr. B met his spenddown on October 11, 1999. *Medicaid coverage begins on October 11, 1999 and ends on March 31, 2000, the end of the six month spenddown budget period*.

He is discharged from the nursing facility to his home without CBC on November 1, 1999. He was in the nursing facility for less than 30 days. His patient pay for the October 8, 1999 through November 1, 1999 stay is determined:

a) 3 number of days in the nursing facility that are NOT covered by the individual's Medicaid coverage period (October 8 through October 10)
x 120 facility private pay daily rate
$ 360 amount of the spenddown liability for which the individual is responsible.

b) $90 is the spenddown balance on the date the spenddown was met, therefore, the individual is responsible to pay the $90 to the nursing facility. Medicaid will pay the remainder of the cost.

c) $360 amount of the spenddown liability for which the individual is responsible (October 8 - October 10)
+ 90 spenddown balance on October 11; begin date of coverage
$450 individual's patient pay for October 11 through October 31

If his dates in the nursing facility include part of a second month, his patient pay for the second month would be $0.

3. Individual Who Does Not Meet Spenddown

An individual who meets the spenddown on a date after the date he left the facility has full responsibility for the days he was in the facility. Send the individual a Notice of Action showing the dates of Medicaid coverage and that the facility care was not covered by Medicaid. Send the provider a DMAS-225 regarding the individual's eligibility status.

M1470.400 MEDICAID CBC PATIENTS - ALLOWABLE DEDUCTIONS FROM INCOME

A. Introduction

Sections M1470.410 through 430 are the only *allowable* deductions from a Medicaid CBC patient's gross monthly income when calculating patient pay when the patient does not have a community spouse. *If* the patient has a community spouse, go to subchapter M1480 to determine patient pay.

Medicaid CBC patients are not allowed a home maintenance deduction because shelter costs are included in the personal maintenance allowance.

B. Procedure

Subtract the deduction(s) from gross monthly income in the order presented below:

1. Medicaid CBC Personal Maintenance Allowance (M1470.410)

2. Dependent Child Allowance (M1470.420)

3. Medicaid CBC - Incurred Medical Expenses (M1470.430)

C. Appeal Rights

The patient or his representative has the right to appeal the patient pay determination, the amounts used in the calculation and denial of any request for adjustment. If a recipient or his representative appeals the patient pay, the EW who made the decision prepares the appeal summary and attends the hearing.

M1470.410 MEDICAID CBC - PERSONAL MAINTENANCE ALLOWANCE

A. Individuals

For the month of entry and subsequent months, deduct from the patient's gross monthly countable income a personal maintenance allowance (PMA). The amount of the allowance depends upon under which Medicaid CBC waiver the patient receives LTC services.

The total amount of the PMA cannot exceed 300% SSI.

1. Basic Maintenance Allowance

a. Elderly or Disabled with Consumer-Direction (EDCD) Waiver, Intellectual Disabilities/Mental Retardation (ID/MR) Waiver, Technology-Assisted Individuals Waiver, Individual and Family Developmental Disabilities Support (DD) Waiver and Day Support (DS) Waiver

Patients receiving Medicaid CBC under the following waivers are allowed a monthly basic PMA:

- EDCD Waiver,
- ID/MR Waiver,
- Technology-Assisted Individuals Waiver
- DD Waiver, and
- DS Waiver

The PMA is:

- January 1, 2011 through December 31, 2011: $1,112 (no change for 2011)
- January 1, 2010 through December 31, 2010: $1,112.

Contact a Medical Assistance Program Consultant for the PMA in effect for years prior to 2009.

b. AIDS Waiver

Patients under the AIDS waiver are allowed a monthly basic PMA that equals 300% of the SSI payment limit for one person (see M0810.002 A. 3).

2. Guardianship Fee

Deduct an amount up to 5% of the patient's gross monthly income (including amounts not counted as income and excluded income) for guardianship fees, if the patient has a legally appointed guardian or conservator AND the guardian or conservator charges a fee. The guardianship **filing** fees CANNOT be deducted from the individual's income. Document how it was determined that the guardian/conservator charges a fee and the amount of the fee.

No deduction is allowed if the patient's guardian is affiliated with a public agency or organization that receives funding for guardianship services.

No deduction is allowed for representative payee or "power of attorney" fees or expenses.

3. Special Earnings Allowance for Recipients in EDCD, DD, *ID*/MR or DS Waivers

Deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

a. for individuals employed 20 hours or more per week, all earned income up to 300% of SSI ($2,022 *in 2011*) per month.

b. for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI ($1,348 *in 2011*) per month.

4. Example – Special Earnings Allowance (Using January 2009 figures)

A working patient receiving EDCD waiver services is employed 18 hours per week. His income is gross earnings of $928.80 per month and SSA of $300 monthly. His special earnings allowance is calculated by comparing his gross earned income ($928.80) to the 200% of SSI maximum ($1,348.00). His gross earned income is less than 200% of SSI; therefore, he is entitled to a special earnings allowance. His personal maintenance allowance is computed as follows:

$ 1,112.00 CBC basic maintenance allowance
+ 928.80 special earnings allowance
$ 2,040.80 PMA

Because the PMA may not exceed 300% of SSI, the PMA for the patient in this example must be reduced to $2,022.00.

B. Couples

The Medicaid CBC waivers do not specify personal maintenance allowances for a married couple living together when both spouses receive Medicaid CBC because each spouse is considered an individual for patient pay purposes. The individual maintenance allowance in section M1470.410 applies to each spouse in a couple when each receives Medicaid CBC.

M1470.420 DEPENDENT CHILD ALLOWANCE

A. Unmarried Individual, or Married Individual With No Community Spouse

For an unmarried Medicaid CBC patient, or a married Medicaid CBC patient without a community spouse, who has a dependent child(ren) under age 21 years in the community:

- Calculate the difference between the appropriate MN income limit for the **child's** home locality for the number of children in the home and the child(ren)'s gross monthly income. If the children are living in different homes, the children's allowances are calculated separately using the MN income limit for the number of the patient's dependent children in each home.

- The result is the dependent child allowance. If the result is greater than $0, deduct it from the patient's income as the dependent child allowance. If the result is $0 or less, do not deduct a dependent child allowance.

Do not deduct an allowance if the child(ren)'s monthly income exceeds the MN income limit in the child's home locality for the number of dependent children in the home.

Do not deduct an allowance for any other family member.

1. Example--Two Dependent Children In One Home (Using January 2009Figures)

Mr. H is a single individual with gross monthly income of $920, living in the community in Group II and receiving Medicaid CBC. He is divorced and has two children under age 18 who live with his ex-wife in Group I. His two children each receive $75 SSA.

The allowance for his dependent children is calculated as follows:

$ 337.92	MN limit for 2 (Group I)
- 150.00	children's SSA income
$ 187.92	dependent children's allowance

2. Example--Three Dependent Children In Two Homes (Using January *2009* Figures)

Mrs. K is a married individual who lives at home in a Group II locality and receives Medicaid CBC. Her spouse is in a medical facility and is not a community spouse. One of their three dependent children lives with Mrs. K. The other two children live with her sister in a Group III locality. The children each receive $95.00 per month SSA.

The allowance for the dependent children is calculated as follows:

$ 306.23	MN limit for 1 (Group II)
- 95.00	child's SSA income
$ 211.23	child's allowance
$ 480.00	MN limit for 2 (Group III)
- 190.00	children's SSA income
$ 290.00	children's allowance
$ 211.23	*child's* allowance
+ 290.00	*children's* allowance
$ 501.23	total dependent children's allowance

NOTE: If Mrs. K's institutionalized spouse is eligible for Medicaid, an allowance for their children may also be deducted from his income in determining his patient pay. However, the allowance the children receive from Mrs. K will be counted as part of their income when determining any allowance from Mr. K's income.

M1470.430 MEDICAID CBC - NONCOVERED MEDICAL EXPENSES

A. Policy

Amounts for incurred medical and dental expenses not covered by Medicaid or another third party are deducted from the patient's gross monthly income when determining patient pay.

B. Health Insurance Premiums

Payments for medical/health insurance which meet the definition of a health benefit plan, *including dental insurance*, are deducted from patient pay when:

- the premium amount is deducted from the patient's benefit check;

- the premium is paid from the patient's own funds; OR

- the premium is paid by a relative (other than a spouse or parent for minor child) when that relative receives a benefit payment (income) which includes a benefit amount for the patient.

The amount deducted is the amount of the monthly premium. If the patient pays the premium less often than monthly, such as quarterly, prorate the amount paid by the number of months covered by the payment to obtain the monthly amount to deduct in the patient pay calculation.

"Health benefit plan" means any accident and health insurance policy or certificate, health services plan contract, health maintenance organization subscriber contract, plan provided by a MEWA (Multiple Employer Welfare Arrangement) or plan provided by another benefit arrangement.

Health benefit plan does not mean accident only, credit, or disability insurance; long-term care insurance; vision only insurance; specified disease insurance; hospital confinement indemnity coverage; limited benefit health coverage; coverage issued as a supplement to liability insurance; insurance arising out of a workers' compensation or similar law; automobile medical payment insurance; or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance (14VAC5-234-30).

Income protection insurance (indemnity) policy premiums are not medical expenses and are not deducted from the patient pay.

Membership fees for an organization that sponsors or provides the health insurance are not part of the premium and are not deductible.

1. Medicare Part A and/or Part B Premiums

For CNNMP and MN recipients, the Medicare buy-in is effective **2 months after the begin date** of Medicaid coverage. If the begin date of coverage is other than the first day of a month, the buy-in is effective the first of the month in which the 60th day occurs. Part B premiums (and Part A premiums if the recipient must pay the Part A premium) must be deducted from patient pay in the month(s) in which the buy-in is not effective.

Deduct the Medicare premium(s) for the first two months of coverage eligibility for the following recipients:

- CNNMP individuals who are not dually eligible QMB,
- MN recipients who are not dually eligible QMB.

The Medicaid Medicare buy-in does NOT pay for Medicare premiums in closed periods of coverage for LTC patients who are on spenddown and whose eligibility is for a closed period. Deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from patient pay in the month(s) in which the buy-in is NOT effective.

For cash assistance and QMB (either just QMB or dually-eligible) enrollees, the buy-in is effective with the begin date of Medicaid coverage. Therefore, do NOT

deduct Medicare premiums in the patient pay determination for months in the retroactive and ongoing coverage periods.

Do not deduct Medicare premiums in retroactive and ongoing coverage periods for the following recipients:

- SSI recipients,
- AG recipients,
- ABD 80% FPL recipients,
- IV-E cash assistance recipients,
- QMB eligible recipients (either dually-eligible or just QMB).

The Medicaid Medicare buy-in pays for Medicare premiums in retroactive coverage and closed periods of coverage EXCEPT for LTC patients who are on spenddown. DO NOT deduct the Medicare Part B premiums (and Part A premiums if the recipient must pay the Part A premium) from the patient pay in the month(s) in which the buy-in is effective for LTC patients who are NOT on spenddowns.

2. Example - Medicare Buy-in (Using January 2009 Figures)

Mr. A is 80 years old and started receiving CBC on February 15. He applied for Medicaid on February 2. His only income is $1500 per month. He has no Medicare Part A premium. His Part B premium is withheld from his SSA benefit. Therefore, his gross SSA entitlement is actually $1596.40. He is CNNMP eligible, but he is not dually-eligible as QMB.

Mr. A submitted bills for January and met a retroactive spenddown in January. Ongoing Medicaid began in February because he began receiving Medicaid CBC in February and became CNNMP. The Medicare Buy-in begins on April 1.

His Medicare Part B premium is deducted in February's and March's patient pay. April and subsequent months will not include a deduction for the Medicare premium.

3. *Medicare Advantage (Part C) Premiums*

Medicare Advantage plans, also referred to as Medicare Part C, are voluntary managed-care Medicare plans. In addition to Medicare Part B premiums, some individuals may pay an extra Medicare Advantage premium. The Medicaid Medicare buy-in is initiated for individuals with Medicare Advantage; however, the buy-in covers only the allowable Medicare Part A and/or B premiums. The individual is responsible for any additional Medicare Advantage monthly premium. The Medicare Advantage monthly premium remains the individual's responsibility and is an allowable deduction from patient pay.

4. **Medicare Part D Premiums**

The federal government sets a yearly "benchmark" premium for Medicare Part D Prescription Drug Plans (PDP). An individual who is eligible for Medicare and Medicaid is entitled to premium-free enrollment in a Medicare Part D basic prescription drug plan (PDP) with a "benchmark" premium. However, the individual may elect enrollment in a basic plan with a premium above the benchmark or in an enhanced plan, which offers additional benefits.

Individuals who enroll in a higher-premium basic plan or an enhanced plan are responsible for that portion of the premium attributable above the benchmark

rate. When a full benefit Medicaid enrollee is enrolled in a higher-premium PDP, the portion of the premium that remains the individual's responsibility is an allowable deduction from patient pay.

The benchmark Medicare Part D premium for Virginia for 2011 is $33.25.

***5.* LTC Insurance**

a. Deduct LTC premium in admission month only

When an individual has an LTC insurance policy that covers long-term care services received in the home, the individual stops paying premiums beginning the month after he is admitted to the home-based LTC. The premium paid for the policy in the LTC admission month can be deducted from the admission month's patient pay only. The LTC insurance premium is not deducted from patient pay for the months following the admission month.

b. LTC insurance benefits

LTC insurance benefits are treated as TPL. If the individual receives the payment from the insurance company, the payment is not income for patient pay or eligibility determinations. The individual should assign it to the waiver services provider. If the individual cannot do this, or the policy prohibits assignment, the LTC insurance payment should be given directly to the provider. The provider should report the payment as a third party payment on its claim form.

If the provider is unable to accept payment directly from the individual, the individual must send the insurance payment to:

DMAS Fiscal Division, Accounts Receivable
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

C. Noncovered Medical/Dental Services

Deductions for the cost of a patient's medically necessary medical or dental services not covered by Medicaid, other insurance (such as Medicare), or another person are subtracted from income to determine patient pay.

See M1470.430 B.3 for the procedures used to deduct Medicare Part D prescription drug co-pays for patients who have Medicare.

DMAS approval **is not** required for deductions of noncovered services from patient pay when the individual receives CBC services, regardless of the amount of the deduction.

1. Zero Patient Pay Procedures

If deductions from patient pay cannot be allowed because the recipient has no income remaining after deducting the personal maintenance allowance, dependent child allowance(s) and health insurance premiums, or the recipient has no income available for patient pay, deny the request.

Notify the patient or the patient's representative using the Notice of Action.

If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service has been approved, notify the patient or his authorized representative that the deduction for the new non-covered service will be made after the first noncovered service deductions are completed.

2. Allowable Non-covered Expenses

When a patient has income available for patient pay, the following can be deducted as noncovered expenses:

a. Old Bills

Old bills are deducted from patient pay as non-covered expenses. Old Bills are unpaid medical, dental or remedial care expenses which:

- were incurred prior to the Medicaid application's retroactive period, or during the retroactive period if the individual was not eligible for Medicaid in the retroactive period or the service was not a Medicaid-covered service;
- were not fully deducted from (counted in) any previous spenddown budget period where the spenddown was met, and
- remain a liability to the individual.

b. Medically Necessary Covered Services Provided By A Non-participating Provider

Medically necessary medical and dental services that are covered by Medicaid, but that the recipient received from a provider who does not participate in Virginia Medicaid, are deducted from patient pay as non-covered services.

c. Covered Services Outside of Medicaid's Scope

Medically necessary medical and dental services that can be deducted from patient pay are:

- services exceeding Medicaid's amount, duration, or scope;
- services rendered during a prior period of Medicaid eligibility (i.e., LTC services not covered because of a property transfer).

d. Other Allowable Non-covered Services

Medically necessary medical and dental services that are NOT covered by Medicaid and can be deducted from patient pay include:

1) medical supplies, such as antiseptic solutions, incontinent supplies (adult diapers, pads, etc.), dressings, EXCEPT for patients under the Technology-assisted Individuals Waiver (Medicaid covers these services for Technology-assisted Individuals Waiver patients). For Medicaid CBC recipients who have Medicare Part B, do not deduct the cost of supplies/equipment obtained from a Medicare/Medicaid supplier since the supplier receives direct payment from Medicare and Medicaid.

2) routine dental care, necessary dentures and denture repair for recipients 21 years of age and older;

3) routine eye exams, eyeglasses and eyeglass repair;

4) hearing aids (when medically necessary), hearing aid batteries and hearing aid repair;

5) batteries for power wheelchairs or other power mobility items owned by the recipient, not to exceed four batteries in a 12-month period;

6) chiropractor services, except for Medicare recipients (Medicare covers chiropractor services and Medicaid covers the Medicare deductible and coinsurance amounts);

7) dipyridamole (Persantine) and other prescription medications not covered by Medicaid but ordered by the recipient's physician;

8) copayments for prescription drugs obtained under Medicare Part D.

e. Medicare Part D copays

Individuals who:

- *qualify for Medicare Part D,*
- *are NOT enrolled in a Medicare PDP, and*
- *are NOT Medicaid eligible at the time of admission to CBC*

will be fully responsible for their drug costs until Medicaid eligibility is determined and the Medicare Part D PDP enrollment process is completed. The individual remains responsible for any drugs purchased prior to the effective date of the PDP enrollment; Medicaid cannot pay for these drugs. The cost of drugs purchased before the PDP begin date can be deducted from patient pay.

Full benefit Medicaid enrollees who have Medicare, are receiving Medicaid CBC services, and are enrolled in a Medicare Part D PDP are responsible for the payment of co-pays, but are not subject to payment of deductibles or a coverage gap in their Part D benefits.

1) Monthly Statements

PDPs must issue a periodic (at least monthly) statement to the beneficiary explaining all benefits paid and denied. Part D drugs that are not covered by the PDP may not be covered by Medicaid and, absent other drug coverage, remain the responsibility of the individual. When a PDP denies coverage of a prescription, the beneficiary has the right to request an exception for coverage of the drug. The beneficiary is notified in writing of the decision on any exception requested.

2) Verifying Allowable Co-pays

To determine whether or not prescription expenses can be deducted from patient pay, apply the following rules:

- *If the drug expense appears on the statement as a denial, and no exception was requested, **do not** allow the expense.*
- *If the drug expense appears on the statement as a denial, and an exception was requested and denied, allow the expense.*

Enrollees should be advised to maintain these monthly statements if they wish to request patient pay adjustments for Medicare Part D co-pays and for drugs for which the PDP denied coverage.

3. Services NOT Allowed

Types of services that CANNOT be deducted from patient pay include:

a. medical supplies covered by Medicaid, or Medicare when the recipient has Medicare, such as:

- diabetic and blood/urine testing strips,
- bandages and wound dressings,
- standard wheelchairs,
- air or egg-crate mattresses,
- IV treatment,
- splints,
- certain prescription drugs (placebos).

b. TED stockings (billed separately as durable medical supplies),
c. acupuncture treatment,
d. massage therapy,
e. personal care items, such as special soaps and shampoos,
f. physical therapy,
g. speech therapy,
h. occupational therapy.

4. Documentation Required

a. Requests For Adjustments From A Patient or An Authorized Representative

Request the following documentation from the patient or his representative:

- a copy of the bill;
- the amount still owed by the patient;
- if applicable, the amount owed that was not covered by the patient's insurance;
- proof that the service was medically necessary. Proof may be the prescription, doctor’s referral or a statement from the patient’s doctor or dentist.

b. Requests For Adjustments From CBC Providers

If the request for an adjustment to patient pay to deduct a noncovered expense is made by a Medicaid CBC waiver service provider or case manager, the request must be accompanied by:

1) the recipient's correct Medicaid ID number;

2) the current physician's order for the non-covered service (not required for replacement of hearing aid batteries or eyeglass frames or for repair of hearing aids or eyeglasses);

3) actual cost information;

4) documentation that the recipient continues to need the equipment for which repair, replacement, or battery is requested; and

5) a statement of denial or non-coverage by other insurance. The denial may be from the insurance carrier or may be a written statement from the facility that the insurance company was contacted and the item/service is not covered.

If the request from a provider or case manager does not include all the above documentation, return the request to the provider or case manager asking for the required documentation.

5. Procedures

a. Determine Deduction

*When the individual receives CBC services, DMAS approval **is not required** for deductions of noncovered services from patient pay, regardless of the amount of the deduction.*

Determine if the expense is deducted from patient pay using the following sequential steps:

1) Upon receipt of the requested documentation, determine the amount of the bill that is a valid deduction. Do not deduct more than the available income that remains after the personal needs, dependent child allowance(s), and health insurance premiums are deducted.

   If a noncovered service is already being deducted leaving no patient pay, and a new deduction for another noncovered service is requested, deduct the new noncovered services after the first noncovered service deductions have been completed.

2) Subtract the deduction for the current month. If the deduction exceeds the available income, the remaining balance can be carried over to the following month(s).

b. Notice Procedures

Upon the final decision to allow the deduction, use the MMIS Patient Pay process to adjust the patient pay. MMIS will generate and send the Notice of Obligation for LTC Costs.

D. Example--CBC Deduction of Noncovered Services (Using January *2009* Figures)

An aged, single individual, with no dependent child and no guardian or conservator, who lives in Group II, applied for Medicaid for the first time in June. He is approved by the screener for long-term care under the *EDCD* waiver. His gross income is $950 Civil Service Annuity (CSA) and $500 SSA. His resources are within the Medicaid limit. He has Medicare and federal employee's health insurance (Medicare is withheld from his SSA check at the rate of *$96.40* per month and $80 is withheld from his CSA for the Health Insurance). Because his income is less than 300% of the SSI income limit, he meets the 300% SSI group.

He is denied retroactive eligibility because he had no Medicaid covered service in the retroactive period. He owes $1,500 on a hospital bill he incurred the prior September *and is making payments*. His patient pay for June is determined in the following steps:

Step 1. gross income:

$ 950	CSA
+ 500	SSA
$1,450	total gross income

Step 2. deduct the correct personal maintenance allowance:

$ 1,450	total gross income
- *1,112*	personal maintenance allowance
$ *338*	remaining income

Step 3. deduct the appropriate medical expense deductions in the correct sequential order:

$ *338.00*	remaining income
- *176.40*	*96.40* Medicare + 80.00 health insurance premium
161.60	remaining income
- *161.60*	non-covered medical expenses ($1,500-*161.60=$1,338.40*)
$ 0	patient pay for June

The *$1,338.40* balance remaining from the $1,500 hospital bill that was not deducted from the June patient pay can be deducted in subsequent month(s) as long as it remains a liability.

M1470.500 MEDICAID CBC PATIENTS

A. Overview

This section is only for unmarried individuals and or married individuals who have no community spouse. For married patients who have a community spouse, go to subchapter M1480 for patient pay determination.

This section provides policy and procedures for calculating Medicaid CBC recipients' patient pay.

B. Policy and Procedures

Policy and procedures for determining Medicaid CBC admission month patient pay in the most common admission situations are contained in the following sections:

- Community Living Arrangement Admission to Medicaid CBC (M1470.510)
- *PACE (M1470.520)*

M1470.510 COMMUNITY LIVING ARRANGEMENT ADMISSION TO MEDICAID CBC WAIVER SERVICES

A. Policy

The policy in this section describes the procedures for calculating patient pay for the month of admission and ongoing months for **all** persons residing in the community who are screened and approved for Medicaid CBC waiver services.

B. Procedures

1. All Covered Groups Except MN Spenddown

For an individual admitted to Medicaid CBC waiver services (EXCEPT an individual who meets a spenddown**),** use these procedures:

a. Count all income received in the admission month (M1470.100).

b. Deduct a personal needs allowance (M1470.410):

- basic maintenance allowance based on the waiver;
- guardianship fees, if *any*;
- special earnings allowance, if *any*.

c. Deduct a dependent child allowance, if *any* (M1470.420).

d. Deduct the Medicare premium withheld if the individual is a Medicare recipient and was not receiving Medicaid prior to admission, if *any* (see M1470.430).

e. Deduct other health insurance premiums, deductibles or co-insurance charges, if *any* (M1470.430).

f. Deduct other allowable noncovered medical expenses, if *any* (M1470.430).

g. Any remainder is the patient pay for the month(s).

2. MN Individual Who Meets Spenddown

An MN individual who is on a spenddown is not eligible for Medicaid until the spenddown is met. If an individual is screened and approved for Medicaid waiver services, he is considered "institutionalized" and his eligibility for Medicaid is determined as an institutionalized individual. If the individual's income exceeds the 300% SSI income limit, he must meet an MN institutionalized individual monthly spenddown.

Go to section M1470.600 below to determine patient pay for a CBC patient who is on a spenddown.

M1470.520 PACE

A. Policy

The Program of All-inclusive Care for the Elderly (PACE) serves individuals aged 55 and older who (1) meet the nursing facility level of care criteria and (2) reside in their own communities. PACE provides all of an individual's health care and long-term care medical needs. PACE is not a CBC Waiver; individuals who meet the criteria for the EDCD Waiver may be enrolled in PACE in lieu of the EDCD Waiver. Individuals who are enrolled in Medicaid as Auxiliary Grant *(AG)* recipients (Aid Categories 012, 032, and 052) are not eligible for PACE. See M1440.108 for additional information about PACE.

Individuals enrolled in PACE have a patient pay obligation.

B. Procedures

The patient pay for an individual enrolled in PACE who is not Medically Needy is calculated using the procedures in M1470.400 through M1470.520 for an individual in CBC, with the exceptions listed below.

1. Medicare Part D Premiums

PACE recipients are not responsible for Medicare Part D premiums because their prescriptions are provided through PACE and they are eligible for the full Medicare Part D subsidy. Therefore, the cost of the Medicare Part D premium is not allowable as a deduction from patient pay.

2. Covered Medical Expenses

Because PACE includes most medically-necessary services the individual needs, the allowable medical expense deductions differ from the allowable medical expense deductions for CBC.

The following services are provided through PACE:

- adult day care that offers nursing, physical, occupational, speech and recreational therapies;
- meals and nutritional counseling; social services;
- medical care provided by a PACE physician; personal care and home health care;
- all necessary prescription drugs;
- access to medical specialists such as dentists, optometrists and podiatrists;
- respite care;
- hospital and nursing facility care when necessary; and
- transportation.

Any medical expenses incurred by the individual for the services listed above are not allowable patient pay deductions. With the exception of the services listed above, the noncovered expenses listed in M1470.430 C.2 are allowable for PACE recipients. *DMAS approval **is not required** for deductions of noncovered services from patient pay for PACE recipients, regardless of the amount of the deduction.*

3. PACE Recipient Enters a Nursing Facility

Because PACE is a program of all-inclusive care, nursing facility services are part of the benefit package for PACE recipients who can no longer reside in the community. When a PACE recipient enters a nursing facility, the PACE provider or the individual has 60 days from the date of admission to notify the eligibility worker of the individual's placement in the nursing facility and the need for a recalculation of the patient pay.

After notification of the individual's entrance into a nursing facility, the eligibility worker will take action to recalculate the individual's patient pay prospectively for the month following the month the 10 day advance notice period ends. There is NO retroactive calculation of patient pay back to the date the individual entered the facility. When the change is made, the individual is entitled to a personal needs allowance of $40 per month.

M1470.600 MN PATIENTS - SPENDDOWN LIABILITY

A. Policy

This section is for unmarried individuals or married individuals who have no community spouse. **DO NOT USE this section** for a married individual with a community spouse, go to subchapter M1480.

MN individuals have a spenddown liability that must be met before they are eligible for Medicaid because their monthly income exceeds 300% of SSI, which exceeds the MN income limits. When an MN individual meets the spenddown, he is eligible for Medicaid (see section M1460.700 for spenddown determination policy and procedures). Patient pay for **each** month in which the individual meets the spenddown must be determined.

A patient *under 22 years of age receiving inpatient psychiatric services* in an IMD (Institution for Treatment of Mental Diseases) whose income exceeds 300% of SSI may be eligible for Medicaid as MN if he meets the spenddown liability.

Coverage in an IMD is not part of the Medicaid benefit package for any other MN individuals who are eligible for Medicaid while in an IMD, including individuals age 65 years or older. Individuals under age 22 years who are not receiving inpatient psychiatric services and all individuals over age 22 years but under age 64 years are not eligible for Medicaid while in an IMD (see M0280.201).

B. Definitions

The following definitions are used in this section and subsequent sections of this subchapter:

1. Medicaid Rate

The Medicaid rate for facility patients is the facility's Medicaid per diem multiplied by the number of days in the month. For the month of entry, use the actual number of days that care was received or is projected to be received. For ongoing months, multiply the Medicaid per diem by 31 days.

The Medicaid rate for CBC patients is the number of hours per month actually provided by the CBC provider multiplied by the Medicaid hourly rate.

PACE has a capitated monthly rate that is due and payable on the first day of the month. The monthly PACE rate is available from the PACE provider.

2. Remaining Income

Remaining income is the amount of the patient's total monthly countable income for patient pay minus all allowable patient pay deductions.

3. Spenddown Liability

The spenddown liability is the amount by which the individual's countable income exceeds the medically needy income limit.

C. Procedures

The subsections identified below contain the procedures for determining patient pay when an LTC patient meets a spenddown liability and is determined eligible for Medicaid.

1. Facility Patients

Patient pay determination procedures are different for medically needy facility patients, depending on whether the spenddown liability is less than or equal to or greater than the Medicaid rate. To determine patient pay for MN facility patients:

a. Determine the individual's spenddown liability using the policy and procedures in subchapter M1460.

b. Compare the spenddown liability to the Medicaid rate.

c. If the spenddown liability is less than or equal to the facility Medicaid rate, go to section M1470.610 below to determine patient pay.

d. If the spenddown liability is greater than the facility Medicaid rate, go to section M1470.620 to determine patient pay.

2. Medicaid CBC Patients

Medicaid CBC patient pay determination procedures are different from facility procedures. For CBC patients with a spenddown liability, go to section M1470.630.

3. PACE Recipients

For PACE recipients with a spenddown liability, go to section M1470.640.

M1470.610 FACILITY PATIENTS--SPENDDOWN LIABILITY LESS THAN OR EQUAL TO MEDICAID RATE

A. Policy

This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

An MN facility patient whose spenddown liability is less than or equal to the Medicaid rate is eligible for Medicaid effective the first day of the month, based on the projected facility Medicaid rate for the month. Medicaid must NOT pay any of the recipient's spenddown liability to the provider. In order to prevent any Medicaid payment of the spenddown liability, the spenddown liability is added to available income for patient pay.

B. Procedures

Determine patient pay for the month using the procedures below.

1. Patient Pay Gross Monthly Income

Determine the recipient's patient pay gross monthly income according to M1470.100 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. Subtract Spenddown Liability

From the individual's gross monthly income for the month, subtract the spenddown liability. The result is the remaining income.

3. Subtract Allowable Deductions

Deduct the following from the remaining income:

a. a personal needs allowance (M1470.210),

b. a dependent child allowance, if appropriate (M1470.220),

c. any allowable noncovered medical expenses (M1470.230), not including the facility cost of care,

d. a home maintenance deduction, if appropriate (M1470.240).

The result is the **remaining income**.

4. Add Spenddown Liability

Add the spenddown liability to the remaining income (**because the individual is responsible to pay his spenddown liability to the facility**). The result is the **contributable income** for patient pay.

5. Patient Pay

Compare the contributable income to the facility's Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Examples

1. Facility--MN And Patient Pay Income Are The Same (Using April 2000 Figures)

Mr. Cay first applied for Medicaid in April. He was admitted to the facility a year earlier. He has a monthly Civil Service Annuity (CSA) benefit of $1,600. He last lived outside the facility in a Group III locality. His income exceeds the CNNMP 300% SSI income limit. He has no old bills, but he has a health insurance premium of $50 monthly plus a $25 noncovered medical expense he incurred on April 2, and a guardian who charges a guardian fee of 5% of Mr. Cay's income. His MN eligibility is being determined for April. The MN determination results in a spenddown liability of $1,255:

$1,600	monthly MN income
- 20	exclusion
1,580	countable MN income
- 325	MN limit for 1 (Group III)
$1,255	spenddown liability for month

The facility's Medicaid rate is $45 per day, or $1,395 for a projected 31-day month. By projecting the month's cost of facility care, he meets his spenddown because his spenddown liability is less than the Medicaid rate. He is eligible effective the first day of the month and for the whole month of April. Because his spenddown liability is less than the Medicaid rate, Mr. Cay will have ongoing Medicaid eligibility. His patient pay for April is determined:

$1,600	total patient pay gross income
- 1,255	spenddown liability
345	
- 110	personal needs allowance (basic plus guardian fee)
- 50	health insurance premium
- 25	noncovered medical expense incurred April 2
160	remaining income
+1,255	spenddown liability (his responsibility to pay)
$1,415	contributable income for patient pay (April)

Compare the contributable income for patient pay ($1,415) to the facility's Medicaid rate for April, $1,395. The facility can collect no more that the Medicaid rate. Because the Medicaid rate is less than the contributable income for patient pay, Mr. Cay's patient pay for April is the Medicaid rate of $1,395. Any income retained by Mr. Cay is a resource in May.

2. Facility--MN And Patient Pay Income Are Different (Using July 1999 Figures)

Mr. Day is a disabled individual who applied for Medicaid in July 1999. He was admitted to the facility in November 1998. He has a monthly CSA benefit of $1,500 and a monthly Seminole Indian payment of $235. He last lived outside the facility in a Group III locality. His income of $1,735 exceeds the CNNMP 300% of SSI income limit. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His MN eligibility is determined for July 1999. The MN determination results in a spenddown liability of $1,155:

$1,500	monthly MN income (Seminole Indian payment excluded)
- 20	exclusion
1,480	countable MN income
- 325	MN limit for 1 (Group III)
$1,155	spenddown liability for month

He has an old bill of $250 incurred in December 1998, which was not used to meet a spenddown, and a health insurance premium of $50 monthly plus a noncovered medical expense of $25 that he incurred on July 2. The facility's Medicaid rate is $40 per day, or $1,240 for a projected 31-day month. By projecting the month's cost of facility care, he meets his spenddown because his spenddown liability is less than the Medicaid rate. He is eligible for full month's coverage. His patient pay for July is determined:

$1,500	CSA
+ 235	Seminole Indian payment (not excluded for patient pay)
1,735	patient pay gross income
- 1,155	spenddown liability
580	
- 30	personal needs allowance
- 50	health insurance
- 250	old bill from December 1998
- 25	non-covered medical expense incurred July 2
$ 225	remaining income
+1,155	spenddown liability (his responsibility to pay)
$1,380	contributable income for patient pay (July)

Compare the contributable income for patient pay to the facility's Medicaid rate for July. The facility can collect no more than the Medicaid rate. Because the Medicaid rate is less than the contributable income for patient pay for July, Mr. Day's patient pay for July is the Medicaid rate of $1,240. Any income that is retained becomes a resource the following month.

3. Facility-Not Eligible in Admission Month, Eligible in Following Month (Using April 2000 Figures)

Mr. C first applied for Medicaid on April 25. He was admitted to the facility on April 22. He last lived outside the facility in a Group III locality. He is a 40-year-old disabled individual with one dependent child age 10 years; the child lives with his sister in a Group II locality. He has a monthly CSA benefit of $1,700; the child has a CSA benefit of $150 per month. Mr. C has a guardian who charges a 5% guardian fee. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period.

Mr. C's income exceeds the CNNMP 300% of SSI income limit, so he is not eligible as CNNMP. He has a carry-over expense of $200 incurred in the retroactive period. He has a monthly health insurance premium of $50 paid on the 15th of the month plus a $25 noncovered medical expense he incurred on April 2. His MN eligibility is determined for April. The MN determination results in a spenddown liability of $1,355:

$1,700	monthly MN income
- 20	exclusion
1,680	countable MN income
- 325	MN limit for 1 (Group III)
$1,355	spenddown liability for month

The facility's Medicaid rate is $45 per day, or $405 for April 22 - 30 (9 days), the admission month. He does not meet his spenddown by projecting the cost of care at the Medicaid rate for the admission month because his spenddown liability ($1,355) exceeds the Medicaid rate of $405 for the admission month. Therefore, his spenddown cannot be met by projecting the nursing facility costs at the Medicaid rate. His spenddown eligibility must be determined retrospectively using the private pay rate for the number of days of facility care to reduce his spenddown liability. The private pay rate is $50 per day, or $450 for the days April 22 - 30. After subtracting all allowable expenses, he does not meet his spenddown in April and is not eligible for Medicaid in April.

His eligibility for May is determined. His April facility expenses are not deducted because he paid them in April. His $200 January bill is not deducted as a carry-over expense, but any current payments on that bill can be deducted. He incurred a noncovered medical expense on May 2, and paid $65 on his January medical bill.

The facility's Medicaid rate is $45 per day, or $1,395 for a projected 31-day month. By projecting the cost of care at the Medicaid rate, he meets his spenddown on the first of the month (May) because his spenddown liability of $1,355 is less than the Medicaid rate ($1,395). His patient pay for May is determined:

$1,700	total patient pay gross income
- 1,355	spenddown liability
345	
- 105	personal needs allowance (basic plus guardian fee)
- 100	dependent child allowance ($250-150=100)
- 50	health insurance premium
- 25	noncovered medical expense incurred May 2
65	
- 65	current payment on January medical bill
0	remaining income
+1,355	spenddown liability (his responsibility)
$1,355	contributable income for patient pay (May)

Compare the contributable income for patient pay to the facility's Medicaid rate for May. The facility can collect no more than the Medicaid rate. Because the contributable income for patient pay is less than the Medicaid rate, Mr. C's patient pay for May is his contributable income of $1,355.

M1470.620 FACILITY PATIENTS--SPENDDOWN LIABILITY GREATER THAN THE MEDICAID RATE

A. Policy

This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

1. Retrospective Determination

An MN facility patient whose spenddown liability exceeds the Medicaid rate is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. ALL of these determinations are made monthly, retrospectively, **after** the month has passed and the expenses have actually been incurred. The individual's resources and income must be verified each month before determining if the spenddown has been met.

2. Full Month's Coverage If Spenddown Met

When incurred expenses equal or exceed the spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month in which the spenddown was met, and ending the last day of the month in which the spenddown was met. See subchapter M1460 for procedures to determine spenddown eligibility for these individuals. Patient pay for the month in which the spenddown was met is calculated after determining that the spenddown was met.

3. Patient Pay

Medicaid must not pay any of the recipient's spenddown liability to the provider. Because the spenddown determination is completed after the month and expenses are not projected, the spenddown liability is NOT added to remaining income for patient pay. Use the following procedures to calculate the patient pay for the month in which the spenddown was met.

B. Patient Pay Procedures

1. Patient Pay Gross Monthly Income

Determine the recipient's patient pay gross monthly income according to section M1470.100 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. Calculate Remaining Income For Patient Pay

Calculate remaining income for patient pay by deducting the following from gross patient pay income:

a. a personal needs allowance (M1470.210),

b. a dependent child allowance, if appropriate (M1470.220),

c. any allowable noncovered medical expenses (M1470.230) **NOT** including the facility cost of care, and

d. a home maintenance deduction, if appropriate (M1470.240).

The result is individual's **remaining income**.

3. Patient Pay

Compare the remaining income to the facility's Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Example—In a Facility, Spenddown Liability Exceeds Medicaid Rate; No Dependent *(Using July 1999 Figures)*

Ms. Day is an institutionalized individual with no dependents who filed an initial application for Medicaid on November 13, 1999. She was admitted to the facility on November 12, 1999. She has a monthly CSA benefit of $1,700 and a monthly payment of $225 from the Seminole Indians Land Trust. She has a $75 old bill incurred in July 1998, and she has a health insurance premium payment of $50 per month paid on the 20th of the month. She does not have Medicare. She last lived outside the facility in a Group II locality. Her income exceeds the 300% SSI income limit. Her MN eligibility is determined for November 1999. The MN determination results in a spenddown liability:

$1,700	monthly MN income (Seminole Indians payment excluded)
- 20	exclusion
1,680	countable MN income
- 250	MN limit for 1 (Group II)
$1,430	spenddown liability for November

The facility's Medicaid rate is $40 per day, or $760 for the 19 days in November, the admission month. Because her spenddown liability of $1,430 exceeds the $760 Medicaid rate for the admission month of November, Ms. Day is not eligible until she actually incurs medical expenses, including the private facility rate, on or before November 30 that equal or exceed the spenddown liability of $1,430. The private rate is $65 per day. The old bill of $75 is deducted on November 1. She incurs $1,235 for 19 days of care and the $50 insurance premium on November 21; she incurs no other expenses. She does not meet the spenddown in the admission month of November. She paid her all of her November medical expenses in November.

Her eligibility for December (the month following the admission month) is determined. The Medicaid rate of $40 per diem is projected for a 31-day month and equals $1,240. The spenddown liability for the month is compared to the Medicaid rate before deducting any incurred medical expenses. Because the monthly spenddown liability of $1,430 exceeds the Medicaid rate, eligibility must be determined, retrospectively, after the actual facility care costs have been incurred.

In January, to determine if the spenddown was met in December, the worker compares the spenddown liability to the private cost of care for December. The private daily rate of $65 per day is multiplied by 31 days in December to determine the private monthly cost of care. Because the monthly spenddown liability of $1,430 is less than the private monthly cost of care of $2,015, Ms. Day met her spenddown in December and is eligible for the full month of December. She is enrolled *for a* closed period of eligibility, beginning 12-01-99 and ending 12-31-99. On December 3, she made a payment of $75 on her July 1998 medical expense. Her patient pay for December is calculated as follows:

$1,700	CSA
+ 225	Seminole Indians payment (not excluded for patient pay)
1,925	gross income for patient pay
- 30	personal needs allowance
- 75	12/3/99 current payment on medical bill from July 1998
- 50	health insurance premium paid on the 21st
$1,770	remaining income for patient pay (December)

The eligibility worker compares the remaining income to the Medicaid rate ($1,240) for December. The facility can collect no more than the Medicaid rate. Because the Medicaid rate is less than the remaining income for patient pay, Ms. Day's patient pay for December is the Medicaid rate of $1,240. Since she paid the nursing facility the private rate of $2,015 for December, the facility will reimburse her after receiving the Medicaid payment for December. If she retains this money, it becomes a resource to her in the month in which she receives the reimbursement (January at the earliest). Her countable resources must be verified for January before determining if her January spenddown was met.

M1470.630 CBC PATIENTS WITH SPENDDOWN LIABILITY

A. Policy

This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

1. Retrospective Determination

Community Based Care (CBC) patients who have income over the 300% of SSI income limit are placed on a monthly spenddown as institutionalized individuals because they have been screened and approved for waiver services. The monthly CBC expenses are determined retrospectively; they cannot be projected for the spenddown budget period.

Retrospective spenddown eligibility determinations are made monthly after the month has passed and the expenses have actually been incurred. The CBC expenses, along with other allowable medical and dental expenses, are deducted

daily and chronologically as the expenses are incurred. The individual's resources and income must be verified each month before determining if the spenddown has been met.

2. Full Month's Coverage If Spenddown Met

When incurred medical expenses equal or exceed the monthly spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month, and ending the last day of the month.

Patient pay for the month in which the spenddown was met is calculated after determining that the spenddown was met.

3. Patient Pay

Medicaid must not pay any of the recipient's spenddown liability to the provider(s). Because the spenddown is completed after the month and expenses are not projected, the spenddown liability is NOT added to the available income for patient pay. Use the following procedures to calculate the patient pay for the month in which the spenddown was met.

B. Patient Pay Procedures

1. Patient Pay Gross Monthly Income

Determine the CBC recipient's patient pay gross monthly income according to section M1470.100 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. Calculate Remaining Income for Patient Pay

Calculate remaining income for patient pay by deducting the following from gross patient pay income:

a. a personal needs allowance (M1470.410),

b. a dependent child allowance, if appropriate (M1470.420),

c. any allowable noncovered medical expenses (M1470.430) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of CBC care.

The result is the individual's **remaining income** for patient pay.

3. Patient Pay

Compare the remaining income to the Medicaid rate (hours of CBC waiver services multiplied by the Medicaid hourly rate) for the month. The patient pay is the lesser of the two amounts.

4. Example--CBC Spenddown Met (Using January 2000 Figures)

Ms. G. lives in Group III and filed an initial application for Medicaid in January. She is approved by the screener for the *EDCD* Waiver in January. She has no community spouse or dependent child. Her monthly income of $1800 SSA and a $200 private pension and exceeds the CNNMP 300% SSI limit. Her monthly spenddown liability is determined:

$1,800	SSA
+ 200	private pension
$2,000	total monthly income
- 20	exclusion
$1,980	countable income
- 325	MNIL for Group III
$1,655	monthly spenddown liability

Her January application is denied and she is placed on a monthly spenddown during the 12-month certification period of January through December.

In February she submits bills to determine if her January spenddown has been met. Her spenddown eligibility is evaluated first by comparing the private cost of care to her spenddown liability. The private cost of care is $15 per hour, 4 hours per day, or $60 per day. She received care on 20 days in January at the private rate of $60 per day. The private cost of care for January was $1,200. Because the private cost of care was less than her spenddown liability, her spenddown eligibility must be determined on a daily basis. She has old bills of $600 incurred prior to the retroactive period, a health insurance premium of $100 paid on the first of the month, and prescription costs of $500 incurred January 2. Her spenddown eligibility is determined:

$1,655	spenddown liability
- 600	old medical bills incurred prior to retroactive period
- 100	medical insurance premium paid January 1
- 60	cost of care incurred January 1
895	balance beginning January 2
- 500	prescription costs incurred January 2
- 60	cost of care incurred January 2
335	balance beginning January 3
- 300	cost of care incurred January 3 -7 (5 days)
35	spenddown liability balance at beginning of January 8
- 60	cost of care incurred on January 8
$ 0	spenddown met on January 8

Because she met the spenddown on January 8, she is eligible for *full* Medicaid coverage beginning January 1 and ending January 31. Her patient pay for January is calculated as follows:

$1,800	SSA
+ 200	private pension
- 512	personal maintenance allowance
- 600	old bill incurred prior to retroactive period
- 100	medical insurance premium paid January 1
$ 788	remaining income for patient pay (January)

The worker compares the remaining income for patient pay to the Medicaid rate for Medicaid CBC waiver services. The Medicaid hourly rate of $10.50 is multiplied by the 80 hours of CBC waiver services received in January. Because her remaining income ($788) is less than the Medicaid rate ($840), Ms. G's patient pay for January is the remaining income of $788.

The following month, Mrs. G submits bills to determine if and when her February spenddown was met. Her February spenddown eligibility is evaluated as follows:

$1,655	spenddown liability
- 100	medical insurance premium paid February 1
- 60	cost of care incurred on February 1
1,495	spenddown balance beginning February 2
-1,140	cost of care for remainder of February (19 days)
$ 355	spenddown balance on February 29

Mrs. G does not meet her spenddown for the month of February, so she is not eligible for February and no patient pay is calculated. In March and subsequent months, Mrs. G might have additional medical expenses which could enable her to meet her spenddown liability and establish eligibility.

M1470.640 PACE RECIPIENTS WITH SPENDDOWN LIABILITY

A. Policy

This section is applicable ONLY to an unmarried individual, or a married individual without a community spouse. **DO NOT USE this section** for a married individual with a community spouse; go to subchapter M1480.

1. Monthly Spenddown Determination

PACE recipients who have income over the CNNMP 300% of SSI income limit are placed on a monthly spenddown as institutionalized individuals because they have been screened and approved for LTC services.

Unlike CBC, PACE has a capitated monthly rate that is due and payable on the first day of the month. The monthly PACE rate is available from the PACE provider. When an MN individual is in PACE, the amount of allowed PACE expenses is the rate that is due as of the first day of each month.

PACE recipients are not responsible for Medicare Part D premiums, which are included in the monthly PACE rate. **Therefore, the cost of the Medicare Part D premium cannot be used to meet a spenddown and must be subtracted from the monthly PACE rate when determining if the spenddown has been met.**

The individual's spenddown liability and the PACE monthly rate (minus the Medicare Part D premium) establish whether the spenddown eligibility determination can be projected or must be determined retrospectively.

2. Projected Spenddown Determination

If the MN individual's spenddown liability is less than or equal to the monthly PACE rate (minus the Medicare Part D premium), the individual is eligible for Medicaid. As long as the individual's spenddown liability and the PACE monthly rate do not change, the individual is enrolled in ongoing coverage effective the first day of the month in which the spenddown is initially met.

3. Retrospective Spenddown Determination

If the MN individual's spenddown liability exceeds the monthly PACE rate (minus the Medicare Part D premium), he is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. The monthly medical expenses are determined retrospectively; they cannot be projected for the spenddown budget period.

Retrospective spenddown eligibility determinations are made monthly after the month has passed and the expenses have actually been incurred. The PACE rate (minus the Medicare Part D premium) along with other allowable medical and dental expenses are deducted daily and chronologically as the expenses are incurred. The individual's income and resources must be verified each month before determining if the spenddown has been met. See M1470.520 for allowable medical deductions.

When incurred medical expenses equal or exceed the monthly spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month and ending the last day of the month.

4. Patient Pay

a. Projected Spenddown Eligibility Determinations

Medicaid must NOT pay any of the individual's spenddown liability to the provider. In order to prevent any Medicaid payment of the spenddown liability, the spenddown liability is added to available income for patient pay. Follow the instructions in M1470.610 for calculating spenddown and patient pay when spenddown liability is less than or equal to the PACE rate (minus the Medicare Part D premium).

b. Retrospective Spenddown Eligibility Determinations

Because the spenddown eligibility determination is completed after the month in which the PACE services were received and expenses are not projected, the spenddown liability is NOT added to the available income for patient pay. Follow the instructions in M1470.630 for calculating the spenddown and patient pay when the spenddown liability exceeds the monthly PACE rate (minus the Medicare Part D premium).

M1470.800 COMMUNICATION BETWEEN LOCAL DSS AND LTC PROVIDER

A. Introduction

Certain information related to the individual's eligibility for and receipt of Medicaid LTC services must be communicated between the local agency and the LTC provider. The Medicaid LTC Communication Form (form DMAS-225) is used by both the local agency and LTC providers to exchange information.

B. Purpose

The DMAS-225 is available on SPARK at: http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi. The form is used to:

- notify the LTC provider of a patient's Medicaid eligibility status;
- notify a new provider that the patient pay is available through the verification systems;
- reflect changes in the patient's deductions, *such as a medical expense allowance*;
- document admission, death or discharge of a patient to an institution or community-based care services;

- provide information on health insurance, LTC insurance or VA contract coverage, and

- provide other information unknown to the provider that might cause a change in eligibility status or patient pay amount.

Do not use the DMAS-225 to relay the patient pay amount. Providers are responsible for obtaining patient pay information from the ARS/MediCall verification systems.

C. When to Complete the DMAS-225

Complete the DMAS-225 at the time of eligibility determination and/or the recipient's entry into LTC. Complete a new DMAS-225 when the recipient's eligibility status changes, such as when the recipient's Medicaid coverage is canceled or changed to limited QMB or SLMB coverage, *or when the LTC provider changes.*

Additionally, complete a DMAS-225 for an ongoing enrollee whose patient pay has been initially transitioned into MMIS to notify the provider that the patient pay information is available through ARS/MediCall.

D. Where to Send the DMAS-225

Refer to M1410.300 B.3.b to determine where to send the form.

M1470.900 ADJUSTMENTS AND CHANGES

A. Policy

The Medicaid recipient or his authorized representative is responsible to report any changes in his or her situation within 10 days of the day the change is known. In situations where the patient pay amount is less than the Medicaid rate the patient pay must be adjusted within 30 days of notification or discovery of the change. This section contains the procedures for when and how to adjust patient pay.

There are situations when the EW **cannot increase** the patient pay, such as when the current patient pay amount equals the Medicaid rate for the month. In this situation, an adjustment that results in an increase in patient pay cannot be made and a referral to the DMAS Recipient Audit Unit must be completed following the procedures in D.3.c.1) below.

B. Action When A Change Is Reported

Upon receipt of notice that a change in an enrollee's income or deductions has occurred, the EW must evaluate continued income eligibility (see subchapter M1460). If eligibility no longer exists, follow the procedures for LTC medically needy income and spenddown (see M1460.700). If eligibility continues to exist, the EW must:

1. Recalculate the patient pay.

2. If the patient pay remains the same, send written notification to the person handling the patient's income that the patient pay is unchanged.

3. If the patient pay decreases, follow the instructions found in Item C. below. If the patient pay increases, follow the instructions found in Item D. below.

C. Patient Pay Decreases

1. When to Adjust

Reflect a patient pay decrease using the MMIS Patient Pay process effective the month following the month in which the change was reported when:

- the patient's income decreases;
- an allowable deduction is added or increased;
- the patient did not receive, or no longer receives, some or all of his income.

Adjust the patient pay for the month following the month in which the change was reported. DO NOT adjust patient pay retroactively, unless the patient meets a condition specified in section M1470.910 below.

2. Procedures

Using the MMIS Patient Pay process, take the following steps to reflect a decrease in patient pay:

a. Verify the decrease.

b. Calculate the new patient pay based on the change(s).

c. Subtract the "new" patient pay from the "old" patient pay amount; the result is the reduced amount.

d. Multiply the reduced amount by the number of months in which the reduced amount should have been effective; the result is the total reduction.

e. Subtract the total reduction from the next month's (the month following the month in which the worker is taking this action) patient pay. If the total reduction exceeds the patient pay, the patient pay amount will be zero until the total reduction has been subtracted from the patient pay.

3. Example-Patient Pay Decrease

Mr. F is an institutionalized individual who had been receiving a SSA payment of $1,000 and a workman's compensation payment of $400 each month. On June 30, he reported he received his final worker's compensation payment on June 15. The EW requested verification of the termination of the worker's compensation and received the verification on August 22. His patient pay had been $1,370 per month. His new patient pay is calculated to be *$960* per month. The "new" patient pay of *$960* is subtracted from the "old" patient pay of $1,370. The monthly amount is reduced by *$410*. Since Mr. F reported the change in June, the patient pay must be adjusted for July and subsequent months. The reduction of *$410* is multiplied by 2 months (July and August) and totals *$820*. The EW *adjusts Mr. F's* September *patient pay* to reflect the decreased monthly income for July and August. *MMIS shows a* September patient pay of *$140* and also shows a patient pay of *$960* for October and subsequent months.

D. Patient Pay Increases

Using the MMIS Patient Pay process, reflect a patient pay increase effective the month following the month in which the 10-day advance notice period ends when:

- the patient's income increases;
- an allowable deduction stops or decreases.

1. Prospective Month(s)

Calculate the new patient pay based on the current income and make the change effective the month following the month in which the 10-day advance notice period ends. This will be the new ongoing patient pay.

2. Current and Past Month(s)

Determine the amount of the recipient underpayment when:

- the income counted was less than the income actually received; or
- an allowable deduction stopped or decreased.

Do not revise the *patient pay* retroactively for the current and past month(s) unless the requirements in section M1470.910 below are met.

3. Procedures

a. Determine the amount of the underpayment(s):

1) Calculate the new monthly patient pay based on the change(s), beginning with the month in which the change occurred.

2) Subtract the "old" monthly patient pay from the "new" monthly patient pay amount. The result is the amount of the recipient's underpayment for that month.

3) Add the monthly underpayment(s) together to determine the total amount of the recipient's underpayment. If the underpayment is less than $500, follow the procedures in "b" below. If the underpayment is $500 or more, follow the procedures in "c" below.

b. Total underpayment of less than $500

To adjust the patient pay obligation for the month following the month in which the 10-day advance notice period ends, take the following steps:

1) Add the total underpayment to the new ongoing patient pay. This is the total patient pay obligation.

2) Compare the total patient pay obligation to the provider's Medicaid rate.

a) If the total patient pay obligation is less than the provider's Medicaid rate, the total amount of the patient's underpayment can be collected in one month. The total patient pay obligation is the patient pay for the month following the month in which the 10-day advance notice period ends.

b) If the total patient pay obligation exceeds the provider's Medicaid rate, determine the difference between the ongoing patient pay and the provider's Medicaid rate. The difference is the amount of the underpayment that can be collected the first month. The patient pay for the first month (current patient pay and a portion of the underpayment) will equal the Medicaid rate. The balance of the underpayment must be collected in subsequent months. Repeat these procedures for subsequent months until the total amount of the underpayment has been reduced to zero.

c. Total underpayment of $500 or more

1) Underpayment amounts totaling $500 or more must be referred to the DMAS Recipient Audit Unit for collection.

a) Complete and send a "Notice of Recipient Fraud/Non-Fraud Overissuance" (see Appendix 1 to chapter M17) to:

Recipient Audit Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

b) Complete and send a "Notice of Action on Medicaid" (available at *http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi*) informing the patient of the referral to DMAS for collection of the underpayment.

2) Prospective months' patient pay

MMIS will automatically generate and send a "Notice of Obligation for LTC Costs" to the patient or the patient's representative for the month following the month in which the 10-day advance notice period ends.

4. Example--Patient Pay Increase -Total Underpayment Less than $500

Mr. S is an aged individual who has received Medicaid covered CBC services for two years. His "old" monthly patient pay was $300. On February 25, he reports his pension increased $50 per month in February. On March 22 the EW recalculated the patient pay based on the current income. His new monthly patient pay is $350. Because of the 10-day advance notice requirement the change could not be made for April and must be made for May 1.

His "old" patient pay is subtracted from his "new" patient pay for February, March and April to determine his underpayment for those months. The $50 underpayment for three months ($150) is added to his "new" ongoing patient pay ($350) and the total patient pay obligation ($500) is compared to the Medicaid rate of $1700. Since the total patient pay obligation of $500 is less than the Medicaid rate of $1700, the patient pay for May is $500. The ongoing patient pay starting in June is $350.

5. Example--Patient Pay Increase -Total Underpayment $500 or More

Mr. M is an institutionalized individual. On February 25, he reports his pension increased $200 per month in February. On March 22 the EW recalculated the patient pay based on the current income. His new monthly patient pay is $1400. His "old" monthly patient pay was $1200.

Because of the 10-day advance notice requirement the change could not be made for April and must be made for May 1. His "old" patient pay is subtracted from his "new" patient pay for February, March and April to determine his underpayment for those months. The $200 underpayment for three months totals $600. Since the total underpayment exceeds $500, a patient pay adjustment can not be made. A referral must be made to the DMAS Recipient Audit Unit for collection and the recipient must be notified of the referral (see M1470.900 D. 3. c).

M1470.910 RETROACTIVE ADJUSTMENTS FOR PRIOR MONTHS

A. Retroactive Adjustment

If a change was reported timely and the patient pay for prior months is incorrect, adjust the patient pay for the prior months only in the following situations:

1. a deceased individual had health insurance premiums or noncovered medical expenses that should have reduced patient pay; *or*

2. a community spouse is owed money for a spousal allowance and the institutionalized spouse is deceased or no longer in long-term care. However, if the community spouse had decreased income and did not report the change in a timely manner, do not adjust the patient pay.

In these situations, adjust the patient pay retroactively using *MMIS Patient Pay process* for the prior months in which the patient pay was incorrect. **In all other situations when a change is reported timely, do not adjust the patient pay retroactively.**

B. Notification Requirements

MMIS automatically generates and sends the Notice of Obligation for LTC Costs.

M1470.920 LTC PROVIDER CHANGE WITHIN A MONTH

A. Policy

A change in LTC providers requires a review of patient pay to determine if a patient pay amount needs to be paid to the new provider. When a recipient changes LTC providers within a month, *revise the patient pay* if necessary.

B. *Procedures*

This procedure applies to the following changes in LTC Providers during a month:

- *CBC Provider to CBC Provider;*
- *Nursing Facility Provider to Nursing Facility Provider;*
- *CBC Provider to Nursing Facility Provider; and*
- *Nursing Facility Provider to CBC Provider*

Refer to Chapter G in the *MMIS User's Guide for DSS, available at: http://www.dmas.virginia.gov/dss_mmis_manual.htm, for patient pay data entry procedures for change in provider during a month.*

1. CBC to CBC; NF to NF; CBC to NF

a. Contact the former Medicaid provider to obtain the actual Medicaid cost of services received for the month in which the transfer occurred.

b. Compare the Medicaid monthly patient pay amount for the month of admission to the current provider to the actual cost of the Medicaid services received under the former provider.

c. If the actual Medicaid cost for the former provider for the month of admission to the current provider is greater than or equal to the amount of patient pay, do not revise the patient pay amount to the former provider. Patient pay for the current provider is zero for the month of admission. Show the ongoing patient pay to the current provider effective the following month.

d. If the actual Medicaid cost for the former provider is less than the amount of patient pay, subtract the actual cost from the amount of patient pay. The actual cost is the patient pay to the former provider. For the month of admission to the current provider, the patient pay to the current provider is the difference between the amount paid to the former provider and the monthly patient pay amount. Show the ongoing patient pay to the current provider effective the following month.

2. NF to CBC

a. Contact the NF to obtain the actual Medicaid cost of services received for the month in which the transfer occurred.

b. Compare the Medicaid monthly patient pay amount for the month of admission to CBC to the actual cost of the Medicaid services received from the NF.

c. If the actual Medicaid costs in the NF for the month of admission to CBC are greater than or equal to the amount of patient pay, do not revise the patient pay amount to the NF. Patient pay for the CBC provider is zero for the month of admission. Show the ongoing patient pay to the CBC provider effective the following month.

d. If the actual Medicaid cost for the NF is less than the amount of patient pay, subtract the actual cost from the amount of patient pay. The actual cost is the patient pay to the NF. For the month of admission to CBC, the remaining balance of the patient pay obligation is considered income for patient pay for CBC services.

e. Determine patient pay to the CBC provider for the month of admission. From the remaining patient pay balance, subtract the PMA, which is determined as follows:

The PMA equals the waiver's basic allowance minus the NF PNA (including any Special Earnings Allowance and/or guardianship fee). The Special Earnings Allowance and guardianship fee may only be deducted once and are included in the NF PNA.

Show the ongoing patient pay to the CBC provider effective the following month.

3. PACE *Enrollment in PACE begins on the first day of a month and ends on the last day of a month. Patient pay for PACE participants is not adjusted due to provider changes within a month.*

M1470.930 DEATH OR DISCHARGE FROM LTC

A. Policy *The LTC provider may not collect an amount of patient pay that is more than the Medicaid rate for the month.* When a patient dies or is discharged from LTC to another living arrangement that does not include LTC services, *do not* recalculate patient pay for the month in which the patient died or was discharged. *The provider is responsible for collecting an amount of patient pay for the month of death or discharge that does not exceed the Medicaid rate for the month.*

B. Procedure Refer to *Chapter G* in the *MMIS User's Guide for DSS for procedures regarding death or discharge from LTC. Send a DMAS-225 to the provider regarding the eligibility status of the patient. Send a notice to the patient or the patient's representative that reflects the reduction or termination of services.*

M1470.1000 LUMP SUM PAYMENTS

A. Policy Lump sum payments of income or accumulated benefits are counted as income in the month they are received. Patient pay must be adjusted to reflect this income change for the month following the month in which the 10-day advance notice period expires. Any amount retained becomes a resource in the following month.

B. Lump Sum Defined Income such as interest, trust payments, royalties, etc., which is received regularly but is received less often than quarterly (i.e., once every four months or three times a year, once every five months, once every six months or twice a year, or once a year) is treated as a lump sum for patient pay purposes.

EXCEPTION: Income that has previously been identified as available for patient pay, but which was not actually received because the payment source was holding the payment(s) for some reason or had terminated the payment(s) by mistake, is **NOT** counted again when the corrective payment is received.

See section M1470.1030 below for instructions for determining patient pay when a lump sum is received.

M1470.1010 LUMP SUM REPORTED IN RECEIPT MONTH

A. Lump Sum Available Lump sum payments reported in the month the payment was received are counted available for patient pay effective the first of the month following the month in which the 10-day advance notice period expires.

If the individual is no longer in the facility and is not receiving Medicaid CBC, adjust the patient pay for the lump sum receipt month if the money is still available.

B. Lump Sum Not Available If the money is not available, complete and send a "Notice of Recipient Fraud/Non-Fraud Overissuance" to the DMAS, Recipient Audit Unit.

M1470.1020 LUMP SUM NOT REPORTED TIMELY

A. Effective Date

Lump sum payments reported AFTER the month in which the payment was received are not reported timely. Evaluate total resources including the lump sum. If the resources are within the limit, determine availability for patient pay. See B. & C. below. If they exceed the resource limit, go to section M1470.1100 below.

B. Lump Sum Not Available

If the money is not available, complete and send a "Notice of Recipient Fraud/Non-Fraud Overissuance" to the DMAS, Recipient Audit Unit.

C. Lump Sum Available

1. If the money is still available and the individual is no longer in the facility and is not receiving Medicaid CBC, complete and send a "Notice of Recipient Fraud/Non-Fraud Overissuance" to the DMAS, Recipient Audit Unit.

2. If the money is still available and the individual is still in the facility or is still receiving Medicaid CBC, adjust the patient pay according to procedures in section M1470.1030 below.

M1470.1030 PATIENT PAY DETERMINATION FOR LUMP SUMS

A. Policy

When a lump sum payment is received, the patient pay for the month in which the 10-day advance notice period expires must be adjusted using the procedures in this section.

B. CNNMP Procedures

1. Total Income

Add the lump sum to the patient's regular monthly income; the result is total income for the month.

2. Less Than Or Equal To 300% of SSI

If the total gross income (including the lump sum) is equal to or less than the 300% of SSI income limit, adjust the patient pay. None of the lump sum remains to be evaluated.

3. Greater Than 300% of SSI

If the total gross income (including the lump sum) exceeds the 300% of SSI income limit, adjust the patient pay. Compare the income available for patient pay to the Medicaid rate for the month.

If the income available for patient pay is less than or equal to the Medicaid rate, the available income is the patient pay. If the income available for patient pay exceeds the Medicaid rate, adjust the patient pay to equal the Medicaid rate for the month.

Evaluate the difference between the Medicaid rate and the available income as a resource for the next month. If the patient’s total countable resources exceeds the resource limit, take appropriate action to cancel the patient’s Medicaid.

C. MN Procedures

1. Facility Patients--Spenddown Liability Less Than or Equal To Medicaid Rate

For facility patients who have a spenddown liability that is less than or equal to the facility Medicaid rate and who are enrolled in ongoing Medicaid coverage:

a. add the lump sum to the patient's regular monthly income; the result is total gross income for the month;

b. subtract the correct personal needs/maintenance allowance and any other allowable deductions; the remainder is the income available for patient pay for the month

c. compare the spenddown liability to the Medicaid rate for the month:

- if the available income for patient pay is less than or equal to the Medicaid rate, the available income is the patient pay.
-
- if the available income for patient pay is **greater than** the Medicaid rate, adjust the patient pay to the Medicaid rate for the month. Evaluate the difference between the Medicaid rate and the available income as a resource for the next month. If the patient's total countable resources, including the remainder of the available income, exceed the resource limit, take appropriate action to cancel the patient's Medicaid.

2. Facility Patients With Spenddown Liability Greater Than Medicaid Rate, & All Medicaid CBC Patients

For facility patients who have a spenddown liability that is greater than the facility Medicaid rate, and for ALL Medicaid CBC patients whose eligibility and patient pay are determined retrospectively:

a. Spenddown Eligibility & Patient Pay Previously Determined

If the individual's spenddown eligibility for the month has been determined without including the lump sum amount and the individual was enrolled for the month:

1) add the lump sum to the patient's regular monthly income in the month the lump sum was received; the result is total gross income for the month;

2) subtract the correct personal needs/maintenance allowance and any other allowable deductions; the remainder is the revised patient pay for the month;

3) compare the revised patient pay to the patient pay that was previously determined and sent to the provider:

- if the revised patient pay is **greater than** the previously determined patient pay, adjust the patient pay to the revised patient pay amount or the Medicaid rate, whichever is less. If the Medicaid rate is less, evaluate the difference between the Medicaid rate and the revised amount as a resource for the next month.

- if the revised patient pay is **less than or equal to** the previously determined patient pay, DO NOT adjust the patient pay.

  Note: If the patient's total countable resources, including the remainder of the available income, exceed the resource limit, take appropriate action to cancel Medicaid eligibility the next month because of excess resources.

b. Spenddown Eligibility & Patient Pay NOT Previously Determined

If the individual's spenddown eligibility for the month has not yet been determined:

1) Recalculate the individual's spenddown liability by adding the lump sum to the patient's regular monthly income in the month the lump sum was received; determine spenddown eligibility by policy and procedures in section M1460.700.

2) If the individual meets the revised spenddown, determine patient pay by using the policy and procedures in section M1470.620 or 630.

M1470.1100 REDUCTION OF EXCESS RESOURCES

A. Policy

Medicaid policy allows for a full month of eligibility if the resource limit is met at anytime during the month. LTC patients whose patient pay is less than the Medicaid rate can choose to reduce excess resources by expending the excess for the cost of LTC services.

B. Resource Reduction Defined

A decrease in property value, such as an official reassessment or a lien placed against property, is not a reduction of resources. It is a decrease in the value of the resource.

In order to reduce resources, a resource must be transferred out of the patient's possession. Liquid resources such as bank accounts and prepaid burial accounts must actually be expended or encumbered. Non-liquid resources must be liquidated and the money expended.

A reduction of resources is an asset transfer and must be evaluated under asset transfer policy in subchapter M1450.

C. Procedures

1. Required Contact

When a Medicaid-enrolled LTC recipient is found to have excess resources, evaluate whether an adjustment to patient pay by using the excess toward the cost of care will allow continued eligibility in the month in which the 10-day advance notice period expires. Do not assume that the recipient or the recipient's representative will agree to use the excess resources to pay an increased patient pay.

Prior to initiating the following procedures, contact the individual or his authorized representative and tell him of the alternatives available. In the case record, document the conversation and the decision made. If unable to make contact by phone, send the Advance Notice of Proposed Action for cancellation due to excess resources.

2. Reduce Excess Resources

When the patient agrees to use the excess resources toward the cost of care, take the following steps for the month in which the 10-day advance notice period expires:

Step 1 Determine amount of excess resources (total resources minus the resource limit).

Step 2 Determine the monthly Medicaid rate:

- for a facility patient, the monthly rate is the facility's Medicaid per diem rate multiplied by 31 days.
- for a CBC patient, the monthly rate is each CBC service provider's hourly rate multiplied by the number of hours of services provided to the patient in the month.

Step 3 Add the amount of excess resources to the current patient pay.

Step 4 If the result of Step 3 is less than the monthly Medicaid rate obtained in Step 2, adjust the patient pay for one month to allow the excess resources to be reduced.

Step 5 If the result of Step 3 is more than the monthly Medicaid rate obtained in Step 2, the patient is ineligible due to excess resources. Send an "Advance Notice of Proposed Action" to cancel Medicaid coverage due to excess resources.

D. Example--Recipient Reduces Resources

An institutionalized Medicaid recipient's resources accumulate to $2,200 in February. His monthly income is $500 from Social Security (SS) and $100 VA Compensation. His patient pay *of $560* is less than the Medicaid rate. He pays the amount of his excess resources ($200) to the nursing facility as part of his March patient pay, so he remains eligible.

$ 500	SS
+ 100	VA Compensation
$ 600	total gross income
- *40*	personal needs allowance
$ 560	current patient pay (prior to adding excess resources)

$ 560	current patient pay
+ 200	excess resources
$760	patient pay for March only

His patient pay for April and subsequent months is calculated:

$ 500	SS
+ 100	VA Compensation
$ 600	total gross income
- *40*	personal needs allowance
$ 560	patient pay for April and subsequent months

M1470.1200 INCORRECT PAYMENTS TO PROVIDER

A. Introduction

There may be instances when the amount of patient pay collected by an LTC provider is less than the amount *determined* available for payment. This situation is most likely to occur when some other person is the payee for the patient's benefits.

B. Procedures

This section provides policy and procedures used to determine patient pay when the provider collects less than the patient pay *amount.* Patient pay can be adjusted *according to whether* certain criteria, specified in sections *M1470.1210 and M1470.1220* below, are met.

M1470.1210 ADJUSTMENTS NOT ALLOWED

A. Policy

The facility or CBC provider is responsible to collect the patient pay from the patient or the person handling the patient's funds. When the provider is not successful in collecting the patient pay, the EW **cannot** adjust the patient pay.

B. Do Not Adjust Patient Pay

The patient pay *reported in ARS/MediCall* is considered available by Medicaid. Do not adjust the patient pay when:

1. the patient directly receives his benefits and is considered to be competent but does not meet his patient pay responsibility; or

2. the amount of patient pay in question is from the patient's own funds which have been withheld by a payee or other individual receiving the patient's funds and have not been paid toward the cost of the patient's care, as specified by policy in this chapter and by the "Notice of Obligation for LTC Costs" sent to the individual.

Should the situation indicate that a change in payee is necessary, contact the program which is the source of the benefit payment and recommend a change. *Additionally,* be alert to situations that may require a referral to Adult Protective Services for an evaluation of exploitation.

C. Entitlement Benefits Adjustment

For an ongoing case, if benefits from entitlement programs (such as Social Security) are not received because the program is holding the check(s) for some reason, but the benefits will be paid some time in the future in a lump sum, do not adjust the patient pay for the months the benefits are not received.

When the lump sum payment is received, do **not** count the lump sum payment and do **not** follow instructions for lump sum payments as found in this subchapter because the patient must use the lump sum to pay the previous months' remaining patient pay amounts the patient still owes to the provider.

M1470.1220 ADJUSTMENTS ALLOWED

A. Adjust Patient Pay

Adjust the patient pay when:

- the income counted in the patient pay calculation was not actually received because the source did not pay; *and*
- the income will not be paid some time in the future; and
- documentation of the change in income is received by the worker.

See section M1470.900 for instructions on adjusting patient pay.

B. Adjustment Allowed Due To Income Changes

Some examples of when income is not received and will not be paid in the future are:

1. Rental Income

Rental income is no longer received because the property was not rented for a period of time, or the renter did not pay. Be aware that if property no longer produces income, the resource exclusion may be affected. Evaluate *the individual's* continued eligibility.

2. Contribution Not Received

A contribution from a responsible relative or other source is not received. Advise the responsible relative of his legal responsibility. If there is a legal responsibility to support the individual, advise the responsible relative that continued failure to meet that responsibility may result in a non-support petition being filed with the appropriate court.

3. Income Source Exhausted

Interest income is not received because the source of income was exhausted or is no longer available.

4. Trust Income

Income from a trust fund is not received because the trustee did not make it available and/or will no longer make it available.

5. Policy/Benefits Ran Out

Payment from an insurance company or organization is not paid because the policy is no longer in force, benefits ran out, the organization refuses to or cannot pay, etc.

Sample Notice of Obligation for Long-term Care Costs Generated by MMIS

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF MEDICAL ASSISTANCE SERVICES

NOTICE OF OBLIGATION FOR LONG-TERM CARE COSTS

TO: _____

_____

_____

_____

Local Agency: _____
Address: _____
_____
_____

Local Agency Phone #:

Provider #: _____
Provider: _____

Recipient Name: _____ **Recipient ID#:** _____

This form serves as your notice of patient pay which is the amount of your income that must be paid to the provider every month for the cost of long-term care services you receive. If you are a current recipient of long-term care services, this will serve as the 10-day advance notice when your patient pay amount is increased. Please contact your eligibility worker if you have questions.

For individuals assigned to a VALTC Managed Care Organization (MCO), notification of the name of the provider to which you are to make payment will be given to you by your MCO's Care Coordinator.

You must report any changes in income or resources to the local agency. Failing to report changes or providing false or misleading information may result in your prosecution for fraud.

Patient Pay Calculation

Effective Date of Patient Pay

Reason

Income
SSA
Other Unearned Income
Total Earned Income
Total Gross Income
Minus Spenddown Liability (SDL)
Remaining Income

Allowances The amounts below were deducted from your income to determine your patient pay.

Personal/Maintenance Needs
Spousal
Child/Family Member
Non-covered Medical Expense
Home Maintenance
Income Remaining After Allowances

Spenddown Liability
Contributable Income
Medicaid Rate for Month

Patient Pay

Patient pay may be the lesser of the SDL amount, contributable income amount (income remaining after deductions plus the SDL), remaining income or the Medicaid Rate, whichever is applicable to the individual's circumstances. Patient pay will not exceed the Medicaid Rate.

Eligibility Worker: _____ **Date of Notice:** _____

If you disagree with the patient pay calculation you may appeal this decision within 30 days of receipt of this notice. If you appeal an increase in patient pay within 10 days of receipt of this notice, the increase will not take effect until a hearing decision is made. If the decision upholds the increase, you will have to pay the increased amount and the amount that was not paid during the appeal process. Appeals should be in writing and should be sent to Client Appeals, Department of Medical Assistance Services, 600 E. Broad St., Suite 1300, Richmond, Virginia 23219. Please read below for additional information about Appeals and Fair Hearings.

APPEALS AND FAIR HEARINGS

A fair hearing provides you the opportunity to review the way the amount of your patient pay for Medicaid was determined. The fair hearing is a private, informal meeting with you and anyone you wish to bring as a witness or to help you tell your story, such as a lawyer or a friend. The Medicaid Technician or a representative of the local agency and possibly other staff who know about your case will be present to tell how the amount of patient pay was reached. Also present will be a hearings officer. The hearings officer, who is the official representative of the Department of Medical Assistance Services, will make a decision on your appeal.

In addition to filing an appeal, you have the right to request a conference with your Medicaid Technician or local agency at which time the Medicaid Technician or local agency must give you an explanation of the proposed change in patient pay. You will be given the opportunity to present any information on which your disagreement with the proposed patient pay is based. At the conference you have the right to have your story presented by an authorized representative, such as a friend, relative, or lawyer. If you request the conference within 10 days of receipt of this notice and the proposed action is to increase your patient pay, the proposed action will not be taken until a decision is made at your conference.

If you are not satisfied with the explanation you receive at the conference and want your present patient pay to continue until a hearing decision on the increase in patient pay is received, you must file an appeal within two days following the date of the conference. If you do not request a conference but file an appeal within 10 days of this notice, your present patient pay will be continued until a hearing decision is reached. If your present patient pay continues and the action to increase patient pay is upheld, you will be required to pay the patient pay that was not paid during the appeal process. If you do not file an appeal within two days of the conference, the increase in your patient pay will occur but you can still appeal the action within 30 days of the date of this notice.

If you wish to request a hearing, follow the instructions on the front of this form. You will be notified of the date and time for your hearing at a location agreeable to you and the Medicaid Technician or local agency. If you cannot be there on that day, call the Medicaid Technician or local agency immediately.

At the hearing, you and/or your representative will have the opportunity to:

1) Examine all documents and records which are used at the hearing;
2) present your case or have it presented by a lawyer or by another authorized representative;
3) Bring witnesses;
4) Establish pertinent facts and advance arguments; and
5) Question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

The decision or recommendation of the hearing officer shall be based exclusively on evidence and other material introduced at the hearing, except when medical information is requested or other essential information is needed. In such an event, you and the Medicaid Technician or the local agency representative would be given the opportunity to question or refute this additional information. You will be notified of the decision in writing within 90 days of the date your Medicaid appeal is received by the Department of Medical Assistance Services.

It is **YOUR RIGHT TO APPEAL** decisions. If you want more information or help with an appeal, you may contact the local agency or Medicaid Technician. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you desire free legal advice, you may contact your local legal aid office.

CHAPTER M14
LONG-TERM CARE
SUBCHAPTER 80

MARRIED INSTITUTIONALIZED INDIVIDUALS' ELIGIBILITY & PATIENT PAY

M1480 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	pages 7, 14, 66, 71
UP #5	7/1/11	page 66
TN #95	3/1/11	pages 7-9, 13, 18a, 18c, 66, pages 69, 70
TN #94	9/1/10	pages 64, 66, 69, 70
TN #93	1/1/10	Table of Contents, page ii pages 3, 8b, 18, 18c, 20a pages 21, 50, 51, 66, pages 69, 70, 93 Appendix 4 removed.
Update (UP) #1	7/1/09	page 66
TN # 91	5/15/09	pages 67, 68 pages 76-93

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M1480 MARRIED INSTITUTIONALIZED INDIVIDUALS' ELIGIBILITY & PATIENT PAY

M1480.000 GENERAL

A. Introduction

Section 1924 of the Social Security Act contains special eligibility rules that apply ONLY to married institutionalized individuals whose first continuous period of institutionalization began on or after September 30, 1989. These rules are intended to prevent the impoverishment of a spouse living in the community when the other spouse enters long-term care. **For resource assessment and eligibility determination, the resource value is its value as of the first moment of the first day of a calendar month.**

Section 1924 supersedes all other sections of Medicaid law when determining countable resources and income of a married institutionalized individual who has a community spouse. Therefore, the usual Medicaid eligibility rules do not apply to an institutionalized individual with a community spouse whenever the usual Medicaid rules conflict with the law in section 1924.

An institutionalized spouse is an individual who is in a medical institution, who is receiving Medicaid waiver services or who has elected hospice services, and who is married to a spouse who is not in a medical institution or nursing facility. The term "community spouse" means the spouse of an institutionalized spouse. The community spouse can be living outside an institution or in a residential institution such as an adult care residence.

B. Applicability

1. Admitted Before 9-30-89

DO NOT use this subchapter to determine the individual's financial eligibility for Medicaid when the married institutionalized individual was admitted to long-term care **prior to** September 30, 1989 and has been continuously institutionalized since admission. Use subchapters M1410 - M1460 to determine the individual's financial eligibility for Medicaid.

2. Admitted On/ After 9-30-89

Use this subchapter in determining Medicaid eligibility for an institutionalized spouse who

- was admitted to long-term care **on or after** September 30, 1989 and has been continuously institutionalized since admission, and
- has a community spouse.

Do NOT use this subchapter to determine the eligibility of a married institutionalized individual whose spouse is NOT a "community spouse" as defined in this subchapter. Use subchapters M1410 - M1470 to determine the individual's eligibility and patient pay.

The rules in this subchapter apply only to the institutionalized spouse's financial eligibility. If the community spouse applies for Medicaid, use the financial eligibility rules for non-institutionalized persons in the community spouse's covered group to determine the community spouse's Medicaid eligibility.

M1480.010 DEFINITIONS

A. Introduction

This section provides definitions for those words and terms used in this subchapter.

B. Definitions

1. Beginning of a Continuous Period of Institutionaliz-ation

means the first calendar month of a continuous period of institutionalization (in a medical institution or receipt of a Medicaid Community-based Care (CBC) waiver service). See section M1410.010 for definition of a medical institution.

2. Community Spouse

means a person who:

- is married to an institutionalized spouse and
- is not an inpatient in a medical institution or nursing facility.

The community spouse can be living in the home with the institutionalized spouse who is a Medicaid CBC patient, can be living in a residential institution such as an Adult Care Residence, or can be living in the institutionalized spouse's former home.

NOTE: A spouse living in the couple's home who is also receiving Medicaid CBC waiver services is a community spouse. The community spouse monthly income allowance policy applies.

3. Community Spouse Monthly Income Allowance

means an amount by which the minimum monthly maintenance needs allowance (MMMNA) exceeds the amount of monthly income otherwise available to the community spouse. [Section 1924(d)(2) of the Social Security Act].

The community spouse monthly income allowance is the maximum amount of the institutionalized spouse's income which is allowed to supplement the community spouse's income, up to the minimum monthly maintenance needs allowance (MMMNA).

4. Community Spouse Resource Allowance (CSRA)

means the amount (if any) by which the greatest of

- the spousal share;
- the spousal resource standard;

- an amount transferred to the community spouse by the institutionalized spouse pursuant to a court spousal support order; or

- an amount designated by a DMAS Hearing Officer

exceeds the amount of resources otherwise available to the community spouse.

5. Continuous Period of Institutionalization means 30 consecutive days of institutional care in a medical institution, or 30 consecutive days of receipt of Medicaid waiver services (CBC), or 30 consecutive days of a combination of institutional and waiver services. Continuity is broken only by 30 or more days absence from a medical institution or 30 or more days of non-receipt of waiver services.

6. Couple's Countable Resources means all of the couple's non-excluded resources, regardless of state laws relating to community property or division of marital property. For purposes of determining the combined and separate resources of the institutionalized and community spouses when determining the institutionalized spouse's eligibility, the couple's home, contiguous property, household goods, and one automobile are excluded.

7. Dependent Child **means a child 21 years old or older**, of either spouse, who lives with the community spouse and who may be claimed as a dependent by either member of the couple for tax purposes pursuant to the Internal Revenue Code. Tax dependency is verified by a verbal or a written statement of either spouse.

8. Dependent Family Member means a dependent parent, minor child, dependent child, or dependent sibling (including half brothers/sisters and adopted siblings) of either member of a couple who resides with the community spouse and who may be claimed as a dependent by either member of the couple for tax purposes under the Internal Revenue Code. Tax dependency is verified by a verbal or a written statement of either spouse.

9. Excess Shelter Allowance means the actual monthly expense of maintaining the community spouse's residence that exceeds the excess shelter standard (30% of the monthly maintenance needs standard). Actual monthly expenses are the total of:

- rent or mortgage including interest and principal;

- taxes and insurance;

- any maintenance charge for a condominium or cooperative; and

- the utility standard deduction under the *Supplemental Nutrition Assistance Program (SNAP) (formerly* Food Stamps*)* that would be appropriate to the number of persons living in the community spouse's household, if utilities are not included in the rent or maintenance charge [Section 1924(d)(4) of the Social Security Act].

10. Excess Shelter Standard means 30% of the monthly maintenance needs standard. See section M1480.410 below for the current excess shelter standard.

11. Family Member's Income Allowance means an allowance for each dependent family member residing with the community spouse. The family member's income allowance is equal to 1/3 of the amount by which the monthly maintenance needs standard exceeds the family member's income. The family member's income allowance is deducted from the institutionalized spouse's income for the family member's needs.

Family member allowance = (monthly maintenance needs standard - family member income) ÷ 3

EXAMPLE #1:

$1,383	monthly maintenance needs standard
- 300	family member's income
1,083	amount by which monthly maintenance needs standard exceeds the family member's income
÷ 3	
$ 361	family member's monthly income allowance.

12. First Continuous Period of Institutionaliz-ation means the first day of the month of the first continuous period of institutionalization which began on or after September 30, 1989. For example, a person was institutionalized from September 8, 1989 through March 12, 1991, then readmitted on May 28, 1991. His first continuous period of institutionalization that began on/after September 30, 1989 began on May 1, 1991.

13. Initial Eligibility Determination means:

a. An eligibility determination made in conjunction with a Medicaid application filed during an individual's most recent continuous period of institutionalization; or

b. The initial redetermination of eligibility for a Medicaid-eligible institutionalized spouse after being admitted to a medical institution or Medicaid CBC waiver services.

The initial eligibility determination period includes the application month and any subsequent month(s) up to the date on which the agency takes action to approve the application.

14. Initial Redeter-mination means the first redetermination of eligibility for a Medicaid-eligible institutionalized spouse which is regularly scheduled or which is made necessary by a change in the individual's circumstances.

15. Institutionalized Spouse

means an individual who:

- is in a medical institution, or who is receiving Medicaid waiver services, or who has elected hospice services;
- is likely to remain in the facility, or to receive waiver or hospice services for at least 30 consecutive days; and
- who is married to a spouse who is NOT in a medical institution or nursing facility.

NOTE: An institutionalized spouse receiving Medicaid CBC Waiver services can also be a community spouse if his spouse is in a medical facility or is receiving Medicaid CBC Waiver services.

16. Likely to Remain in an Institution

means a reasonable expectation based on acceptable medical evidence that an individual will receive *LTC services* for 30 consecutive days, *unless it is known prior to processing the application that the 30-day requirement has not been met or will not be met. If it is known at the time the application is processed that the individual did not or will not meet the 30 consecutive day requirement, the individual is not to be treated as an institutionalized individual.*

17. Maximum Spousal Resource Standard

means the maximum amount of the couple's combined countable resources established for a community spouse to maintain himself in the community ($60,000 in 1989). This amount increases annually by the same percentage as the percentage increase in the Consumer Price Index (CPI) for all urban consumers between September 1988 and the September before the calendar year involved. [1924(f)(2)(A)(ii)].

See section M1480.231 for the current maximum spousal resource standard.

18. Minimum Monthly Maintenance Needs Allowance (MMMNA)

The minimum monthly maintenance needs allowance [1924(d)(3)(A)] is the monthly maintenance needs standard, plus an excess shelter allowance if applicable, up to a maximum [1924(d)(3)(C)]. The minimum monthly maintenance needs allowance is the amount to which a community spouse's income is compared in order to determine the community spouse's monthly income allowance.

The monthly maintenance needs standard and monthly maintenance needs allowance maximum change each year. See section M1480.410 below for the current standard and maximum.

19. Minor Child

means a child under age 21 years, of either spouse, who lives with the community spouse and who may be claimed as a dependent by either member of the couple for tax purposes pursuant to the Internal Revenue Service Tax Code. Tax dependency is verified by a verbal or written statement from either spouse.

20. Monthly Maintenance Needs Standard

The monthly maintenance needs standard is 150% of 1/12 of the federal poverty level for a family of two in effect on July 1 of each year [Section 1924(d)(3)(A)(i)].

See section M1480.410 below for the current monthly maintenance needs standard.

21. Otherwise Available Income or Resources

means income and resources which are legally available to the community spouse and to which the community spouse has access and control.

22. Promptly Assess Resources

means within 45 days of the request for resource assessment, unless the delay is due to non-receipt of documentation or verification, if required, from the applicant or from a third party.

23. Protected Period

means a period of time, not to exceed 90 days after an initial determination of Medicaid eligibility. During the protected period, the amount of the community spouse resource allowance (CSRA) will be excluded from the institutionalized spouse's countable resources IF the institutionalized spouse expressly indicates his intention to transfer resources to the community spouse.

24. Resource Assessment

means a calculation, completed by request or upon Medicaid application, of a couple's combined countable resources at the beginning of the **first** continuous period of institutionalization of the institutionalized spouse beginning on or after September 30, 1989.

25. Spousal Protected Resource Amount (PRA)

means at the time of Medicaid application as an institutionalized spouse, the greater of:

- the spousal resource standard in effect at the time of application;
- the spousal share, not to exceed the maximum spousal resource standard in effect at the time of application;
- the amount actually transferred to the community spouse by the institutionalized spouse pursuant to a court spousal support order; or
- the amount of resources designated by a DMAS Hearing Officer.

26. Spousal Resource Standard

means the minimum amount of the couple's combined countable resources ($12,000 in 1989) necessary for a community spouse to maintain himself in the community. This amount increases each calendar year after 1989 by the same percentage increase as in the Consumer Price Index (CPI). [1924(f)(2)(A)(i)].

See section M1480.231 for the current spousal resource standard.

27. Spousal Share means ½ of the couple's combined countable resources at the beginning of the **first** continuous period of institutionalization, as determined by a resource assessment.

28. Spouse means a person who is legally married to another person under Virginia law.

29. Waiver Services means Medicaid-reimbursed home or community-based services covered under a 1915(c) waiver approved by the Secretary of the United States Department of Health and Human Services.

M1480.015 SUBSTANTIAL HOME EQUITY PRECLUDES ELIGIBILITY FOR LONG-TERM CARE

A. Applicability

The policy in this section applies to nursing facility and CBC/PACE patients, who meet the requirements for LTC on or after January 1, 2006. This includes individuals who filed reapplications after a break in Medicaid eligibility. It does **not apply** to Medicaid recipients who were approved for LTC prior to January 1, 2006, and who maintain continuous Medicaid eligibility.

For Medicaid applicant*s* or enrollee*s* approved for LTC on or after July 1, 2006, *the amount of equity in the home at the time of the initial LTC determination and at each renewal must be evaluated.*

B. Policy

Individuals with equity value (tax assessed value minus encumbrances) in home property that exceeds the limit are NOT eligible for Medicaid payment of long-term care services unless the home is occupied by

- a spouse,
- a dependent child under age 21 years, or
- a blind or disabled child of any age.

Individuals with substantial home equity may be eligible for Medicaid payment of other covered services if they meet all the other Medicaid eligibility requirements.

1. Home Equity Limit

The home equity limit applied is based on the date of the application or request for LTC coverage. Effective January 1, 2011, the home equity limit is subject to change annually. The home equity limit is:

- Effective January 1, 2006 through December 31, 2010: $500,000
- Effective January 1, 2011: $506,000.

2. Reverse Mortgages

Reverse mortgages **do not** reduce equity value until the individual begins receiving the reverse mortgage payments from the lender.

***3.* Home Equity Lines of Credit**

A home equity line of credit **does not** reduce the equity value until credit line has been used or payments from the credit line have been received

B. Verification Required

Do not assume that the community spouse is living in the home. Obtain a statement from the applicant indicating who lives in the home. If there is no spouse, dependent child under age 21, or blind or disabled child living in the home, verification of the equity value of the home is required.

C. Notice Requirement

If an individual is ineligible for Medicaid payment of LTC services because of substantial home equity exceeding *the limit*, the Notice of Action must state why he is ineligible for Medicaid payment of LTC. The notice must also indicate whether the applicant is eligible for other Medicaid covered services.

D. References

See section M1120.225 for more information about reverse mortgages.

M1480.200 RESOURCE ASSESSMENT RULES

A. Introduction

A resource assessment must be completed when an institutionalized spouse with a community spouse applies for Medicaid coverage of long term care services and may be requested without a Medicaid application.

A resource assessment is strictly a:

- compilation of a couple's reported resources that exist(ed) at the first moment of the first day of the month in which the first continuous period of institutionalization began on or after September 30, 1989.
- calculation of the couple's total countable resources at that point, and
- calculation of the spousal share of those total countable resources.

A resource assessment does not determine resource eligibility but is the first step in a multi-step process. A resource assessment determines the spousal share of the couple's combined countable resources.

B. Policy Principles

1. Applicability

The resource assessment and resource eligibility rules apply to individuals who began a continuous period of institutionalization on or after September 30, 1989 and who are likely to remain in the medical institution for a continuous period of at least 30 consecutive days, or have been screened and approved for Medicaid CBC waiver services, or have elected hospice services.

The resource assessment and resource eligibility rules do **NOT** apply to individuals who were institutionalized before September 30, 1989, **unless** they leave the institution (or Medicaid CBC waiver services) for at least 30 consecutive days and are then re-institutionalized for a new continuous period that began on or after September 30, 1989.

2. Who Can Request

A resource assessment without a Medicaid application can be requested by the institutionalized individual in a medical institution, his community spouse, or an authorized representative. See section M1410.100.

3. When to Do A Resource Assessment

a. Without A Medicaid Application

A resource assessment without a Medicaid application may be requested when a spouse is admitted to a **medical institution**. Do not do a resource assessment **without** a Medicaid application unless the individual is in a medical institution.

b. With A Medicaid Application

The spousal share is used in determining the institutionalized individual's resource eligibility. A resource assessment must be completed when a married institutionalized individual with a community spouse *who*

- is in a nursing facility, or
- is screened and approved to receive nursing facility or Medicaid CBC waiver services, or
- has elected hospice services

applies for Medicaid. The resource assessment is completed when the applicant is screened and approved to receive nursing facility or Medicaid CBC services or within the month of application for Medicaid, whichever is later.

The following table contains examples that indicate when an individual is treated as an institutionalized individual for the purposes of the resource assessment:

Screened and Approved in:	In a Facility?	Application Month	Resource Assessment Month	Processing Month	Month of Application/ ongoing as Institutionalized	Retroactive Determination as Institutionalized (in a medical facility)
January	no	January	January	January	yes	no
January	no	February	February	February	yes	no
N/A	yes	January	first continuous period of institution-alization	February	yes	yes
January	no	March	March	April	yes	no
April	no	March	April	Whenever	no, but yes for April	no

c. Both Spouses Request Medicaid CBC

When both spouses request Medicaid CBC, one resource assessment is completed. The $2,000 Medicaid resource limit applies to each spouse.

C. Responsible Local Agency

The local department of social services (DSS) in the Virginia locality where the individual last resided outside of an institution (including an ACR) is responsible for processing a request for a resource assessment without a Medicaid application, and for processing the individual's Medicaid application. If the individual never resided in Virginia outside of an institution, the local DSS responsible for processing the request or application is the local DSS serving the Virginia locality in which the institution is located.

The Medicaid Technicians in the *Department of Behavioral Health and Developmental Services (DBHDS)* facilities are responsible for processing a married patient's request for a resource assessment without a Medicaid application, and for processing the patient's Medicaid application.

M1480.210 RESOURCE ASSESSMENT WITHOUT A MEDICAID APPLICATION

A. Introduction

This section applies only to married individuals with community spouses who are inpatients in medical institutions or nursing facilities and who have NOT applied for Medicaid.

B. Policy

1. Resource Evaluation

For the purposes of the resource assessment and spousal share calculation, countable and excluded resources are determined for all covered groups using the ABD resource policy found in Virginia DSS, Volume XIII, Chapter S11 **regardless of the individual's covered group and regardless of community property laws or division of marital property laws**, except for the following resources which are excluded as indicated below when completing the resource assessment and spousal share [1924(c)(5)]:

- the home and all contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits. For retroactive SSI and SS benefits received **before** 11/01/05, exclude from resources for six (6) calendar months; and
- up to **$1,500** of burial funds for each spouse (NOT $3,500), *if there are designated burial funds.*

Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource and regardless of whether either spouse refuses to make the resource available.

The resource assessment is not affected by the amount disregarded in the eligibility determination as a result of an LTC Partnership Policy (Partnership Policy).

2. No Appeal Rights

When a resource assessment is requested and completed **without** a concurrent Medicaid application, it cannot be appealed pursuant to the existing Virginia Client Appeals regulations (VR 460-04-8.7). The spousal share determination may be appealed when a Medicaid application is filed.

C. Procedures

The Medicaid Resource Assessment Request form (#032-03-815) is completed by the person requesting the resource assessment when the assessment is not part of a Medicaid application.

Nursing facilities are required to advise new admissions and their families that Medicaid resource assessments are available for married individuals from their local department of social services.

1. Case Record Number

If the institutionalized individual does not already have a case record, assign a case number and establish a case record in the institutionalized individual's name. If there is an existing case record for the institutionalized individual, use the established case number and record for the resource assessment.

2. Determining the First Continuous Period of Institutionaliz-ation

The resource assessment is based on the couple's resources owned **on the first moment of the first day of the first month** of the first continuous period of institutionalization that began on or after September 30, 1989. This may be different from the current period of institutionalization. Use the information below to determine exactly when the individual's first continuous period of institutionalization began.

Inquire if the individual was ever institutionalized prior to the current institutionalization but not earlier than September 30, 1989. If yes, ascertain the first date on or after September 30, 1989, on which the individual was admitted to a medical institution.

Ask the following:

- From where was he admitted?

  If admitted from a home in the community that is not an institution as defined in section M1410.010, determine if Medicaid CBC waiver services were received and covered by Medicaid while the individual was in the home. If so, the days of Medicaid CBC receipt are "institutionalization" days.

  If admitted from another institution, ascertain the admission and discharge dates, institution's name and type of institution. The days he was in a medical institution are institutionalization days if there was less than a 30-day break between institutionalizations.

- What was the last date the individual resided outside a medical institution (in the community, at home, or in a non-medical institution)?

3. Verification

The EW must advise the requesting party of the verification necessary to complete the assessment. Ownership interest and value of resources held **on the first moment of the first day of** the first month of the first continuous period of institutionalization must be verified.

Verify all *non-excluded* resources. Acceptable verification, for example, is a copy of the couple's bank statement(s) for the period. Do not send bank clearances; the requesting party is responsible to obtain verification of resources.

The EW is not required to assist the requesting party in obtaining any required verification for the resource assessment.

4. Failure To Provide Verification

If the applicant refuses to or fails to provide requested verification of resources held at the beginning of the first continuous period of institutionalization and does not notify the EW of difficulty in securing the requested data, the worker is unable to complete the resource assessment and is unable to determine the spousal share of resources. Go to item 8 below, "Notification Requirements."

5. Processing Time Standard

A resource assessment must be processed within 45 days of the date on which the agency receives the written and signed Medicaid Resource Assessment Request form.

If the requestor fails to provide requested verification within 45 days of receipt of notification, notify the applicant that the assessment cannot be completed, and of the reason(s) why. Use the Notice of Medicaid Resource Assessment (#032-03-817).

6. Completing the Medicaid Resource Assessment Form or Electronic Workbook

When verification is provided, completion of the resource assessment establishes the spousal share which is equal to ½ of a couple's total countable resources as of **the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989.

a. Compile the Couple's Resources

The value of *non-excluded* resources must be verified and recorded. Either the Medicaid Resource Assessment form (#032-03-816) or the electronic Resource Assessment and Eligibility Workbook may be used. The workbook is located on the Virginia Institute for Social Services Training Activities (VISSTA) web site at:
http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm.
Excluded resources must be listed separately on the form or electronic workbook, but their value does not need to be noted or verified.

On the assessment form, list all resources in which the couple has an ownership interest, *including* resources in their joint names, those in the institutionalized spouse's name and those in the community spouse's name, including those resources owned jointly with others. List each resource separately.

b. Calculate the Spousal Share

Calculate the total value of the couple's countable resources. Divide this total by 2 to obtain the spousal share. The spousal share is ½ of the couple's combined countable resources as of **the first moment of the first day of the first month** of the first continuous period of institutionalization that began on or after September 30, 1989.

Calculate the spousal share only once; it remains a constant amount for any Medicaid application filed after the resource assessment.

EXAMPLE #2: A Medicaid Resource Assessment Request is received on October 20, 1996 for Mrs. H who was admitted to the nursing facility on October 18, 1996. Her first continuous period of institutionalization began on December 21, 1995, and ended with her discharge on May 30, 1996. Mr. H provides verification which proves that the couple's total countable resources as of December 1, 1995 (the first day of the first month of the first continuous period of institutionalization) were $131,000. The spousal share is ½ of $131,000, or $65,500.

On the Medicaid Resource Assessment form *or electronic workbook*, the worker lists the couple's resources as of December 1, 1995 as follows:

Resource	Owner	Countable	Countable Value
Home	Mr & Mrs	No	0
Savings	Mr & Mrs	Yes	$100,000
CD	Mr	Yes	$ 31,000

$131,000	Total Value of Couple's Countable Resources
$ 65,500	Spousal Share

If in the future, Mrs. H applies for Medicaid and she is still married to Mr. H, the worker must use the spousal share of $65,500 determined by the October 1996 resource assessment.

7. Send Loans and/or Judgments to DMAS

When the resource assessment identifies a loan or a judgment against resources, send the documents pertaining to the loan and/or judgment to DMAS for review before taking action on the resource assessment. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

Division of Policy and Research, Eligibility Section
DMAS
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

8. Notification Requirements

a. When the Assessment Is Not Completed

Both spouses and the guardian, conservator or authorized representative must be notified in writing that the assessment was not completed; note the specific reason on the form. Use the form Notice of Medicaid Resource Assessment (#032-03-817).

b. When the Assessment Is Completed

Both spouses and the guardian, conservator, or authorized representative must be notified in writing of the assessment results and the spousal share calculated. Use the form Notice of Medicaid Resource Assessment (#032-03-817). Attach a copy of the Medicaid Resource Assessment form (#032-03-816) to each Notice. A copy of all forms and documents used must be kept in the agency's case record.

M1480.220 RESOURCE ASSESSMENT WITH MEDICAID APPLICATION

A. Introduction

This section applies to married individuals with community spouses who are inpatients in medical institutions or nursing facilities, who have been screened and approved to receive Medicaid CBC waiver services, or who have elected hospice services. If a married individual with a community spouse is receiving private-pay home-based services, he **cannot** have a resource assessment done without also filing a concurrent Medicaid application.

B. Policy

1. Resource Assessment

If a resource assessment was **not completed** before the Medicaid application was filed, the spousal share of the couple's total countable resources that existed **on the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989, is calculated when processing a Medicaid application for a married institutionalized individual with a community spouse.

If a resource assessment was completed before the Medicaid application was filed, use the spousal share calculated at that time in determining the institutionalized spouse's eligibility.

2. Use ABD Resource Policy

For the purposes of the resource assessment and spousal share calculation, countable and excluded resources are determined for all covered groups using the ABD resource policy in Chapter S11, **regardless of the individual's covered group and regardless of community property laws or division of marital property laws,** except for the following resources which are excluded as indicated below when completing the resource assessment and spousal share:

- the home and **all** contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments for nine (9) calendar months following the month in which the individual receives the benefits; and
- up to **$1,500** of burial funds for each spouse (NOT $3,500), *if there are designated burial funds.*

Resources owned in the name of one or both spouses are considered available regardless of whether either spouse agrees to sell or liquidate the resource, and regardless of whether either spouse refuses to make the resource available. The resource assessment is not affected by the amount disregarded in the eligibility determination as a result of a Partnership Policy.

C. Appeal Rights

When the resource assessment is completed as part of a Medicaid application and eligibility determination, the spousal share calculation can be appealed pursuant to the existing Client Appeals regulations (VR 460-04-8.7).

D. Eligibility Worker Responsibility

Each application for Medicaid for a person receiving LTC services who has a community spouse requires the completion of a resource assessment to determine the spousal share used in determining eligibility.

The EW must provide the applicant with a written request for verification of:

- all reported countable resources owned by the couple **on the first moment of the first day of the first month *(FOM)*** of the first continuous period of institutionalization. *Request this information using the Medicaid Resource Assessment form (#032-03-816) when the FOM is prior to the application's retroactive period.*
- all reported countable resources owned by the couple on the first moment of the first day of the month of application, and
- all reported countable resources owned by the couple as of the first moment of the first day of each retroactive month for which eligibility is being determined.

To expedite the application processing, the EW may include a copy of the "Intent to Transfer Assets to A Community Spouse" form, available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi with the request for verifications.

The same verification requirements as for all Medicaid applications apply to the resource assessment.

If the applicant reports to the EW that he cannot obtain certain verifications, the EW must determine why he cannot obtain them and what the EW can do to assist the applicant.

E. Procedures

The resource assessment is only a part of the eligibility determination process. The spousal share is calculated as a result of the resource assessment. The spousal share is used in the calculation of the spousal protected resource amount (PRA) and the institutionalized spouse's countable resources.

1. Forms

The applicant or his representative does not complete a Medicaid Resource Assessment Request form. The Medicaid application is the resource assessment request.

Either the Medicaid Resource Assessment form (#032-03-816) or the electronic Resource Assessment and Eligibility Workbook may be used to complete the assessment of resources and spousal share calculation at the time of the first continuous period of institutionalization. The workbook is located on the VISSTA web site at: http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm.

2. Send Loans and/or Judgments to DMAS

When the resource assessment or eligibility determination identifies a loan or a judgment against resources, send the documents pertaining to the loan and/or judgment to DMAS for review before taking action on the application. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

Division of Policy and Research, Eligibility Section
DMAS
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

3. Determining the First Continuous Period of Institutionaliz-ation

The spousal share is based on the couple's resources owned **on the first moment of the first day of** the first month of the first continuous period of institutionalization which occurred on or after September 30, 1989. This may be different from the current period of institutionalization. Use the information below to determine exactly when the individual's first continuous period of institutionalization began.

Inquire if the individual was ever institutionalized prior to current institutionalization but not earlier than September 30, 1989. If yes, ascertain the first date on or after September 30, 1989, on which the individual was admitted to a medical institution or the first date Medicaid CBC waiver services began.

Ask the following:

- From where was he admitted?

  If admitted from a home in the community which is not an institution as defined in section M1410.010, determine if Medicaid CBC waiver services were received and covered by Medicaid while the individual was in the home. If so, the days of Medicaid CBC receipt are "institutionalization" days.

  If admitted from another institution, ascertain the admission and discharge dates, institution's name and type of institution. The days he was in a medical institution are institutionalization days if there was less than a 30-day break between institutionalizations.

- What was the last date the individual resided outside a medical institution (in the community, at home, or in a non-medical institution)?

4. Failure to Provide Verification

a. Applicant Does Not Notify Agency of Difficulty Securing Verifications

If the applicant fails to provide requested verification of the value of the couple's resources held at the beginning of the first continuous period of institutionalization and does not notify the EW of difficulty in securing the

requested data, the worker is unable to complete the resource assessment and the application must be denied for failure to verify resources held at the beginning of institutionalization.

b. Applicant Notifies Agency of Difficulty Securing Verifications

If the applicant is unable to provide verification of the value of the couple's resources held at the beginning of the first continuous period of institutionalization and notifies the EW of difficulty in securing the requested data, the applicant may claim undue hardship.

Undue hardship can be claimed when both spouses have exhausted all avenues to verify the value of the resources owned on the first day of the first month of the first continuous period of institutionalization. When undue hardship is claimed, the applicant must provide documentation of the attempts made to obtain the verification. **Claims of undue hardship must be evaluated and can only be granted by DMAS.** The EW must send a summary of the needed verifications and documentation of the attempts to secure the verifications, along with the applicant's name and case number to:

Division of Policy and Research, Eligibility Section
DMAS
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

If DMAS determines undue hardship does not exist, the resource assessment cannot be completed and the application must be denied due to failure to verify resources held at the beginning of institutionalization. If DMAS determines undue hardship exists, the completion of a resource assessment is waived, and the spousal resource standard is to be substituted for the spousal share in determining the individual's resource eligibility. Go to section M1480.230 below.

5. Completing the Medicaid Resource Assessment

When verification is provided, completion of the resource assessment establishes the spousal share which is equal to ½ of a couple's total countable resources as of **the first moment of the first day of** the first month of the first continuous period of institutionalization that began on or after September 30, 1989. The spousal share is one factor in determining the spousal protected resource amount (PRA) in section M1480.230 below.

a. Compile the Couple's Resources

The value of countable resources must be verified and recorded on the Medicaid Resource Assessment form (#032-03-816) *or electronic workbook.* Excluded resources must be listed separately on the form, but their value does not need to be noted or verified.

On the assessment form, list all resources in which the couple has an ownership interest - resources in their joint names, those in the institutionalized spouse's name and those in the community spouse's name, including those resources owned jointly with others. List each resource separately.

b. Calculate the Spousal Share

Calculate the total value of the couple's countable resources. Divide this total by 2 to obtain the spousal share. The spousal share is ½ of the couple's total countable resources as of the first moment of the first day of the first month of the first continuous period of institutionalization that began on or after September 30, 1989.

Calculate the spousal share only once; it remains a constant amount for the current Medicaid application and all subsequent Medicaid applications filed.

EXAMPLE #3: A Medicaid application is received on October 20, 1996 for Mrs. H who was admitted to the nursing facility on October 18, 1996. Her first continuous period of institutionalization began on December 21, 1995, and ended with her discharge on May 30, 1996. Neither she nor her spouse requested a resource assessment before applying for Medicaid.

To determine Mrs. H's eligibility and the amount of the couple's current resources that can be "protected" for Mr. H, Mr. H provides verification which proves that the couple's total countable resources as of December 1, 1995 (the first day of the beginning of the first continuous period of institutionalization) were $131,000. The spousal share is ½ of $131,000, or $65,500.

On the Medicaid Resource Assessment form or electronic workbook, the worker lists the couple's resources as of December 1, 1995 as follows:

Resource	Owner	Countable	Countable Value
Home	Mr & Mrs	No	0
Savings	Mr & Mrs	Yes	$100,000
CD	Mr	Yes	$31,000

$131,000 Total Value of Couple's Countable Resources
$ 65,500 Spousal Share

In the eligibility evaluation, the worker uses the spousal share amount ($65,500) as one factor to determine the spousal protected resource amount (PRA) that is subtracted from the couple's current resources to determine the institutionalized spouse's resource eligibility.

F. Notice Requirements

Do not send the Notice of Medicaid Resource Assessment when a resource assessment is completed as a part of a Medicaid application.

Include a copy of the Medicaid Resource Assessment form with the Notice of Action on Medicaid that is sent when the eligibility determination is completed.

M1480.225 INABILITY TO COMPLETE THE RESOURCE ASSESSMENT-UNDUE HARDSHIP

A. Policy

Federal law states that a resource assessment must be completed on all Medicaid applications for institutionalized individuals who have a community spouse. On occasion, however, it is difficult to comply with this requirement because the applicant is unable to establish his marital status or locate a separated spouse, or the community spouse refuses or fails to provide information necessary to complete the resource assessment. In situations where the applicant is unable to provide information necessary to complete the resource assessment, undue hardship can be claimed if each of the following criteria is met:

1. The applicant establishes by affidavit specific facts sufficient to demonstrate (a) that he has taken all steps reasonable under the circumstances to locate the spouse, to obtain relevant information about the resources of the spouse, and to obtain financial support from the spouse; and (b) that he has been unsuccessful in doing so;

   Absent extraordinary circumstances, determined by DMAS, the requirements of A.1 (a) cannot be met unless the applicant and spouse have lived separate and apart without cohabitation and without interruption for at least 36 months.

2. Upon such investigation as DMAS may undertake, no *relevant* facts are revealed that refute the statement contained in the applicant's affidavit, as required by paragraph A.1.

3. The applicant has assigned to DMAS, to the full extent allowed by law, all claims he or she may have to financial support from the spouse; and

4. The applicant cooperates with DMAS in any effort undertaken or requested by DMAS to locate the spouse, to obtain information about the spouse's resources and/or to obtain financial support from the spouse.

B. Procedures

1. Assisting the Applicant

The EW must advise the applicant of the information needed to complete the resource assessment and assist the applicant in contacting the separated spouse to obtain resource and income information.

If the applicant cannot locate the separated spouse, document the file. Refer to Section B below.

If the applicant locates the separated spouse, the EW must contact the separated spouse to explain the resource assessment requirements for the determination of spousal eligibility for long-term care services.

If the separated spouse refuses to cooperate in providing information necessary to complete the resource assessment, document the file. Refer to Section B below.

EXCEPTION: If the separated spouse is institutionalized and is a Medicaid applicant/recipient, the definition of "community spouse" is not met, and a resource assessment is not needed.

2. Undue Hardship

If the applicant is unable to provide the necessary information to complete the resource assessment, he/she must be advised of the hardship policy and the right to claim undue hardship.

a. Undue hardship not claimed:

If the applicant does not wish to claim undue hardship, the EW must document the record and deny the application due to failure to verify resources held at the beginning of institutionalization.

b. Undue hardship claimed:

If the applicant claims an undue hardship, he must provide a written statement requesting an undue hardship evaluation. The applicant or his representative must make an effort to locate and contact the estranged spouse or provide documentation as to why this is not possible. Contact or action to locate the estranged spouse by the EW alone is not sufficient to complete the undue hardship evaluation. When it is reported that the applicant has a medical condition that prevents participation in the process, then a physician's statement must be provided documenting the medical condition.

1) Applicant or Authorized Representative

The applicant or his authorized representative must provide to the EW a letter indicating the following:

- *the applicant is requesting an undue hardship evaluation;*
- the name of the applicant's attorney-in-fact (i.e. who has the power of attorney) or authorized representative;
- the length of time the couple has been separated;
- the name of the estranged spouse and his
    - date of birth,
    - Social Security number,
    - last known address,
    - last known employer,
    - the types (i.e. telephone, in-person visit) and number of attempts made to contact the separated spouse:
        - who made the attempt, the dates the attempts were made,
        - the name of the individual contacted and relationship to estranged spouse; and
- any legal proceeding initiated, protective orders in effect, etc.

2) Eligibility Worker

A cover sheet is to be prepared that includes the following information:

- the applicant's name, case number, and
- documentation of any actions the EW took to locate or contact the estranged spouse.

The cover sheet and all information supporting the undue hardship claim must be sent to:

Division of Policy and Research, Eligibility Section
DMAS
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

If DMAS determines that undue hardship does not exist, and the resource assessment cannot be completed, the EW must deny the application due to failure to verify resources held at the beginning of institutionalization.

If DMAS determines that undue hardship does exist, the EW will be sent instructions for continued processing of the case as well as the DMAS Affidavit and Assignment forms, which the applicant or his representative must sign, have notarized and return to the agency.

M1480.230 RESOURCE ELIGIBILITY OF INSTITUTIONALIZED SPOUSE

A. Introduction

This section contains the resource rules that apply to the institutionalized spouse's eligibility.

If the community spouse applies for Medicaid, do not use the rules in this subchapter to determine the community spouse's eligibility. Use the financial eligibility rules for a non institutionalized person in the community spouse's covered group.

B. Policy

An institutionalized spouse meets the resource eligibility requirements for Medicaid if the difference between the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined and the spousal protected resource amount (PRA) is equal to or less than $2,000.

In initial eligibility determinations for the institutionalized spouse, the spousal share of resources owned by the couple **at the first moment of the first day of the first month of the first continuous period of institutionalization** that began on or after September 30, 1989, remains a constant factor in determining the spousal PRA.

*For the purposes of determining eligibility of an institutionalized spouse with excess resources, an institutionalized spouse **cannot** establish resource eligibility by reducing resources within the month. The institutionalized spouse may become eligible for Medicaid payment of LTC services when the institutionalized spouse's resources are equal to or below the $2,000 CNNMP/MN resource limit as of the first moment of the first day of a calendar month.*

1. Use ABD Resource Policy

For the purposes of eligibility determination, countable and excluded resources are determined for all covered groups using the ABD resource policy in Chapter S11, **regardless of the individual's covered group and regardless of community property laws or division of marital property laws,** except for the following resources which are excluded as indicated below when determining eligibility of the institutionalized spouse:

- the home and all contiguous property;
- one automobile, regardless of value;
- Disaster Relief funds for 9 months;
- retroactive SS & SSI payments received on or after 11/01/05 for nine (9) calendar months following the month in which the individual receives the benefits; and
- up to $3,500 of burial funds for each spouse.

Resources owned in the name of one or both spouses are considered available in the initial month for which eligibility is being determined regardless of whether either spouse agrees to sell or liquidate the resource, and regardless of whether either spouse refuses to make the resource available.

2. After Eligibility is Established

Once an institutionalized spouse has established Medicaid eligibility as an institutionalized spouse, count only the institutionalized spouse's resources when determining the institutionalized spouse's Medicaid eligibility. Do not count or deem the community spouse's resources available to the institutionalized spouse.

If an institutionalized spouse's Medicaid coverage was cancelled and he reapplies as an institutionalized individual, use only the resources of the institutionalized spouse for his eligibility determination.

C. Institutionalized Spouse Resource Eligibility Worksheet"

Use the "Institutionalized Spouse Resource Eligibility Worksheet," available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi, or the electronic Resource Assessment and Eligibility Workbook located at http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm to determine the institutionalized spouse's resource eligibility.

M1480.231 SPOUSAL RESOURCE STANDARDS

A. Introduction

This section provides the amounts and the effective dates of the standards used to determine an institutionalized spouse's initial and ongoing resource eligibility. Use the standard in effect on the date of the institutionalized spouse's Medicaid application. Definitions of the terms are found in section M1480.010.

B. Spousal Resource Standard	*$21,912*	*1-1-11 (no change for 2011)*
	$21,912	1-1-10
C. Maximum Spousal Resource Standard	*$109,560*	*1-1-11 (no change for 2011)*
	$109,560	1-1-10

M1480.232 INITIAL ELIGIBILITY DETERMINATION PERIOD

A. Policy

The initial eligibility determination period begins with the month of application. If the institutionalized spouse is eligible for the month of application, the initial eligibility determination period will both begin and end with that month.

If the applicant is not eligible in the month of application, the initial eligibility determination period continues until the first month in which the institutionalized spouse is eligible. NOTE: Established application processing procedures and timeframes apply.

An institutionalized spouse meets the resource eligibility requirements for Medicaid if the difference between the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined, the community spouse's protected resource amount (PRA) and the institutionalized spouse's partnership policy disregard amount (see M1460.160) is equal to or less than $2,000.

1. First Application

Use the procedures in item B below for the initial resource eligibility determination for an institutionalized spouse's first application for Medicaid in a continuous period of institutionalization that began on or after 9-30-89.

2. Subsequent Applications

a. Medicaid Eligibility For LTC Services Achieved Previously

If an individual achieved Medicaid eligibility as an institutionalized spouse during a period of institutionalization that began on/after 9-30-89, regardless of whether the period of institutionalization is the same continuous period covered by the previous application(s), **do not consider the couple's resources. Use only the institutionalized spouse's resources**. Use the policy and procedures in section M1480.*230 B.2* to determine the institutionalized individual's financial eligibility.

b. Medicaid Eligibility For LTC Services Not Previously Achieved

If an individual has never achieved Medicaid eligibility as an institutionalized spouse, **treat the application** as an "initial eligibility" determination.

- Determine countable resources for the application month (see item B below);
- Deduct the spousal PRA from the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined.
- Deduct a dollar amount equal to the Partnership Policy disregard, if any.

B. Procedures

Use the following criteria to determine Medicaid eligibility for any month in the initial eligibility determination period.

NOTE: The initial eligibility determination period begins with the month of application. If the institutionalized spouse is not eligible in that month, the initial eligibility determination period continues until the first month in which the institutionalized spouse is eligible.

1. Couple's Total Resources

Verify the amount of the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined.

NOTE: When a loan or a judgment against resources is identified, send the documents pertaining to the loan and/or judgment to DMAS for review before taking action on the application. Send the documents, along with case identifying information (institutionalized spouse's and community spouse's names, address, SSN, case number) to:

Division of Policy and Research, Eligibility Section
DMAS
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

2. Deduct Spousal Protected Resource Amount (PRA)

Deduct the spousal protected resource amount (PRA) from the couple's total countable resources owned as of the first moment of the first day of the month for which eligibility is being determined. The PRA is the greatest of the following:

- the **spousal share** of resources as determined by the resource assessment, provided it does not exceed the maximum spousal resource standard in effect at the time of application. **If the spousal share exceeds the maximum spousal resource standard, use the maximum spousal resource standard.** If no spousal share was determined because the couple failed to verify resources held at the beginning of the first continuous period of institutionalization, the spousal share is $0. The spousal share does not change; if a spousal share was previously established and verified as correct, use it;

- the **spousal resource standard** in effect at the time of application;

- an amount **actually transferred** to the community spouse from the institutionalized spouse under a **court spousal support order;**

- an amount designated by a DMAS Hearing Officer.

If the individual does not agree with the PRA, see subsection F. below.

Once the PRA is determined, it remains a constant amount for the current Medicaid application (including retroactive months). ***If the application is denied and the individual reapplies, the spousal share remains the same but a new PRA must be determined.***

3. Deduct Partnership Policy Disregard Amount

When the institutionalized spouse is entitled to a Partnership Policy disregard, deduct a dollar amount equal to the benefits paid as of the month of application.

4. Compare Remainder

Compare the remaining amount of the couple's resources to the appropriate Medicaid resource limit for one person.

a. Remainder Exceeds Limit

When the remaining resources exceed the limit and the institutionalized spouse does not have Medicare Part A, the institutionalized spouse is not eligible for Medicaid coverage because of excess resources.

If the institutionalized spouse has Medicare Part A, he may be eligible for limited coverage QMB, SLMB or QI Medicaid (which will not cover the cost of the LTC services) because the resource requirements and limits are different. **The resource policies in subchapter M1480 do not apply to limited-coverage Medicaid eligibility determinations**. Follow the procedures for determining resource eligibility for an individual in Chapter S11. More information about the QMB, SLMB, and QI covered groups is contained in subchapter M0320.

Note: The institutionalized spouse cannot be eligible for QDWI Medicaid.

b. Remainder Less Than or Equal to Limit

When the remaining resources are equal to or less than the Medicaid limit, the institutionalized spouse is resource eligible in the month for which eligibility is being determined:

- determine the community spouse resource allowance (CSRA). To calculate the CSRA, see sections M1480.240 and 241 below;
- determine a protected period of eligibility for the institutionalized spouse, if the institutionalized spouse expressly states his intent to transfer resources that are in his name to the community spouse; see section M1480.*240* below.

C. Example--Calculating the PRA

EXAMPLE #4: (Use the "Institutionalized Spouse Resource Eligibility Worksheet," *available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi or the electronic Resource Assessment and Eligibility Workbook located at http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm).*

Mr. A is married to a community spouse. He applied for Medicaid on December 2, 1997. The beginning of his first continuous period of institutionalization which began on or after 9-30-89 was October 12, 1993, when he was admitted to a nursing facility. He was discharged from the facility on February 5, 1995, then readmitted to the nursing facility on December 5, 1997 and remains there to date. Eligibility is being determined for December 1997.

Step 1: The couple's total countable resources on October 1, 1993 (the first moment of the first day of the first continuous period of institutionalization) were $130,000.

Step 2: $130,000 ÷ 2 = 65,000. The spousal share is $65,000.

Step 3: The couple's total countable resources as of December 1, 1997 (the first moment of the first day of the month for which eligibility is being determined), are $67,000.

Step 4: Determine the spousal protected resource amount (PRA). The spousal PRA is the greatest of:

- $65,000 (the spousal share, which is less than the maximum spousal resource standard of $79,020 in December 1997, the time of application).
- $15,804 (the spousal resource standard in December 1997, the time of the application).
- $0 (court-ordered spousal support resource amount or DMAS hearing decision amount; there is neither in this case).

Since $65,000 is the greatest, $65,000 is the PRA.

Step 5: Deduct the PRA from the couple's combined countable resources as of December 1, 1997 (the first moment of the first day of the month for which eligibility is being determined.

$67,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined (December 1, 1997)
- 65,000	Step 4 PRA
$2,000	countable resources in month for which eligibility is being determined (December 1, 1997).

The remaining $2,000 is the countable resources available to the institutionalized spouse *on December 1, 1997 (the first moment of the first month for which eligibility is being determined).*

Step 6: Compare the $2,000 countable resources to the resource limit of $2,000. The countable resources of the institutionalized spouse are equal to the limit and he is resource eligible in December *(the month for which eligibility is being determined)*. A CSRA and protected period of eligibility are determined in section M1480.240 and 241 below.

D. Example--PRA Is Amount Transferred Per Court-Ordered Spousal Support

EXAMPLE #5: Mr. B applied for Medicaid on January 2, 1998. He was admitted to a nursing facility on December 20, 1996. He is married to Mrs. B who lives in their community home. This is Mr. B's first application for Medicaid as an institutionalized spouse. The court ordered him to transfer $68,000 of his resources to Mrs. B as spousal support; he transferred $68,000 to her on December 5, 1997. *Mr. B. is not requesting retroactive coverage*.

Step 1: The couple's total countable resources as of December 1, 1996 (the first moment of the first day of the first continuous period of institutionalization) were $130,000.

Step 2: $130,000 ÷ 2 = $65,000. The spousal share is $65,000.

Step 3: The couple's total *countable* resources as of January 1, 1998 *(the first moment of the first day of the month for which eligibility is being determined*) are $67,000.

Step 4: *Determine the spousal protected resource amount (PRA).* The spousal PRA is the greatest of:

- $65,000 (the spousal share, which is less than the maximum spousal resource standard of $80,760 in the application month);
- $16,152 (the spousal resource standard at the time of the application);
- $68,000 amount actually transferred to community spouse pursuant to court-ordered spousal support;
- $0 DMAS hearing decision amount (there is none in this case).

Since $68,000 is the greatest, $68,000 is the PRA.

Step 5: *Deduct the PRA from the couple's combined countable resources as of January 1, 1998 (the first moment of the first day of the month for which eligibility is being determined).*

:

$67,000 Step 3 couple's total *resources owned as of first moment of the first day of the month for which eligibility is being determined*

- 68,000 Step 4 PRA

$ 0 countable resources *in month for which eligibility is being determined (January 1, 1998).*

$0 is the countable resources available to the institutionalized spouse for *January (the month for which eligibility is being determined).*

Steps 6 & 7: Compare the $0 countable resources to the resource limit of $2,000. The countable resources of the institutionalized spouse are less than the limit, so he is resource-eligible for January *(month for which eligibility is being determined)*. He is also income eligible in *January, so Mr. B establishes initial eligibility in January 1998.*

For February and the following months, his eligibility is determined using just his resources. Beginning February (*the month following the month eligibility is established*), none of the community spouse's resources are deemed available to Mr. B. Because his own resources equal $0, he remains resource eligible in the months following the application month.

E. Example--Support Order Greater Than Amount Transferred & Institutionalized Spouse's Actual Resources

EXAMPLE #6: Mrs. Green applied for Medicaid on May 2, 1998. She was admitted to a nursing facility on June 20, 1997. She is married to Mr. Green who lives in their community home. This is Mrs. Green's first application for Medicaid as an institutionalized spouse. The first moment of the first day of the first continuous period of institutionalization is June 1, 1997. The couple's total resources on June 1, 1997 were $110,000. $30,000 were in Mr. Green's name; $80,000 were in Mrs. Green's name. On December 7, 1997, the court ordered her to transfer $180,000 of her resources to Mr. Green as spousal support. However, Mrs. Green's resources were only $80,000. She transferred $80,000 to Mr. Green on December 20, 1997. *Eligibility is being determined for May 1998.*

Step 1: The couple's total countable resources as of June 1, 1997 (the first moment of the first day of the first continuous period of institutionalization) were $110,000.

Step 2: $110,000 ÷ 2 = $55,000. The spousal share is $55,000.

Step 3: The couple's total *countable resources as of the May 1, 1998 (first moment of the first day of the month for which eligibility is being determined*) are $100,000 (all are in Mr. Green's name).

Step 4: *Determine the spousal protected resource amount (PRA)*. The spousal PRA is the greatest of:

- $55,000 (the spousal share, which is less than the maximum spousal resource standard of $80,760 in the application month);
- $16,152 (the spousal resource standard at the time of the application);
- $80,000 amount actually transferred to community spouse pursuant to court-ordered spousal support;
- $ 0 DMAS hearing decision amount (there is none in this case).

Since $80,000 is the greatest, $80,000 is the PRA.

Step 5: *Deduct the PRA from the couple's combined countable resources as of May 1, 1998 (the first moment of the first day of the month for which eligibility is being determined).*

$100,000	Step 3 couple's total *resources owned as of first moment of the first day of the month for which eligibility is being determined*
- 80,000	Step 4 PRA
$20,000	countable resources *in month for which eligibility is being determined.*

$20,000 is the countable resources available to the institutionalized spouse, *in May 1998 (the month for which eligibility is being determined).*

Steps 6 & 7: Compare the $20,000 countable resources to the resource limit of $2,000. *Mrs. Green's countable resources exceed the resource limit in the month for which eligibility is being determined (May 1, 1998).* Her application is denied because of excess resources. She and Mr. Green are notified of the denial action and the resource calculations upon which it is based.

F. PRA Revisions Policy

Revisions to the community spouse's calculated protected resource amount (PRA) can be made when:

1. A DMAS Hearing Officer determines that the income generated from the resources is inadequate to raise the community spouse's income to the minimum monthly maintenance needs allowance (MMMNA). Substitute the amount the DMAS Hearing Officer determines for the PRA calculated in section M1480.232 above.

2. A DMAS Hearing Officer confirms that the initial PRA determination was incorrect.

3. A court orders spousal support in an amount that is greater than the PRA established in subsection B above.

4. The agency determines that inaccurate information was provided when the agency calculated the spousal share and determined the PRA for the initial eligibility determination. The agency must revise the calculations using the correct information.

G. Example--DMAS Hearing Officer Revised PRA

EXAMPLE #7: Mr. C applied for Medicaid on November 21, 1996. He was admitted to a nursing facility on December 20, 1994. This is his first application for Medicaid as an institutionalized spouse. He is married to Mrs. C who lives in their community home. The first moment of the first day of the first month of the first continuous period of institutionalization is December 1, 1994. *Mr. C is not resource eligible in the retroactive period. Eligibility is being determined for November 1996.* The couple's total countable resources as of *December 1, 1994 (the first moment of the first day of the first continuous period of institutionalization)* were $150,000.

Step 2: $150,000 ÷ 2 = $75,000. The spousal share is $75,000.

Step 3: The couple's total countable resources on November 1, 1996 (first moment of the first day of the month for which eligibility is being determined) are $80,000.

Step 4: Determine the spousal protected resource amount (PRA). The spousal PRA is the greatest of:

$75,000 (the spousal share, which is less than the maximum spousal resource standard of $76,740 in November 1996);

Step 5: Deduct the PRA from the couple's combined countable resources as of November 1, 1996 (the first moment of the first day of the month for which eligibility is being determined.

$80,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 75,000	Step 4 PRA
$ 5,000	countable resources in month for which eligibility is being determined.

$5,000 is the countable resources available to the institutionalized spouse in the month for which eligibility is being determined.

Steps 6 & 7: Compare the $5,000 countable resources to the resource limit of $2,000. The countable resources of the institutionalized spouse exceed the limit, so he is not eligible for Medicaid in November 1996 (the month for which eligibility is being determined). He is not a QMB, so his application was denied in January 1997 because of excess resources.

Mrs. C appealed the denial because she believes that she needs more resources protected so that her income will be sufficient to meet her needs. After a hearing in March 1997, and evidence gathered of Mrs. C's extraordinary shelter and medical expenses, the DMAS Hearing Officer decided that more of the couple's resources should be protected in order to raise Mrs. C's income to the minimum monthly maintenance needs allowance (MMMNA). The Hearing Officer decided that the spousal resource maximum of $76,740 should be the PRA. Mr. C's eligibility was recalculated using the $76,740 PRA.

Step 5 again: The revised PRA was deducted from the couple's total combined countable resources in November 1996 (the initial month for which eligibility is being determined):

$80,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 76,740	Step 4 PRA
$3,260	countable resources in month for which eligibility is being determined.

$3,260 is the countable resources available to Mr. C in November 1996 (the month for which eligibility is being determined). Because he has excess resources, and because he is not a QMB (has no Medicare Part A), he is not eligible for Medicaid and the denial was sustained.

M1480.233 INITIAL ELIGIBILITY - RETROACTIVE MONTHS

A. First Application

Use the procedures for the initial resource eligibility determination (section M1480.232 above) for each of the three (3) months preceding an institutionalized spouse's first application for Medicaid in a continuous period of institutionalization that began on or after 9-30-89.

To determine the institutionalized spouse's countable resources in each retroactive month, subtract the spousal PRA from the couple's total countable resources held **on the first moment of the first day of each retroactive month.** Use the procedures in C below.

B. Subsequent Applications

1. Medicaid Eligibility Established Previously

If an individual established Medicaid eligibility as an institutionalized spouse during a period of institutionalization that began on/after 9-30-89, regardless of whether the period of institutionalization is the same continuous period covered by the previous application(s), **do not consider the couple's resources. Use only the institutionalized spouse's resources**. Use the policy and procedures in section M1480.*230 B.2* to determine the institutionalized individual's financial eligibility.

For the application's retroactive month(s), determine resources using only the institutionalized spouse's resources in each retroactive month. If the institutionalized spouse's countable resources exceed the Medicaid resource limit in a retroactive month, the institutionalized spouse is NOT eligible for that month.

2. Medicaid Eligibility Not Previously Established

If an individual has never established Medicaid eligibility as an institutionalized spouse, **treat the application** as an "initial eligibility" determination (section M1480.232 above).

- Determine countable resources for the application month (see section M1480.232 above).
- Deduct the spousal PRA from the couple's total countable resources held **on the first moment of the first day of each retroactive month.**
- Deduct a dollar amount equal to the Partnership Policy disregard as of **the month of application** (Note: this amount is also used when determining eligibility for a retroactive month).

For the application's retroactive month(s), determine resources using the procedures in subsection C below.

C. Procedures

The procedures in this subsection are used for the retroactive determination based on a

- first application; or
- subsequent application when Medicaid eligibility as an institutionalized spouse was NOT previously established.

1. **Couple's Resources** — Determine the couple's total countable resources as of the **first moment of the first day of each retroactive month.**

2. **Subtract PRA** — Subtract the spousal PRA (M1480.232 above) from the couple's total resources in each retroactive month. Each result is the countable resources available to the institutionalized spouse in each retroactive month.

3. ***Subtract Partnership Policy Disregard*** — *When the institutionalized spouse is entitled to a Partnership Policy disregard, deduct the dollar amount equal to the benefits paid as of the month of application.*

4. **Countable Resources Within Limit** — If the countable resources in a *retroactive* month are less than or equal to the resource limit, the institutionalized spouse is eligible in that month.

5. **Countable Resources Exceed Limit** — If the countable resources exceed the Medicaid resource limit in a retroactive month, the institutionalized spouse is NOT eligible for that month.

D. Retroactive Example

EXAMPLE #8: Mr B's first continuous period of institutionalization began on 9-20-92. He **first applied for Medicaid on February 3, 1998** and requested retroactive coverage for December 1997 and January 1998. Mrs. B is his community spouse.

Retroactive Month — December 1997

Step 1: The couple's total resources as of September 1, 1992 (the first moment of the first day of the first continuous period of institutionalization) were $200,000.

Step 2: $200,000 ÷ 2 = $100,000. The spousal share is $100,000.

Step 3: The couple's total countable resources as of December 1, 1997 (the retroactive month for which eligibility is being determined) are $96,000.

Step 4: Determine the spousal protected resource amount (PRA). The spousal PRA is the greatest of:

- $80,760 (the maximum spousal resource standard in effect at the time of application (February 20, 1998) is less than the spousal share of $100,000);
- $16,152 (the spousal resource standard in effect at the time of application (February 20, 1998),
- $0 (no amount designated by DMAS Hearing Officer),
- $0 (no amount transferred pursuant to court support order).

The PRA is $80,760 (the lesser of the maximum resource standard and the spousal resource standard, because there was no amount designated by DMAS Hearing Officer or transferred per court order).

NOTE: Once the PRA is determined, it remains the same for all retroactive months and for months in the initial eligibility determination period.

Step 5: *Deduct the PRA from the couple's combined countable resources on as of December 1, 1997 (the first moment of the first day of the month for which eligibility is being determined)*

$96,000	Step 3 couple's total *resources owned as of first moment of the first day of the month for which eligibility is being determined*
- 80,760	Step 4 PRA
$15,240	countable resources *in month for which eligibility is being determined.*
$15,240	countable to Mr. B.

Step 6: Since $15,240 exceeds the $2,000 limit, Mr. B is not eligible for Medicaid for December 1997 (the retroactive month for which eligibility is being determined.

Complete a retroactive determination for January 1998.

Retroactive Month *January 1998*

Step 1: *The couple's total resources as of September 1, 1992 (the first moment of the first day of the first continuous period of institutionalization) were $200,000.*

Step 2: *$200,000 ÷ 2 = $100,000. The spousal share is $100,000.*

Step 3: *The couple's total countable resources as of January 1, 1998 (the retroactive month for which eligibility is being determined) are $93,000.*

Step 4: *Determine the PRA: Once the PRA is determined, it remains the same for all retroactive months and for months in the initial eligibility determination period.*

The PRA is $80,760 (See Step 4 in the retroactive determination for December 1997 above).

Step 5: *Deduct the PRA from the couple's combined countable resources as of January 1, 1998 (the first moment of the first day of the month for which eligibility is being determined):*

$93,000	*Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined*
- 80,760	*Step 4 PRA*
$ 12,240	*countable resources in month for which eligibility is being determined.*

$12,240 countable resources for Mr. B.

Step 6: *Since $12,240 exceeds the $2,000 limit, Mr. B is not eligible for Medicaid in for January 1998 (the retroactive month for which eligibility is being determined. Proceed to determine eligibility for the initial eligibility determination period that begins with February 1998 (month of application).*

Initial Eligibility Determination February 1998
Month

Step 1: The couple's total resources as of September 1, 1992 (the first moment of the first day of the first continuous period of institutionalization) were $200,000.

Step 2: $200,000 ÷ 2 = $100,000. The spousal share is $100,000.

Step 3: The couple's total countable resources as of February 1, 1998 (the month for which eligibility is being determined) are $90,000.

Step 4: Determine the PRA: Once the PRA is determined, it remains the same for all retroactive months and for months in the initial eligibility determination period.

The PRA is $80,760 (See Step 4 in the retroactive determine for December 1997 above).

Step 5: Deduct the PRA from the couple's combined countable resources on February 1, 1998 (the first moment of the first day of the month for which eligibility is being determined):

$90,000	Step 3 couple's total resources owned as of first moment of the first day of the month for which eligibility is being determined
- 80,760	Step 4 PRA
$9,240	countable resources in month for which eligibility is being determined.

$ 9,240 countable resources for Mr. B.

Step 6: Since $9,240 exceeds the $2,000 limit, Mr. B is not eligible for Medicaid in February 1998 (the month for which eligibility is being determined).

Note: The initial eligibility determination period continues until the individual is found eligible. If Mr. B reapplies, he will still be in the initial eligibility determination period.

M1480.240 *INTENT TO TRANSFER - PROTECTED PERIOD*

A. Policy

After the initial eligibility determination, an institutionalized spouse who has resources in his name which exceed the Medicaid resource limit may have his Medicaid resource eligibility "protected" for a period of time if all of the following criteria are met:

- *resources in the community spouse's name are less than the PRA at the time of application,*

- *the amount of resources that may be transferred to bring the community spouse up to the PRA will reduce the resources in the institutionalized spouse's name to no more than $2,000,* ***and***

- *the institutionalized spouse has expressly indicated in writing his intent to transfer resources to the community spouse.*

The protected period is designed to allow the institutionalized spouse time to legally transfer some or all of his resources to the community spouse. ***Resources in the institutionalized spouse's name are excluded only for one 90-day period.***

If the institutionalized spouse does not transfer resources to the community spouse within the 90-day period, all of the institutionalized spouse's resources will be counted available to the institutionalized spouse when the protected period ends. If the institutionalized spouse loses eligibility after the 90-day protected period is over, and then reapplies for Medicaid, he CANNOT have resource eligibility protected again and a PRA is NOT subtracted from his resources.

B. Protected Period Is Not Applicable

A protected period of eligibility is not applicable to an institutionalized spouse when:

- the institutionalized spouse is not eligible for Medicaid;

- the institutionalized spouse previously established Medicaid eligibility as an institutionalized spouse, had a protected period of eligibility, became ineligible, and reapplies for Medicaid*; or*

- *at the time of application, a community spouse has title to resources equal to or exceeding the PRA.*

C. Intent to Transfer Resources To Community Spouse

The institutionalized spouse or authorized representative must expressly indicate ***in writing*** *his intention to transfer resources to the community spouse. If not previously obtained, send an "Intent to Transfer Assets to A Community Spouse" form, available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi, to the institutionalized spouse or authorized representative, allowing 10 days from the date of mailing for return of the form.*

If the completed Intent to Transfer Assets form is not returned by the time the application is processed, no protected period of eligibility may be established. All resources in the institutionalized spouse's name must be counted in his eligibility determination beginning with the month following the initial eligibility determination period. If eligible, enroll the institutionalized spouse for a closed period of coverage beginning with the retroactive period and ending with the last day of the month of the initial eligibility period.

If the institutionalized spouse submits a new application for Medicaid payment of long-term care services, the process starts again and a new Intent to Transfer form must be mailed.

When the community spouse is a Medicaid recipient, the eligibility worker must inform the couple that the transfer of resources to the community spouse could impact the community spouse's Medicaid eligibility.

D. How to Determine the Protected Period

The 90-day protected period begins with the date the local agency takes action to approve the institutionalized spouse's initial eligibility for Medicaid LTC services, if the institutionalized spouse or his authorized representative *has signed the Intent to Transfer Assets form.*

E. Protected Period Ends

Set a special review for the month in which the 90-day period ends. When the protected period of eligibility is over, all resources owned in the institutionalized spouse's name are counted available to the institutionalized spouse. Extension of the protected period is NOT allowed.

F. Institutionalized Spouse Acquires Resources During the Protected Period of Eligibility

If the institutionalized spouse obtains additional resources during the protected period of eligibility, the additional resources shall be excluded during the protected period if:

- the new resources combined with other resources that the institutionalized spouse intends to retain do not exceed the appropriate Medicaid resource limit for one person, OR
- the institutionalized spouse intends to transfer the new resources to the community spouse during the protected period of eligibility and the total resources to be transferred do not exceed the balance remaining (if any) of the *PRA*.

NOTE: Some assets, such as inheritances, are income in the month of receipt. Be careful to count only those assets that are resources in the month of receipt, and to count assets that are income as a resource if retained in the month following receipt.

M1480.241 COMMUNITY SPOUSE RESOURCE ALLOWANCE (CSRA)

A. Policy

When the Intent to Transfer form has been completed, the institutionalized spouse's eligibility is protected for 90 days to allow time for resources in the institutionalized spouse's name to be transferred to the community spouse for the community spouse's support.

The community spouse resource allowance (CSRA) is the amount of the resources in the institutionalized spouse's name (including his share of jointly owned resources) which can be transferred to the community spouse to bring the resources in the community spouse's name up to the PRA. This amount is disregarded in the institutionalized spouse's Medicaid eligibility determination during the protected period.

B. CSRA Calculation Procedures

Use the following procedures for calculating the CSRA. The "Institutionalized Spouse Resource Eligibility Worksheet," available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi, or the electronic Resource Assessment and Eligibility Workbook located at http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm *may be used* to determine countable resources and the CSRA.

1. Determine Community Spouse's Resources

Determine the amounts of the couple's total resources which are in the community spouse's name only and the community spouse's share of jointly owned resources owned as of the first moment of the first day of the initial month for which eligibility was established.

2. Determine Institutional-ized Spouse's Resources

Determine the amounts of the couple's total resources which are in the institutionalized spouse's name only and the institutionalized spouse's share of jointly owned resources owned as of the first moment of the first day of the al month for which eligibility was established. If the institutionalized spouse's resources changed during initial month (after the first moment of the first day of the initial month which eligibility was established) verify the institutionalized spouse's resources owned as of the first moment of the first day of the month following the initial month.

3. Calculate CSRA

To calculate the *Community Spouse Resource Allowance* (CSRA):

***a.* Determine PRA**

Find the spousal PRA (determined in section M1480.232 above).

b. Subtract CS Resources from the PRA

Subtract from the PRA an amount equal to the resources in the community spouse's name only and the community spouse's share of jointly owned resources as of the first moment of the first day of the initial month in which eligibility was established.

***c.* Remainder**

The remainder, if greater than zero, is the CSRA and the amount to be disregarded in the institutionalized spouse's Medicaid eligibility determination during the protected period. This is the amount to be transferred to the community spouse during the protected period.

If the remainder is $0 or a negative number, the CSRA = $0. The community spouse does not have a CSRA.

C. Example CSRA Calculation

EXAMPLE #9*: (Using January 2008 figures)*

Mrs. Tea applied for Medicaid on *May 21, 2008*. She was admitted to the nursing facility on *January 20, 2008*. She is married to Mr. Tea who lives in their community home. This is her first application for Medicaid as an institutionalized spouse. The first day of the first month of the first continuous period of institutionalization is *January 1, 2008*. Eligibility is being determined for May 2008. *Mrs. Tea signs the Intent to Transfer from June 1, 2008.*

Step 1:

Determine the PRA

The couple's total countable resources as of *January 1, 2008* (the first moment of the first day of the first continuous period of institutionalization) were $50,000.

- $25,000 spousal share ($50,000 ÷ 2), *not to exceed the maximum spousal resource standard of $104,400, eff. 01-01-2008*
- $20,880 spousal resource standard in effect on January 1, 2008
- $0 (amount actually transferred as court-ordered spousal support); or
- $0 (DMAS hearing decision amount).

Since $25,000 is the greatest of the above, $25,000 is the PRA.

Steps 2. and 3:

Subtract CS Resources from the PRA to Determine CSRA

The couple's total *resources owned as of first moment of the first day of the month for which eligibility is being determined are $26,500. The community spouse has $7,000 in his name. The institutionalized spouse has $19,500 in her name. From the PRA of $25,000, deduct the community spouse resource amount of $7000. The remaining $18,000 is the CSRA that can be transferred to the community spouse and disregarded in the institutionalized spouse' Medicaid eligibility determination during the protected period.*

$25,000	*PRA*
- 7,000	*Resources in the CS name*
$18,000	*CSRA (amount that can be transferred to CS)*

***D.* Community Spouse Acquires Additional Resources During Protected Period**

If the **community spouse** obtains additional resources during the protected period of eligibility, the institutionalized spouse's eligibility is NOT affected. The community spouse's new resources are not counted when determining the institutionalized spouse's eligibility during or after the protected period of eligibility. **Do NOT recalculate the CSRA.**

***E.* Reviewing Resource Eligibility**

When reviewing the institutionalized spouse's resource eligibility at the end of the protected period and at scheduled redeterminations, the community spouse's resources are NOT counted available.

***F.* Asset Transfers**

Instructions for treatment of asset transfers are found in subchapter M1450.

PAGES 35 THROUGH 46 HAVE BEEN DELETED.

M1480.260 SUSPENSION PROCEDURES

A. Policy

This section applies to institutionalized individuals who:

- *are enrolled in ongoing Medicaid coverage,*
- *have Medicare Part A,*
- *have a patient pay that exceeds the Medicaid rate, and*
- *have resources between $2,000 and $4,000.*

B. Procedures

If the conditions above are met, take the following actions:

1. Prepare and Send Advance Notice

Prepare and send an advance notice to reduce the recipient's full Medicaid coverage to the appropriate MI ABD covered group. Specify the effective date, which is the last day of the month in which the 10-day advance notice period expires. Write a note on the notice telling the recipient that if he verifies that his resources are less than or equal to the $2,000 resource limit before the specified date (specify the date which is 3 months from the cancel effective date), he should request reinstatement of Medicaid coverage.

2. Suspend Case Administratively

Suspend the case administratively for a maximum of 3 months; do not close the case statistically. The suspension effective date is the effective date of the Medicaid cancellation in the MMIS. The case is counted as a "case under care" while suspended. While suspended, the case remains open for a maximum of 3 months.

If, by the end of 3 months from the suspension effective date, the individual provides verification that his resources have been reduced to or below the resource limit, update the latest application or redetermination form in the individual's case record. Reinstate his Medicaid coverage in the MMIS effective the first day of the month in which his resources are less than or equal to the resource limit.

If the individual does NOT provide verification within 3 months of the suspension effective date that his resources have been reduced to or below the resource limit, close the case administratively and statistically. Do not take any action on his enrollment in the MMIS, because his coverage has already been canceled. The individual will have to file a new Medicaid application.

M1480.300 INCOME ELIGIBILITY OF INSTITUTIONALIZED SPOUSE

A. Introduction

The income rules in this section apply only to the institutionalized spouse's eligibility.

The rules in this section supersede all other manual chapters and sections wherever those chapters or sections conflict with these rules. The ABD income policy rules in Virginia DSS Volume XIII, Chapter S08 are used to determine income eligibility for married institutionalized individuals.

1. When Applicable

The income rules apply to an institutionalized spouse regardless of when the continuous period of institutionalization began.

2. When Not Applicable

If the institutionalized spouse no longer meets the definition of an institutionalized spouse in section M1480.010, the income rules in this subchapter do not apply effective the first day of the first full calendar month following the month in which he no longer meets the definition of an institutionalized spouse.

These rules NEVER apply when determining the eligibility of the community spouse. The income rules applicable to non-institutionalized individuals, found in other sections and chapters of the manual, apply to the community spouse.

B. Policy

An institutionalized spouse's income shall be determined as follows without regard to state laws governing community property or division of marital property:

1. Income From Non-trust Property

Unless a DMAS Hearing Officer determines that the institutionalized spouse has proven to the contrary (by a preponderance of the evidence):

a. income paid to one spouse belongs to that spouse;

b. each spouse owns one-half of all income paid to both spouses jointly;

c. each spouse owns one-half of any income which has no instrument establishing ownership [1924(b)(2)(C)];

d. income paid in the name of either spouse, or both spouses and at least one other party, shall be considered available to each spouse in proportion to the spouse's interest. When income is paid to both spouses and each spouse's individual interest is not specified, consider one-half of their joint interest in the income as available to each spouse.

2. Income From Trust Property

Ownership of income from trust property shall be determined pursuant to regular income policy, except as follows:

a. Income is considered available to each spouse as provided in the trust.

b. If a trust instrument is not specific as to the ownership interest in the trust income, ownership shall be determined as follows:

1) Income paid to one spouse belongs to that spouse.

2) One-half income paid to both spouses shall be considered available to each spouse.

3) Income from a trust paid in the name of either spouse or both spouses, and at least one other party, shall be considered available to each spouse in proportion to the spouse's interest in the trust principal. When income from a trust is paid to both spouses and each spouse's individual interest in the trust principal is not specified, consider one-half of their joint interest in the income as available to each spouse.

3. Income Deeming

Do not deem a community spouse's income available to an institutionalized spouse for purposes of determining the institutionalized spouse's Medicaid eligibility for any month of institutionalization (including partial months). For the month of entry into institutionalization and subsequent months, only the institutionalized individual's income is counted for eligibility and patient pay purposes.

The community spouse's income is used only to determine the community spouse monthly income allowance, if any.

4. Income Determination

For purposes of the income eligibility determination of a married institutionalized spouse, regardless of the individual's covered group, income is determined using the income eligibility instructions in section M1480.310 below and chapter S08.

For individuals who are within a spenddown budget period prior to the month in which they become institutionalized, prorate and shorten the spenddown budget period to include months **prior to admission** to long-term care services. A separate monthly budget period is established for each month of receipt of long-term care services.

5. Post-eligibility Treatment of Income

After an institutionalized spouse is determined eligible for Medicaid, his or her patient pay must be determined. See the married institutionalized individuals' patient pay policy and procedures in section M1480.400 below.

M1480.310 300% SSI AND ABD 80% FPL INCOME ELIGIBILITY DETERMINATION

A. Introduction

This section provides those income requirements specific to determinations of eligibility for Medicaid participation in payment of long-term care services.

For ABD individuals, first determine the individual's eligibility in the 300% SSI covered group. If the individual is ineligible in the 300% SSI covered group due to excess resources, determine the individual's eligibility in the ABD 80% FPL covered group.

For purposes of this section, we refer to the ABD covered group and the F&C covered group of "individuals in medical facilities who have income less than or equal to 300% of the SSI individual payment limit" and "individuals receiving Medicaid waiver services who have income less than or equal to 300% of the SSI individual payment limit" as one covered group. We refer to this one group as "institutionalized individuals who have income within 300% of SSI" or the "300% SSI group."

B. 300% SSI Group

The income limit for ABD and F&C individuals in the 300% SSI group is 300% of the SSI individual payment limit (see M0810.002.A.3).

1. Gross Income

Income sources listed in section M1460.610 are not considered as income.

Income sources listed in section M1460.611 ARE counted as income.

All other income is counted. The institutionalized spouse's gross income is counted; no exclusions are subtracted.

To determine an income type or source and to determine how to count the income, use the policy and procedures in chapter S08 for all individuals (ABD and F&C) in the 300% SSI group.

Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.

2. Income Less Than or Equal to 300% SSI Limit

If the individual's gross income is less than or equal to the 300% SSI income limit, enroll the individual in the appropriate CNNMP PD and determine patient pay according to the policy and procedures found in section M1480.400.

a. Individual Has Medicare Part A

If the individual has Medicare Part A, determine if his income is within the QMB income limit. Calculate the individual's countable income for QMB according to chapter S08, and compare to the QMB limit. If the individual's gross income is less than or equal to the QMB limit, enroll the recipient with the appropriate CNNMP dual-eligible QMB *aid category (AC)*:

- Aged = *0*22
- Blind = *0*42
- Disabled = *0*62

If the income is over the QMB limit, enroll the recipient with the appropriate CNNMP non-QMB *AC*:

- Aged = *0*20
- Blind = *0*40
- Disabled = *0*60

b. Individual Does Not Have Medicare Part A

If the individual does NOT have Medicare Part A, enroll the ABD recipient with the appropriate CNNMP *AC*:

- Aged = *0*20
- Blind = *0*40
- Disabled= *0*60

Enroll the F&C recipient with the appropriate CNNMP *AC*:

- Institutionalized child under age 21= *0*82
- Institutionalized F&C individual age 21 or older = *0*60.

3. Income Exceeds 300% SSI Limit

If income exceeds the 300% SSI limit, evaluate the institutionalized spouse as MN. Go to section M1480.330 below.

C. ABD 80% FPL

The income limit for the ABD 80% FPL covered group is 80% of the federal poverty level (see M0810.002.A.5). See section M0320.210 for details about this covered group.

The ABD income policy in chapter S08 is used to determine countable income for the ABD 80% FPL covered group. Income is projected for the month for which eligibility for LTC is being determined. This calculation is based upon the income received in the past month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount expected to be received.

If the individual's *countable* income is less than or equal to the 80% FPL income limit, enroll the individual in the MMIS with the appropriate ABD 80% FPL PD and determine patient pay according to the policy and procedures found in section M1480.400. The ABD 80% FPL ACs are:

- Aged = 029
- Blind = 039
- Disabled = 049

M1480.315 THIRD PARTY & LONG-TERM CARE INSURANCE PAYMENTS

A. Payments Made by Another Individual

Payment of an individual's bills (including Medicare supplementary medical insurance or other medical insurance premiums) by a third party directly to the supplier is not income.

Payments made directly to the service provider by another person for the individual's private room or "sitter" in a medical facility are NOT income to the individual. Refer all cases of Medicaid eligible enrollees in nursing facilities who have a "sitter" to DMAS, Division of Long-term Care, for DMAS review to assure that DMAS is not paying the facility for services provided by the sitter.

B. LTC Insurance Policy Payments

The LTC insurance policy must be entered into the recipient's TPL file on MMIS. The insurance policy type is "H" and the coverage type is "N." When entered in MMIS on the TPL system, MMIS will not pay the nursing facility's claim unless the claim shows how much the policy paid.

If the patient receives the payment from the insurance company, it is **not** counted as income. The patient should assign it to the nursing facility. If the patient cannot do this, or the policy prohibits assignment, the payment should be given directly to the nursing facility. The facility should report the payment as a third party payment on its claim form.

If the patient received the payment and cannot give it to the facility for some reason, then the patient should send the insurance payment to:

DMAS Fiscal Division, Accounts Receivable
600 E. Broad Street, Suite 1300
Richmond, Virginia 23219

M1480.320 RETROACTIVE MN INCOME DETERMINATION

A. Policy

The retroactive spenddown budget period is the three months immediately prior to the application month, when none of the months overlap (was included in) a previous MN spenddown budget period in which spenddown eligibility was established. When some of the months overlap a previous MN spenddown budget period in which spenddown eligibility was established, the retroactive spenddown budget period is shortened (prorated) to include only the month (s) which were not included in the previous MN spenddown budget period.

1. Institutionalized

For the retroactive months in which the individual was institutionalized, determine income eligibility on a **monthly basis** using the policy and procedures in this subchapter. A spenddown must be established for a month during which excess income existed.

2. Individual Not Institutionalized

For the retroactive months in which the individual was NOT institutionalized, determine income eligibility for ABD groups using the ABD policy and procedures in chapter S08. Determine income eligibility for F&C groups using policy and procedures in chapter M07. A spenddown must be established for a month(s) during which excess income existed.

3. Retroactive Entitlement

If the applicant meets all eligibility requirements, he is entitled to Medicaid coverage for the month(s) in which all eligibility factors were met.

B. Countable Income

Countable income is that which was actually received in the retroactive month(s). Count the income received in the months in which the individual meets all other Medicaid eligibility requirements.

The countable income is compared to the appropriate income limit for the retroactive month, if the individual was CNNMP in the month. **For the institutionalized MN individual, Medicaid income eligibility is determined monthly.**

C. Entitlement

Retroactive coverage cannot begin earlier than the first day of the third month prior to the application month. When an applicant reports that he received a medical service within the retroactive period, entitlement for Medicaid will begin with the first day of the third month prior to the application month, provided all eligibility factors were met in all three months. If the applicant had excess income in the retroactive period and met his spenddown, he is enrolled beginning the first day of the month in which his retroactive spenddown was met. For additional information refer to section M1510.101.

D. Retroactive Example

EXAMPLE #15: A disabled institutionalized spouse applies for Medicaid on June 5 and requests retroactive coverage for unpaid medical bills that he incurred in March, April, and May. His disability onset date was April 10. He was institutionalized on April 10. The retroactive period is March, April and May. He is not eligible for March because he did not meet a covered group in March. His countable resources are less than $2,000 in April, May and June. The income he received in April and May is counted monthly because he was institutionalized in each month.

His April income is calculated and compared to the monthly 300% SSI income limit. It exceeds that limit. His May income is calculated and compared to the monthly 300% SSI income limit; it is within the limit. Therefore, he is placed on a one-month retroactive spenddown for April, and is enrolled in retroactive Medicaid in the CNNMP 300% SSI covered group for May.

M1480.330 MEDICALLY NEEDY INCOME & SPENDDOWN

A. Policy

An institutionalized spouse whose income exceeds the 300% SSI income limit must be placed on a monthly medically needy (MN) spenddown if he meets a medically needy (MN) covered group and has countable resources that are less than or equal to the MN resource limit. His income is over the MN income limit because 300% of SSI is higher than the highest MN income limit for one person for one month.

MN countable income must be calculated to exclude income and portions of income that were counted in the 300% SSI income limit group calculation. Income is determined on a monthly basis and an institutionalized individual's spenddown budget period is one month. The certification period for all long term care cases is 12 months from the last application or redetermination month. This includes MN cases placed on spenddown.

B. Recalculate Income

Evaluate income eligibility for an institutionalized spouse who has income over the 300% SSI income limit using a one-month budget period and the following procedures:

1. ABD MN Covered Groups

The income sources listed in both sections M1460.610 "What is Not Income" and M1460.611 "Countable Income for 300% SSI Group" are NOT counted when determining income eligibility for the ABD MN covered groups. Countable income is determined by the income policy in chapter S08; applicable exclusions are deducted from gross income to calculate the individual's countable income.

The income actually received in the retroactive period is considered for retroactive eligibility. The income expected to be received within the application month is considered when determining eligibility in that month.

The income expected to be received within a month is counted in that month for ongoing eligibility.

a. Start with the gross monthly income figure countable for the ABD MN income determination.

b. Subtract the $20 general income exclusion. If the institutionalized spouse has earned income, subtract the ABD earned income exclusions found in section S0820.500. Subtract any appropriate unearned income exclusions in subchapter S0830.

c. The remainder is the monthly countable ABD MN income.

2. F&C MN Covered Groups

The income sources listed in both sections M1460.610 "What is Not Income" and M1460.611 "Countable Income for 300% SSI Group" are NOT counted when determining income eligibility for the F&C MN covered groups. Countable income is determined by the income policy in chapter M07; applicable exclusions are deducted from gross income to calculate the individual's countable income

Anticipated income is projected for the month for which eligibility is being determined. This calculation is based upon the income received in the prior month unless there is documentation that a change has occurred or can reasonably be expected to occur which will change the amount to be received

a. Start with the gross monthly income figure countable for the F&C MN income determination.

b. If the unit has earned income, subtract the F&C earned income exclusions in section M0720.500 **except** for the $30 + 1/3 exclusion which is not applicable to MN F&C covered groups.

c. If the Unit has child support income, subtract the $50 child support exclusion. See section M0730.400.

d. The remainder is the monthly countable F&C MN income.

D. MN Income Limits

The monthly medically needy (MN) individual income limits are *listed in Appendix 5 to subchapter M0710 and in section M0810.002 A. 4.*

E. Determine Spenddown Liability

Compare monthly countable income to the **monthly** MN individual income limit in the institutionalized spouse's locality.

The amount by which the institutionalized spouse's countable MN income exceeds the MN income limit is the **spenddown liability.**

F. Spenddown Eligibility Procedures

To be eligible for Medicaid coverage, the institutionalized spouse must incur medical expenses in the month in an amount that equals or exceeds the spenddown liability. The policy and procedures for determining if an institutionalized spouse has met the spenddown are the "spenddown eligibility" policy and procedures.

The spenddown eligibility procedures for facility patients differ from the spenddown procedures for Medicaid CBC waiver patients. The expected monthly cost of the facility care (at the Medicaid rate) is projected at the beginning of the month. The cost of CBC is NOT projected.

1. Facility Patients

Facility patients in the MN classification fall into two distinct subgroups for the purpose of spenddown eligibility determination. These subgroups are:

- individuals with a spenddown liability less than or equal to the monthly Medicaid rate for the facility; and
- individuals with a spenddown liability greater than the monthly Medicaid rate for the facility.

a. Determine the Facility's Medicaid Rate

The facility's projected Medicaid rate is the Medicaid per diem multiplied by 31 days.

b. Compare Spenddown Liability

Compare the individual's spenddown liability to the facility's projected Medicaid rate.

c. SD Liability Is Less Than or Equal To Medicaid Rate

If the spenddown liability is **less than or equal to** the facility's projected Medicaid rate, the institutionalized spouse is income eligible as medically needy because he meets the spenddown based on the projected Medicaid rate alone.

1) Medicaid eligibility begins the first day of the month. Enroll as eligibility Type 1.

2) The institutionalized spouse has ongoing eligibility for the 12-month application certification period. The individual must file a redetermination after the 12-month certification period ends.

3) If the institutionalized spouse does **NOT** have Medicare Part A, enroll with the appropriate MN PD that follows:

   - Aged = **18**
   - Blind = **38**

- Disabled = **058**
- Child Under 21 in ICF/ICF-MR = **098**
- Child Under Age 18 = **088**
- Juvenile Justice Child = **085**
- Foster Care/Adoption Assistance Child = **086**
- Pregnant Woman = **097**.

4) If the institutionalized spouse has Medicare Part A, compare the individual's monthly MN countable income to the QMB monthly income limit for 1 person (see section M0810.002 for the current QMB limit):

a) When income is less than or equal to the QMB limit, enroll using the appropriate *AC* that follows:

- Aged = **028**
- Blind = **048**
- Disabled = **068**

b) When income is greater than the QMB limit, enroll using the appropriate PD that follows:

- Aged = **018**
- Blind = **038**
- Disabled = **058**

5) Patient Pay: Determine patient pay according to section M1480.400 below.

d. SD Liability Is Greater Than Medicaid Rate

If the spenddown liability is **greater than** the facility's Medicaid rate, the institutionalized spouse is NOT eligible unless he incurs medical expenses which meet the spenddown liability in the month. To determine if the spenddown is met, go to section M1480.*335* below.

2. Medicaid CBC Waiver Patients

The institutionalized spouse meets the definition of "institutionalized" when he is screened and approved for Medicaid waiver services and the services are being provided. An institutionalized spouse who has been screened and approved for Medicaid waiver services and whose income exceeds the CNNMP 300% SSI income limit is not eligible for Medicaid until he meets the monthly spenddown liability.

To determine if the spenddown is met, go to section M1480.*335* below.

3. PACE Recipients

The individual's spenddown liability and the PACE monthly rate (minus the Medicare Part D premium) establish whether the spenddown eligibility determination can be projected or must be determined retrospectively.

To determine if the spenddown is met, go to section M1480.340 below.

M1480.*335* FACILITY PATIENTS WITH SPENDDOWN LIABILITY GREATER THAN MEDICAID RATE & ALL MN CBC PATIENTS

A. Facility Patients--SD Liability Is Greater Than Medicaid Rate

An MN institutionalized spouse whose spenddown liability is greater than the facility's Medicaid rate is not eligible for Medicaid until he incurs medical expenses that meet the spenddown liability within the month. These determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred. The institutionalized spouse's resources and income must be verified each month before determining if the spenddown was met.

To determine if the institutionalized spouse met the spenddown, use the following procedures:

1. Calculate Private Cost of Care

Multiply the facility's **private** per diem rate by the number of days the institutionalized spouse was actually in the facility in the month. Do not count any days the institutionalized spouse was in a hospital during the month.

The result is the private cost of care for the month.

2. Compare to Spenddown Liability

Compare the private cost of care to the institutionalized spouse's spenddown liability for the month.

3. Cost of Care Greater Than Spenddown Liability

When the private cost of care is **greater than** the institutionalized spouse's spenddown liability, the institutionalized spouse meets the spenddown in the month because of the private cost of care. He is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the institutionalized spouse in Medicaid with the begin date of the first of the month, the end date the last day of the month. Go to section M1480.350 below for enrollment procedures. Determine patient pay according to section M1480.440 below.

4. Cost of Care Less Than or Equal To Spenddown Liability

When the private cost of care is less than or equal to the institutionalized spouse's spenddown liability, **determine spenddown on a day-by-day basis** in the month by deducting allowable incurred expenses from the spenddown liability.

To determine spenddown eligibility:

- Go to section M1480.341 below if the institutionalized spouse was NOT previously on a spenddown.
- Go to section M1480.342 below if the institutionalized spouse was previously on a spenddown.

B. All MN CBC Patients

An MN institutionalized spouse who has been screened and approved for Medicaid CBC waiver services is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. These determinations are made monthly, retrospectively, **after** the month has passed and the expenses have actually been incurred. The private cost of his home-based medical care is deducted on a day-by-day basis as a noncovered medical expense, along with any other incurred medical expenses.

The institutionalized spouse's resources and income must be verified each month before determining if the spenddown was met. To determine if the institutionalized spouse met the spenddown:

- Go to section M1480.341 below if the institutionalized spouse was NOT previously on a spenddown.
- Go to section M1480.342 below if the institutionalized spouse was previously on a spenddown.

M1480.340 MN PACE RECIPENTS

A. Policy

1. Monthly Spenddown Determination

PACE recipients who have income over the CNNMP 300% of SSI income limit are placed on a monthly spenddown as institutionalized individuals because they have been screened and approved for LTC services.

Unlike CBC, PACE has a capitated monthly rate that is due and payable on the first day of the month. The monthly PACE rate is available from the PACE provider. When a MN individual is in PACE, the amount of allowed PACE expenses is the rate that is due as of the first day of each month.

PACE recipients are not responsible for Medicare Part D premiums, which are included in the monthly PACE rate. ***Therefore, the cost of the Medicare Part D premium cannot be used to meet a spenddown and must be subtracted from the monthly PACE rate when determining if the spenddown has been met.***

The individual's spenddown liability and the PACE monthly rate (minus the Medicare Part D premium) establish whether the spenddown eligibility determination can be projected or must be determined retrospectively.

2. Projected Spenddown Determination

If the MN individual's spenddown liability is less than or equal to the monthly PACE rate (minus the Medicare Part D premium), the individual is eligible for Medicaid effective the first day of the month in which the spenddown is met. As long as the individual's spenddown liability and the PACE monthly rate do not change, the individual is enrolled in ongoing coverage.

3. Retrospective Spenddown Determination

If the MN individual's spenddown liability exceeds the monthly PACE rate (minus the Medicare Part D premium), he is not eligible for Medicaid until he actually incurs medical expenses that meet the spenddown liability within the month. The monthly medical expenses are determined retrospectively; they cannot be projected for the spenddown budget period.

Retrospective spenddown eligibility determinations are made monthly after the month has passed and the expenses have actually been incurred. The PACE

rate(minus the Medicare Part D premium) along with other allowable medical and dental expenses are deducted daily and chronologically as the expenses are incurred. The individual's income and resources must be verified each month before determining if the spenddown has been met. See M1470.530 for allowable medical deductions.

When incurred medical expenses equal or exceed the monthly spenddown liability, the individual is eligible for the full month of Medicaid coverage beginning the first day of the month and ending the last day of the month.

M1480.341 NOT PREVIOUSLY ON SPENDDOWN

A. Procedure

To determine eligibility in the one-month budget period for an institutionalized spouse who has NOT previously been on a spenddown, take the following actions:

- deduct old bills,
- deduct carryover expenses from the retroactive period,
- deduct medical/remedial care expenses incurred within the budget period (month).

Use the "Medical Expense Record-Medicaid" found in Appendix 1 to subchapter M1340 to document expenses and file it in the case record.

If the institutionalized spouse was on a spenddown in the retroactive period, whether or not the retroactive spenddown was met, go to section M1480.342 below.

B. Old Bills

Old bills for medical, dental, or remedial care services received prior to the retroactive period based on the initial application that can be deducted are:

1. Paid by Public Program

Expenses for medical services for which the applicant was legally liable received on or after December 22, 1987, which were provided, covered, or paid for by a public state or local government program, can be deducted. The amount deducted is the amount that the applicant would have been liable for if the service had not been covered by a public program, up to the spenddown liability amount.

2. Legally Liable

Expenses incurred for medical services that the applicant is legally liable to pay are deducted. For the expense to be deducted:

- the applicant must still owe the service provider a specific amount for the service and present current verification of the debt;

- the expense (or remainder of the expense) must not have been forgiven or written-off by the provider; and

  a claim for the expense must have been submitted to the liable third party and the applicant must provide evidence of the third party's payment denial or the amount paid for the expense.

3. Amount Deducted

The amount deducted is the balance of the old bills owed by the applicant as of the first day of the first prospective budget period, less any portion of the amount that was used to meet the retroactive spenddown.

4. When Deducted

Allowable old bills are deducted on the first day of the budget period.

C. Carry-over Expenses from Retroactive Period

Paid or unpaid expenses incurred during the retroactive period of an initial application can be deducted IF:

- the individual established eligibility in the retroactive budget period **without having to meet a spenddown**, AND
- the expenses are allowable by kind of service.

1. Amount Deducted

The amount deducted is the amount of the expense owed as of the beginning of the budget period, up to the spenddown liability amount.

2. When Deducted

Allowable expenses carried over from the retroactive period are deducted on the first day of the one-month budget period.

D. Expenses Incurred Within the Budget Period

Allowable expenses incurred on or after the beginning of the one-month budget period that can be deducted are:

1. Paid By Public Program

Allowable incurred expenses for medical or remedial care which the applicant received after the beginning of the budget period which were provided, covered, or paid for by a public state or local government program can be deducted. The incurred expense amount that can be deducted is the amount that the applicant would have been liable for if the service had not been covered by a public program, up to the spenddown liability amount.

2. Legally Liable

Allowable expenses (paid or unpaid) incurred during the budget period for which the applicant is legally liable are deducted. To be deducted, the claim for the expense must have been submitted to the liable third party. The applicant must provide evidence of the third party's payment denial or the February spenddown eligibility evaluated.

amount paid for the expense.

3. Amount Deducted

The amount that is deducted is the amount that was not or will not be paid by a third party, up to the spenddown liability amount. When determining the amount of long-term care expense incurred, use the daily private rate.

4. When Deducted

The incurred expenses are deducted in chronological order on the date the expense is incurred. The incurred expenses are deducted even if they have been paid.

EXAMPLE #16: Mr. Not lives in Group III and applied for Medicaid on November 21, 1999, as a disabled institutionalized spouse. He is in a nursing facility and was admitted on November 1, 1999. The MDU determined that he is disabled. He has not been on spenddown before. He has a $8,400 hospital bill and a $1,500 physician's bill for July 10 to July 20, 1998 (total $9,900) on which he still owes a total of $9,000. He has a $578 outpatient hospital bill for October 3, 1998. He has no health insurance. His income is $1,800 per month disability benefit from a private company. He is not eligible for retroactive Medicaid because he had excess resources throughout the retroactive period. His resources are within the Medicaid limit in November 1999 (application month).

He is not eligible as CNNMP because his $1,800 gross income exceeds the 300% SSI income limit. The facility's Medicaid rate is $45 per day. His MN income eligibility is calculated:

$1,800	disability benefit
- 20	general income exclusion
1,780	MN countable income.
- 325	MNIL for 1 month for 1 person in Group III
$1,455	spenddown liability

The facility rate for the admission month is calculated as follows:

$ 45	Medicaid per diem
x 30	days
$1,350	facility Medicaid rate admission month

The $1,455 spenddown liability is greater than the Medicaid rate of $1,350.

Because he was not previously on spenddown, his verified old bills for July 1999 are deducted first from the spenddown liability. He owes the hospital $8,000 and the physician $1,000, total $9,000, as of November 1, 1999 (the first day of the budget period). His eligibility is calculated:

$1,455	spenddown liability
- 9,000	old bills owed 11-01-99
$ 0	spenddown balance on 11-1-99

Because the spenddown was met on November 1, Mr. Not is entitled to medically needy Medicaid for the budget period 11-1-99 through 11-30-99.

The old bills balance, or $7,545 ($9,000- 1,455 = $7,545) not used to achieve eligibility can be deducted in the subsequent month(s) from the subsequent spenddown liability if he continues to establish spenddown eligibility.

M1480.342 PREVIOUSLY ON SPENDDOWN

A. Procedure

To determine spenddown eligibility for the budget period for an institutionalized spouse who has previously been on spenddown, take the following actions:

B. Prorate Spenddown Prior To Institutionalization

If the institutionalized spouse is in a spenddown budget period when he becomes institutionalized, prorate the spenddown period and recalculate the spenddown liability for the months prior to the month in which he became institutionalized.

C. Old Bills

Deduct the remaining balance on old bills incurred prior to the retroactive period if there has been no break between spenddown budget periods and no break in spenddown eligibility (each spenddown was met in all prior budget periods). Only the amount NOT deducted in a previous spenddown, and which remains the liability of the individual, can be deducted.

D. Current Payments on Bills Incurred Prior to Retroactive Period

Deduct only the amount of the current payment(s) actually made on expenses incurred prior to the retroactive period, and which were not used previously to achieve eligibility, when there has been a break between spenddown budget periods or a break in spenddown eligibility (spenddown eligibility was NOT established in a prior spenddown budget period).

1. Legally Liable

Current payments for expenses that the applicant is legally liable to pay are deducted. For the expense to be deducted:

- the applicant must still owe the service provider a specific amount for the service and present current verification of the payment amount and date(s) paid.
- a claim for the expense must have been submitted to the liable third party and the applicant must provide evidence of the third party's payment denial or the amount paid for the expense.

2. Amount Deducted

The amount deducted is the amount of the payment.

3. When Deducted

Allowable current payments are deducted on the date the payments are made.

E. Expenses from Retroactive Spenddown Budget Period

Expenses from the retroactive spenddown budget period that were not used to achieve eligibility can be deducted from the spenddown liability balance.

1. Retroactive Spenddown Eligibility Achieved

Deduct expenses incurred during the retroactive period which were not previously used to establish eligibility, IF:

a. the individual established eligibility in the retroactive spenddown budget period AND

b. the expenses are:

- paid or unpaid;
- allowable by kind of service; and
- carried over from the retroactive spenddown budget period because the individual had a spenddown liability in the retroactive period that was met without deducting all such paid or unpaid expenses incurred in the retroactive spenddown budget period.

c. The amount deducted is the amount of the expense owed to the provider as of the beginning of the spenddown budget period, less the amount used to meet the retroactive spenddown, up to the spenddown liability amount.

d. Allowable expenses from the retroactive spenddown budget period are deducted on the first day of the prospective spenddown budget period.

2. Retroactive Spenddown Eligibility NOT Achieved

Deduct only **current payments** made on expenses incurred during the retroactive spenddown budget period. When there has been a break in spenddown eligibility, only current payments made on old bills based on a prior Medicaid application can be deducted from the current spenddown liability. For the current payment to be deducted:

a. the applicant must still owe the service provider a specific amount for the service and present current verification of the payment amount and date(s) paid,

b. a claim for the expense must have been submitted to the liable third party and the applicant must provide evidence of the third party's payment denial or the amount paid for the expense.

The amount deducted is the amount of the current payment made.

Current payments on expenses from the retroactive spenddown budget period are deducted on the date the payment is made.

F. Expenses Incurred Within Spenddown Budget Period

Allowable expenses incurred within the spenddown budget period that can be deducted are:

1. Paid By Public Program

Allowable incurred expenses for medical or remedial care which the applicant received after the beginning of the spenddown budget period which were provided, covered, or paid for by a public state or local government program.

The incurred expense amount that can be deducted is the amount that the applicant would have been liable for if the service had not been covered by a public program, up to the spenddown liability amount.

2. Legally Liable

Allowable expenses (paid or unpaid) incurred after the beginning of the spenddown budget period for which the applicant is legally liable are deducted. See subsection M1340.100 B.1. for a description of legal liability. To be deducted, the claim for the expense must have been submitted to any liable third party. The applicant must provide evidence of the third party's payment denial or the amount paid for the expense.

3. Amount Deducted

The amount that is deducted is the amount that was not or will not be paid by a third party, up to the spenddown liability amount.

4. When Deducted

The incurred expenses are deducted in chronological order on the date the expense is incurred. The incurred expenses are deducted even if they have been paid.

G. When Spenddown Is Met

When the institutionalized spouse incurs medical expenses which meet the spenddown on any day in the month, he is entitled to **full-month coverage** for the month in which the spenddown was met.

Enroll the institutionalized spouse in Medicaid with the begin date of the first of the month, the end date the last day of the month, eligibility Type 4. Go to section M1480.350 below for enrollment procedures. Determine patient pay according to section M1480.440 below.

H. Example--Retroactive Spenddown, Institutionalized Spenddown In Admission Month

EXAMPLE #17: Ms. Was lives in Group I and applied for Medicaid on January 6, 2000, as disabled. She is in a nursing facility and was admitted on January 5, 2000. Mr. Was is her community spouse; he lives in their Group I locality home. Her countable resources are less than the Medicaid resource limit in January, and were less than the Medicaid resource limit in all months in the retroactive period. She applied for Medicaid in December 1998 and was on a spenddown from December 1, 1998 through May 31, 1999, which she met on December 1, 1998.

She verifies that she has unpaid balances of $2,300 on a hospital bill and $1,500 on a physician's bill (total = $3,800) for services received August 10 to August 12, 1998 (prior to the retroactive period based on the December 1998 application) on which she pays $50 a month. These balances were not used to meet her December 1998 through May 1999 spenddown. She also has a $678 outpatient hospital bill for services dated November 13, 1999, in the retroactive period. She has no health insurance and is not eligible for Medicare. She has no old bills based on her January 2000 re-application (no unpaid medical expenses incurred in June, July, August or September 1999).

She was not institutionalized in the retroactive period. Her income in the retroactive budget period was $400 per month SSA disability. The retroactive budget period based on her January 2000 re-application is October, November and December 1999; the income limit is $650.

Her retroactive spenddown liability is $490.

$400	SSA disability
- 20	general income exclusion
380	countable income
x 3	months
$1,140	countable income for retroactive budget period
- 650	MNIL for retroactive budget period Group I
$ 490	retroactive spenddown liability

Since there was a break in her spenddown eligibility (the period June, July, August and September 1999 were not covered by a Medicaid application), only the current payments she is making on the August 1998 bills can be deducted from her retroactive spenddown liability. She paid the hospital and the physician $50 each ($100 total) on October 5, November 4 and December 5, 1999. Her retroactive eligibility is calculated:

$ 490	retroactive spenddown liability
- 100	current payment 10-5-99 (Aug.1998 hospital & physician bills)
390	spenddown balance on 10-5-99
- 100	current payment 11-4-99 (Aug.1998 hospital & physician bills)
290	spenddown balance on 11-3-99
- 678	outpatient expense 11-13-99 ($388 of expense carried over)
$ 0	spenddown balance on 11-13-99

The retroactive spenddown was met on November 13, 1999. Ms. Was' retroactive Medicaid entitlement was November 13, 1999 through December 31, 1999.

Her income starting January 1, 2000 increased. Her SSA is $620 per month and she began receiving a Civil Service Annuity of $1,300 per month; total income is $1,920 per month. Because this exceeds the CNNMP 300% SSI income limit, her medically needy income eligibility is calculated as follows:

$1,920.00 total monthly income
- 20.00 general income exclusion
1,900.00 countable income
- 216.67 MNIL for 1 month for 1 person in Group I
$1,683.33 spenddown liability

The facility's private rate is $58 per day; the Medicaid rate is $45 per day. The facility Medicaid rate for the admission month is calculated as follows:

$ 45 Medicaid per diem
x 27 days
$1,215 Medicaid rate admission month

Her spenddown liability of $1,683.33 is greater than the Medicaid rate of $1,215. Therefore, she is not eligible until she has actually incurred medical bills that equal or exceed her spenddown liability in January. The worker is processing the application on February 2. Mrs. Was was in the facility from January 5 through January 31. The facility's private cost is calculated:

$ 58 private per diem
x 27 days in facility in January
$1,566 private cost of care in January

The private cost of care for January, $1,566, is less than Mrs. Was's spenddown liability of $1,683.33. Therefore, her spenddown eligibility for January must be determined on a daily basis. The prospective budget period is January 1 through January 31, 2000. Since she had a break in spenddown eligibility, only the current payments she is making on the August 1998 bills can be deducted from her spenddown liability. She paid the hospital $50 and the physician $50 each ($100 total) on January 5, 2000. Her spenddown eligibility is determined:

$1,683.33 prospective spenddown liability
- 388.00 carry-over expense (balance of 11-13-99 outpatient expense)
- 100.00 current payment Aug,1998 hospital & physician bills 1-1-00
1,195.33 spenddown balance on 1-1-00
- 812.00 14 days private rate @ $58 per day (1-5 through 1-18)
383.33 spenddown balance on 1-19-00
- 348.00 6 days private rate @ $58 per day (1-19 through 1-23)
35.33 spenddown balance on 1-23-00
- 58.00 private cost of care for 1-24-00
$ 0 spenddown balance on 1-24-00

Mrs. Was met her spenddown on January 24, 2000. On February 3, the worker enrolls Mrs. Was in Medicaid as medically needy with eligibility begin date 1-1-2000 and end date 1-31-2000. The worker sends her a "Notice of Action on Medicaid" stating her Medicaid coverage dates and asking her to bring or send in her medical bills for February if she wants her *February spenddown eligibility evaluated.*

M1480.350 SPENDDOWN ENTITLEMENT

A. Entitlement After Spenddown Met

When an institutionalized spouse meets a spenddown within a month, the begin date of eligibility will be the first day of the month in which the spenddown was met. Eligibility will end on the last day of the month in which the spenddown was met.

B. Procedures

1. Coverage Dates

Coverage begin date is the first day of the month; the coverage end date is the last day of the month.

2. Aid Category

a. If the institutionalized spouse does NOT have Medicare Part A:

- Aged = 018
- Blind = 038
- Disabled = 058
- Child Under 21 in ICF/ICF-MR = 098
- Child Under Age 18 = 088
- Juvenile Justice Child = 085
- Foster Care/Adoption Assistance Child = 086
- Pregnant Woman = 097

b. If the institutionalized spouse has Medicare Part A:

Compare the individual's monthly MN countable income to the QMB monthly income limit for 1 person (see M0810.002 for the current QMB limit):

1) When income is less than or equal to the QMB limit, enroll using the following ACs:

- Aged = 028
- Blind = 048
- Disabled = 068

2) When income is greater than the QMB limit, enroll using the following ACs:

- Aged = 018
- Blind = 038
- Disabled =058

3. Patient Pay

Determine patient pay according to section M1480.400 below.

4. Notices & Re-applications

The institutionalized spouse on a spenddown must have his eligibility re-evaluated monthly, unless he is in a facility and the spenddown liability is less than or equal to the Medicaid rate. The institutionalized spouse must complete an annual redetermination.

After eligibility is established, the usual reporting and notification processes apply. Send the "Notice of Action on Medicaid" for the month(s) during which the individual establishes Medicaid eligibility. MMIS will generate the "Notice of Obligation for LTC Costs" and it will be sent to the individual or his authorized representative.

M1480.400 PATIENT PAY

A. Introduction This section contains the policy and procedures for determining an institutionalized spouse's (as defined in section M1480.010 above) patient pay in all covered groups.

B. Married With Institutionalized Spouse in a Facility For a married LTC patient with an institutionalized spouse in a facility, **NO** amount of the patient's income is deducted for the spouse's needs in the patient pay calculation.

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

A. Introduction This subsection contains the standards and their effective dates that are used to determine the community spouse's and other family members' income allowances. The income allowances are deducted from the institutionalized spouse's gross monthly income when determining the monthly patient pay amount. Definitions of these terms are in section M1480.010 above.

B. Monthly Maintenance Needs Standard	$1,838.75	7-1-11
	$1,821.25	7-1-10
C. Maximum Monthly Maintenance Needs Allowance	$2,739.00	1-1-11 (no change for 2011)
	$2,739.00	1-1-10
D. Excess Shelter Standard	$551.63	7-1-11
	$546.38	7-1-10

E. Utility Standard Deduction (SNAP)	*$274*	1 - 3 household members	*10-1-11*
	$345	4 or more household members	*10-1-11*
	$303	1 - 3 household members	10-1-10
	$382	4 or more household members	10-1-10

M1480.420 PATIENT PAY FOR ABD 80% FPL AND 300% SSI INSTITUTIONALIZED SPOUSE

A. Policy After a 300% SSI or ABD 80% FPL institutionalized spouse has been found eligible for Medicaid, determine his patient pay (post-eligibility treatment of income).

B. What Is Patient Pay

The institutionalized spouse's gross monthly income, less all appropriate deductions according to this section, constitutes the patient pay - the amount of income the institutionalized spouse will be responsible to pay to the LTC facility or waiver services provider. The community spouse's and family member's monthly income allowances rules for patient pay apply to all institutionalized spouses with community spouses, regardless of when institutionalization began.

C. Dependent Allowances

A major difference in the institutionalized spouse patient pay policy is the allowance for a dependent child and for a dependent family member. If the institutionalized spouse has a dependent child, but the dependent child does NOT live with the community spouse, then **NO** allowance is deducted for the child. Additionally, an allowance may be deducted for other dependent family members living with the community spouse.

D. Home Maintenance Deduction

A major difference in the institutionalized spouse patient pay policy is the home maintenance deduction policy. A married institutionalized individual with a community spouse living in the home is **NOT allowed** the home maintenance deduction because the community spouse allowance provides for the home maintenance, **UNLESS**:

- the community spouse is not living in the home (e.g., the community spouse is in an ACR), and
- the institutionalized spouse still needs to maintain their former home.

E. *MMIS* Patient Pay *Process*

The patient pay is calculated in the Medicaid Management Information System (MMIS) using the Patient Pay process. The patient pay must be updated in MMIS whenever the patient pay changes, but at least once every 12 months. Refer to the MMIS User Guide for information regarding data entry into MMIS.

The MMIS Allowance and Medically Needy Workbook is available to facilitate the calculation of certain allowances that must be computed outside of MMIS and to calculate patient pay for Medically Needy determinations. The workbook is available at:
http://www.vcu.edu/vissta/bps/bps_resources/ltc_medicaid.htm.

The Automated Response System (ARS) and the MediCall System convey the necessary patient pay information to the provider.

M1480.430 ABD 80% FPL and 300% SSI PATIENT PAY CALCULATION

A. Patient Pay Gross Monthly Income

Determine the institutionalized spouse's patient pay gross monthly income for patient pay. Use the gross income policy in section M1480.310 B.1 for both covered groups.

B. Subtract Allowable Deductions

If the patient has no patient pay income, he has no patient pay deductions.

When the patient has patient pay income, **deduct the following amounts in the following order** from the institutionalized spouse's gross monthly patient pay income. Subtract each subsequent deduction as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

- personal needs or maintenance allowance,
- community spouse monthly income allowance,
- family member's income allowance,
- noncovered medical expenses,
- home maintenance deduction, if applicable.

C. Personal Needs or Maintenance Allowance

The personal needs allowance for an institutionalized spouse in a facility is different from the personal maintenance allowance of an institutionalized spouse in a Medicaid CBC waiver or PACE. The amount of the personal needs or maintenance allowance also depends on whether or not the patient has a guardian or conservator who charges a fee, and whether or not the patient has earnings from employment that is part of the treatment plan.

1. Facility Care

a. Basic Allowance

Deduct the $40 basic allowance, effective July 1, 2007. For prior months, the personal needs allowance is $30.

b. Guardian Fee

Deduct the actual fee a guardian or conservator charges, up to a maximum of 5% of the patient's actual gross income (including amounts not counted as income and excluded income) for guardianship fees, IF:

- the patient has a legally appointed guardian and/or conservator AND
- the guardian or conservator charges a fee.

Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

The guardianship filing fees CANNOT be deducted from the individual's income.

c. Special Earnings Allowance

Deduct a special earnings allowance if the patient participates in a work program as part of treatment. The special earnings allowance is deducted from earned income only. Deduct:

- the first $75 of gross monthly earnings, PLUS
- ½ the remaining gross earnings,
- up to a maximum of $190 per month.

The special earnings allowance cannot exceed $190 per month.

d. Example - Facility Care Personal Needs Allowance

EXAMPLE #18: A patient in the nursing facility is employed as a telephone salesperson as part of his plan of care in the facility. He has a legally appointed conservator who charges a 2% fee. His only income is gross earnings of $875 per month. His special earnings allowance is calculated first:

$875 gross earned income
- 75 first $75 per month
800 remainder
÷ 2
400 ½ remainder
+ 75 first $75 per month
$475 which is > $190

His personal needs allowance is calculated as follows:

$ 40.00 basic personal needs allowance
+190.00 special earnings allowance
+ 17.50 guardianship fee (2% of $875)
$247.50 personal needs allowance

2. Medicaid CBC Waiver Services and PACE

a. Basic Maintenance Allowance

Deduct the appropriate maintenance allowance for one person as follows:

1) For the Elderly or Disabled with Consumer Direction Waiver (EDCD Waiver), Intellectual Disabilities/Mental Retardation (ID/MR) Waiver, Technology-Assisted Individuals Waiver, Individual and Family Developmental Disabilities Support (DD) Waiver, Day Support (DS) Waiver or PACE:

- January 1, *2011* through December 31, *2011*: $1,112 (no change for *2011*).

- January 1, 2010 through December 31, 2010: $1,112.

Contact a Medical Assistance Program Consultant for the SSI amount in effect for years prior to *2010*.

2) For the AIDS Waiver: the personal maintenance allowance is equal to 300% of the SSI limit for one person ($2,022 *in 2011*).

b. Guardian Fee

Deduct the actual fee a guardian or conservator charges, up to a maximum of 5% of the patient's actual gross income (including amounts not counted as income and excluded amounts) for guardianship fees, IF:

- the patient has a legally appointed guardian or conservator AND
- the guardian or conservator charges a fee.

Document how you determined that the guardian/conservator charges a fee and the amount of the fee.

NOTE: The guardianship filing fees CANNOT be deducted from the individual's income.

c. Special Earnings Allowance For EDCD, DD, DS and ID/MR Waivers

[EXAMPLE #19 was deleted]

For EDCD, DD, DS and ID/MR Waivers, deduct the following special earnings allowance if the patient is working (the work does NOT have to be part of treatment). The special earnings allowance is deducted from earned income only. Deduct:

1) for individuals employed 20 hours or more per week, all earned income up to 300% of SSI ($2,022 in *2011*) per month.

2) for individuals employed at least 8 but less than 20 hours per week, all earned income up to 200% of SSI ($1,348 in *2011*) per month.

The total of the basic maintenance allowance, the guardianship fee and the special earnings allowance cannot exceed 300% SSI.

EXAMPLE #20: (Using January 2000 figures)

A working patient in the *ID/*MR Waiver is employed 18 hours per week. He has gross earnings of $928.80 per month and SS of $300 monthly. His special earnings allowance is calculated first:

$ 928.80	gross earned income
- 1,024.00	200% SSI maximum
$ 0	remainder

$928.80 = special earnings allowance

His personal maintenance allowance is calculated as follows:

$ 512.00	maintenance allowance
+ 928.80	special earnings allowance
$1,440.80	personal maintenance allowance

D. Community Spouse Monthly Income Allowance

The community spouse monthly income allowance is the difference between the community spouse's gross monthly income and the minimum monthly maintenance needs allowance determined below.

1. Determine Minimum Monthly Maintenance Needs Allowance (MMMNA)

Calculate the minimum monthly maintenance needs allowance using the following procedures **(do NOT round any cents to a dollar)**:

a. the monthly maintenance needs standard, plus

b. an excess shelter allowance for the community spouse's principal place of residence, if applicable. The excess shelter allowance is the amount by which the total of verified allowable expenses in 1) through 5) below **exceeds** the excess shelter standard.

Allowable expenses are:

1) rent,
2) mortgage (including interest and principal),
3) taxes and insurance,
4) any maintenance charge for a condominium or cooperative, and
5) the utility standard deduction, unless utilities are included in the community spouse's rent or maintenance charges.

The utility standard deduction for a household of 1-3 members is different than the deduction for households of 4 or more members.

2. Maximum Allowance

The minimum monthly maintenance needs allowance calculated above cannot exceed the maximum.

3. DMAS Hearing Officer or Court Ordered Amount

The Eligibility Worker has no flexibility to calculate a minimum monthly maintenance needs allowance greater than the one calculated using the steps listed above. If the individual states there is a need for a greater amount, he has the right to file an appeal using the procedures in chapter M16. A Hearing Officer may increase the community spouse income allowance if it is determined that exceptional circumstances resulting in extreme financial duress exist. If the individual disagrees with the outcome of the appeal, he may then appeal the decision through his local circuit court.

The EW cannot accept a court order for a greater community spouse allowance unless the individual has exhausted the Medicaid administrative appeals process.

4. Calculate Community Spouse Monthly Income Allowance

If no court order or DMAS Hearing Officer determination of the monthly maintenance needs allowance exists, use the following procedures to calculate the community spouse monthly income allowance:

a. Determine Gross Monthly Income

Determine the community spouse's gross monthly income using the income policy in section M1480.310. Do not count any payment that is made to the community spouse by the institutionalized spouse, such as the community spouse's portion of an augmented VA benefit which is included in the institutionalized spouse's VA check. This amount will be counted in the institutionalized spouse's income.

b. Subtract From MMMNA

Subtract the community spouse's gross income from the minimum monthly maintenance needs allowance from D.1. above. **Do NOT round any cents to a dollar.** The remainder is the community spouse monthly income allowance (a negative number equals $0).

c. Remainder Greater Than $0

If the remainder is greater than $0, the remainder is the amount of the community spouse monthly income allowance that is deducted from the institutionalized spouse's patient pay.

d. Remainder Less Than or Equal To $0

If the remainder is $0 or less, the community spouse monthly income allowance is $0.

5. Deduct From Patient Pay

Deduct the community spouse monthly income allowance determined above from the institutionalized spouse's patient pay income UNLESS the institutionalized spouse or his authorized representative does not actually make it available to the community spouse or to another person for the benefit of the community spouse.

6. Example--Allowance Not Deducted

EXAMPLE #21: (Using January 2000 figures)
A community spouse has $800 per month gross income; $600 from Civil Service and $200 VA pension. The community spouse's shelter expenses are: mortgage, taxes, and insurance of $439 per month, plus the standard utility allowance of $168 for a household of one person, totaling $607. Total shelter costs of $607 exceed the excess shelter standard of $415 by $192. The excess shelter allowance is $192.

The minimum monthly maintenance needs allowance (MMMNA) is determined as follows:

$1,383.00	monthly maintenance needs standard
+ 192.00	excess shelter allowance
$ 1,575.00	MMMNA (less than maximum)

The community spouse monthly income allowance is calculated:

$1,575.00	MMMNA
- 800.00	community spouse's monthly gross income
$ 775.00	community spouse monthly income allowance

The institutionalized spouse has monthly income of $1,100. However, he refuses to give the monthly income allowance to his spouse at home; therefore, the community spouse monthly income allowance cannot be deducted. His patient pay is calculated:

$1,100	gross income
- 30	personal needs allowance
$1,070	patient pay

7. Example--Allowance Deducted

EXAMPLE #22: (Using January 2000 figures)
A community spouse has $900 per month gross income from Social Security. The community spouse's shelter expenses are: mortgage, taxes, and insurance of $502 per month, plus the standard utility allowance of $168 for a household of one person, totaling $670. Total shelter costs of $670 exceed $415 by $255. The excess shelter allowance is $255.

The minimum monthly maintenance needs allowance (MMMNA) is determined as follows:

$1,383	monthly maintenance needs standard
+ 255	excess shelter allowance
$1,638	MMMNA

The community spouse monthly income allowance is calculated:

$1,638	MMMNA
- 900	community spouse's gross income
$ 738	community spouse monthly income allowance

The institutionalized spouse has monthly income of $700. He agrees to give the monthly income allowance to his spouse at home; therefore, the community spouse monthly income allowance is deducted. His patient pay is calculated:

$700	gross patient pay income
- 30	personal needs allowance
$670	remainder
- 670	community spouse income allowance
$ 0	patient pay

NOTE: The community spouse monthly income allowance of $738 is greater than the income remaining after the personal needs allowance is deducted, so only $670 is deducted from patient pay for the community spouse monthly income allowance.

E. Family Member's Income Allowance

To be eligible for a family member's income allowance, the family member (as defined in section M1480.010) must live with the community spouse.

1. Minor Child NOT Living With Community Spouse

If an institutionalized spouse has a minor child who is **not** living with the community spouse, **no allowance** is calculated for that child and no deduction from the institutionalized spouse's income is made for that child.

2. Family Member Income Allowance Deductions

The family member income allowance is an amount equal to 1/3 of the amount by which the monthly maintenance needs standard exceeds the amount of the family member's gross monthly income: (maintenance needs standard - family member's income) ÷ 3 = family member's income allowance.

First, deduct the allowance(s) for minor child(ren) living with the community spouse in the home. Deduct other family members' allowances from patient pay after deducting the minor child(ren)'s allowance(s).

3. Calculate Family Member's Allowance

Calculate each family member's allowance as follows:

a. Subtract the family member's gross monthly income from the monthly maintenance needs standard. If the remainder is $0 or less, STOP. The family member is not entitled to an allowance.

b. Divide the remainder by 3.

c. The result is the family member's monthly income allowance. Do NOT round any cents to a dollar.

4. Deduct Family Member's Allowance

Deduct the family member(s)' monthly income allowance(s) from the institutionalized spouse's patient pay income. Do NOT deduct the family member's allowance if the family member does not accept the allowance.

5. Example--Family Member's Allowance

EXAMPLE #23: (Using July 2000 figures)
The couple's minor child lives with the community spouse. The child has no income. The child's family member maintenance allowance is 1/3 of $1,406.25 which is *$468.75*.

The community spouse's father lives with the community spouse and receives $300 per month SSA, which is his only income. The monthly family member allowance for the father is calculated as follows:

$1,406.25	monthly maintenance needs standard
- 300.00	father's income
$1,106.25	remainder
÷ 3	(divide by 3)
$ 368.75	family member maintenance allowance for father

The institutionalized spouse's income is $1,200. The community spouse has no community spouse monthly income allowance in this example, so the institutionalized spouse's patient pay is calculated as follows:

$1,200.00	institutionalized spouse's patient pay income
- 30.00	personal needs allowance
1,170.00	
- 468.75	child's family member's income allowance
701.25	
- 368.75	father's family member's income allowance
$ 332.50	patient pay

F. Noncovered Medical Expenses

Incurred medical and remedial care expenses recognized under State law, but not covered under the Medicaid State Plan and not subject to third party payment are deducted from patient pay after all allowances are deducted.

See section M1470.230 for facility patients, section M1470.430 for Medicaid CBC waiver patients *or section M1470.530 for PACE recipients* for specific instructions in determining allowable noncovered medical expense deductions from patient pay.

G. Home Maintenance Deduction

A married institutionalized individual with a community spouse living in the home is **NOT allowed** the home maintenance deduction, because the community spouse allowance provides for the home maintenance, **UNLESS**:

- the community spouse is not living in the home (e.g., the community spouse is in an ACR), AND
- the institutionalized spouse still needs to maintain their former home.

H. Patient Pay

Compare the **remaining income** (patient pay gross monthly income minus allowable deductions) to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.

I. Example--300% SSI Group Patient Pay

EXAMPLE #25: (Using July 2000 figures)

Mrs. Bay is a disabled institutionalized spouse who first applied for Medicaid for long term care services in July. She was admitted to the facility in June, but she is not eligible for Medicaid in the retroactive months because of excess resources. She has a monthly SSA benefit of $1,000 and a monthly private pension payment of $400. She has Medicare Parts A & B and private Medicare supplement health insurance which costs $75 per month. Her spouse, Mr. Bay, still lives in their Group II home with their dependent son, age 19 years. Mr. Bay has income of $1,500 per month from CSA. Their son has no income. Mrs. Bay's income is less than the CNNMP 300% SSI income limit, so she is eligible for ongoing Medicaid coverage beginning July 1. She is enrolled in Medicaid in AC 060.

Her patient pay for July and subsequent months is determined. The community spouse monthly income allowance is calculated first:

$1,406.25	monthly maintenance needs standard
+ 200.00	excess shelter allowance
1,606.25	MMMNA (minimum monthly maintenance needs allowance)
-1,500.00	community spouse's gross income
$ 106.25	community spouse monthly income allowance

The family member monthly income allowance for their son is calculated:

$1,406.25	monthly maintenance needs standard
- 0	son's income
1,406.25	amount by which the standard exceeds the son's income
÷ 3	
$ 468.75	family member's monthly income allowance

Mrs. Bay has old bills totaling $200, dated the prior January. She has no noncovered expenses from the retroactive period because she paid the nursing facility in full through June. She is eligible in the CNNMP 300% SSI group and is not a QMB; therefore, her Medicare premium is deducted from her patient pay for the first two months of Medicaid coverage (July and August). Her patient pay for July is calculated as follows:

$1,000.00	SSA
+ 400.00	private pension
1,400.00	total gross income

1,400.00	total gross income
- 30.00	PNA (personal needs allowance)
-106.25	community spouse monthly income allowance
-468.75	family member's monthly income allowance
795.00	
-120.50	Medicare premium & health insurance premium
-200.00	old bills
$474.50	remaining income for patient pay (July)

Her patient pay for August is calculated as follows:

$1,000.00	SS
+ 400.00	private pension
1,400.00	total gross income
- 30.00	PNA (personal needs allowance)
- 106.25	community spouse monthly income allowance
- 468.75	family member's monthly income allowance
795.00	
- 120.50	Medicare premium & health insurance premium
$ 674.50	remaining income for patient pay (August)

Mrs. Bay's patient pay for September is calculated as follows:

$1,000.00	SS
+ 400.00	private pension
1,400.00	total gross income
- 30.00	PNA (personal needs allowance)
- 106.25	community spouse monthly income allowance
- 468.75	family member's monthly income allowance
795.00	
- 75.00	health insurance premium
$ 720.00	remaining income for patient pay (September)

The worker completes *the MMIS Patient Pay process* for July, August and September. *MMIS generates and* sends a "Notice of Obligation" to Mr. Bay showing Mrs. Bay's patient pay for July, August and September and each month's patient pay calculation.

M1480.440 MEDICALLY NEEDY PATIENT PAY

A. Policy

When an institutionalized spouse has income exceeding 300% of the SSI payment level for one person, he is classified as medically needy (MN) for income eligibility determination. Because the 300% SSI income limit is higher than the MN income limits, an institutionalized spouse whose income exceeds the 300% SSI limit will be on a spenddown. He must meet the spenddown liability to be eligible for Medicaid as MN. See sections M1480.330, 340 and 350 above to determine countable income, the spenddown liability, and to determine when an institutionalized spouse's spenddown is met.

Section 1924 (d) of the Social Security Act contains rules which protect portions of an institutionalized spouse's income from being used to pay for the cost of institutional care. Protection of this income is intended to avoid the impoverishment of a community spouse. In order to insure that an institutionalized spouse will have enough income for his personal needs or maintenance allowance, the community spouse income allowance and the family members' income allowance, an institutionalized spouse who meets a spenddown is granted a full month's eligibility. The spenddown

determinations are made monthly, retrospectively, after the month has passed and the expenses have actually been incurred. An institutionalized spouse's resources and income must be verified each month before determining if the spenddown has been met. When the spenddown is met, an institutionalized spouse's patient pay for the month is calculated.

1. Patient Pay Deductions

Medicaid must assure that enough of an institutionalized spouse's income is "protected" for his personal needs, the community spouse and family member's income allowances, and noncovered medical expenses, NOT including the facility, CBC or PACE cost of care.

2. When Patient Pay Is Not Required

Intermediate Care Facility for the Mentally Retarded (ICF-MR) and Institution for Mental Diseases (IMD) services are not covered for medically needy (MN) eligible recipients. Therefore, a patient pay determination is not required when a MN enrolled recipient resides in an IMD or ICF-MR.

B. Patient Pay Procedures

Determine an MN institutionalized spouse's patient pay using the policy and procedures in the sections below:

- Facility Patient Pay - Spenddown Liability Less Than or Equal to Medicaid Rate (section M1480.450)
- Facility Patient Pay - Spenddown Liability Greater Than Medicaid Rate (section M1480.460)
- CBC - MN Institutionalized Spouse Patient Pay (section M1480.470)
- PACE - MN Institutionalized Spouse Patient Pay (section M1480.480).

M1480.450 FACILITY PATIENT PAY - SPENDDOWN LIABILITY LESS THAN OR EQUAL TO MEDICAID RATE

A. Policy

An MN institutionalized spouse in a facility whose spenddown liability is less than or equal to the Medicaid rate is eligible for a full month's Medicaid coverage effective the first day of the month, based on the projected Medicaid rate for the month. Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay his community spouse and family member allowances, and his personal needs and noncovered expenses not used to meet the spenddown. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability to the provider.

B. Procedures

Determine patient pay for the month in which the spenddown is met using the procedures below.

1. Patient Pay Gross Monthly Income

Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).

2. Subtract Patient Pay Deductions

Subtract the following from the patient pay gross monthly income in the following order as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

a. a personal needs allowance (per section M1480.430 C.),

b. a community spouse monthly income allowance, if appropriate (per section M1480.430 D.),

c. a family member's income allowance, if appropriate (per section M1480.430 E.),

d. any allowable noncovered medical expenses (per section M1470.230) **including** any old bills and carry-over expenses,

e. a home maintenance deduction, if appropriate (per section M1480.430 G.).

The result is the **remaining income** for patient pay.

3. Patient Pay

Compare the remaining income for patient pay to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Example—Facility Spenddown Liability Less Than Medicaid Rate, Community Spouse Allowance

EXAMPLE #24: (Using July 2000 figures)
Mr. Hay is an institutionalized spouse who applied for Medicaid in July. He was admitted to the facility the prior November. He has a monthly CSA benefit of $1,700 and a monthly Seminole Indian payment of $235. He has Medicare Parts A & B and Federal Employees Health Insurance which costs $75 per month. He last lived outside the facility in a Group III locality. His wife, Mrs. Hay, still lives in their home; she has income of $500 per month from CSA. They have no dependent family members living with Mrs. Hay. Mr. Hay's total income exceeds the CNNMP 300% of SSI income limit. His MN eligibility is determined for July. The MN determination results in a monthly spenddown liability of $1,355:

$1,700	monthly MN income (Seminole Indian payment excluded)
- 20	exclusion
1,680	countable MN income
- 325	MN limit for 1 (Group III)
$1,355	spenddown liability for month

The facility's Medicaid rate is $45 per day, or $1,395 for a 31-day month. By projecting the month's cost of facility care, Mr. Hay meets his spenddown effective the first day of the month and is eligible for Medicaid effective July 1. He is enrolled in Medicaid effective July 1 in AC 018.

The community spouse monthly income allowance is calculated:

$1,406.25	monthly maintenance needs standard
+ 0	no excess shelter allowance
1,406.25	MMMNA (minimum monthly maintenance needs allowance)
- 500.00	community spouse's gross income
$ 906.25	community spouse monthly income allowance

His patient pay is calculated as follows:

$1,700.00	CSA
+ 235.00	Seminole Indian payment (counted for patient pay)
1,935.00	total patient pay gross income
- 30.00	PNA (personal needs allowance)
- 906.25	community spouse monthly income allowance
998.75	
- 45.50	Medicare premium (not paid by Medicaid)
- 75.00	health insurance premium
$ 878.25	remaining income for patient pay (July)

The facility's Medicaid rate for July is $1,395. Because Mr. Hay's remaining income for patient pay is less than the Medicaid rate for July, his patient pay for July is $878.25. From his July income of $1,935, Mr. Hay must pay $878.25 patient pay to the facility, leaving him $1,056.75 from which he can pay the community spouse income allowance of $906.25, his personal needs allowance of $30 and his Medicare and health insurance premiums of $120.50 (total of $1,056.75). Medicaid will pay $476.75 of his spenddown liability ($1,355 spenddown liability - 878.25 patient pay = $476.75). **This is allowed under section 1924 of the Social Security Act (Special Treatment For Married Institutionalized Spouses).**

D. Example-Facility Spenddown Liability Less Than Facility Rate, Community Spouse & Family Member Allowance

EXAMPLE #25: (Using July 2000 figures)
Mrs. Zee is a disabled institutionalized spouse who applied for Medicaid for long term care services in July. She was admitted to the facility in June, but she is not eligible for Medicaid in the retroactive month because of excess resources. She has a monthly SSA benefit of $1,200 and a monthly private pension payment of $600. She has Medicare Parts A & B and private Medicare supplement health insurance which costs $75 per month. Her spouse, Mr. Zee, still lives in their Group II home with their dependent son, age 19 years. Mr. Zee has income of $1,500 per month from CSA. Their son has no income. Mrs. Zee's income exceeds the CNNMP 300% SSI income limit. Her MN eligibility is determined for July. She has old bills totaling $300 dated the prior January. The MN determination results in a spenddown liability of $1,530:

$1,200.00	SSA
+ 600.00	monthly private pension
1,800.00	total monthly income
- 20.00	exclusion
1,780.00	countable MN income
- 250.00	MN limit for 1 (Group II)
$1,530.00	spenddown liability for July

The facility's Medicaid rate is $55 per day, or $1,705 for the month. By projecting the month's cost of facility care, she meets the spenddown effective the first day of the month. Mrs. Zee is eligible for Medicaid, effective July 1. She is enrolled in Medicaid in AC 058.

The community spouse monthly income allowance is calculated:

$1,406.25	monthly maintenance needs standard
+ 200.00	excess shelter allowance
1,606.25	MMMNA (minimum monthly maintenance needs allowance)
- 1,500.00	community spouse's gross income
106.25	community spouse monthly income allowance

The family member monthly income allowance for their son is calculated:

$1,406.25	monthly maintenance needs standard
- 0	son's income
1,406.25	amount by which the standard exceeds the son's income
÷ 3	
468.75	family member's monthly income allowance

Her patient pay for July is calculated as follows:

$1,200.00	SSA
+ 600.00	private pension
1,800.00	total gross income
- 30.00	PNA (personal needs allowance)
- 106.25	community spouse monthly income allowance
- 468.75	family member's monthly income allowance
1,195.00	
- 120.50	Medicare premium & health insurance premium
- 300.00	old bills
$ 774.50	remaining income for patient pay (July)

The facility's Medicaid rate for July is $1,705. Because Mrs. Zee's remaining income for patient pay is less than the Medicaid rate, her patient pay for July is $774.50. From her July income of $1,800, she must pay $774.50 to the facility, leaving her $1025.50 left to pay her personal needs, community spouse and family member's monthly income allowances, the old

bills and her medical insurance premiums, totaling $1025.50. Medicaid will pay $755.50 of her spenddown liability ($1,530 spenddown liability - 774.50 patient pay = $755.50). This is allowed under section 1924 of the Social Security Act (Special Treatment For Married Institutionalized Spouses).

M1480.460 FACILITY PATIENT PAY - SPENDDOWN LIABILITY GREATER THAN MEDICAID RATE

A. Policy

An MN facility institutionalized spouse whose spenddown liability is greater than the Medicaid rate is not eligible for Medicaid unless he incurs additional medical expenses that meet the spenddown liability within the month. If he meets the spenddown liability, his Medicaid coverage begins the first day of the month in which the spenddown is met, and ends on the last day of that month. A patient pay for the month is calculated.

Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay his personal needs, community spouse and family member allowances, and noncovered expenses. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability. Payment of part or all of the spenddown liability is permitted under Section 1924 (d) of the Social Security Act.

B. Procedures

The institutionalized spouse's spenddown eligibility was determined in section M1480.340 above. Because he met the spenddown in the month, he is enrolled in a closed period of coverage for the full month. His patient pay for the month must be determined using the procedures below.

1. Calculate Remaining Income for Patient Pay

a. Determine Gross Monthly Patient Pay Income

Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).

b. Subtract Allowable Deductions

Deduct the following from the patient pay gross monthly income, in the following order as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

1) a personal needs allowance (per section M1480.430 C.),

2) a community spouse monthly income allowance, if appropriate (per section M1480.430 D.),

3) a family member's monthly income allowance, if appropriate (per section M1480.430 E.),

4) allowable noncovered medical expenses (per section M1470.230) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of the facility care, and

5) a home maintenance deduction, if appropriate (per section M1480.430 G.).

The result is the **remaining income** for patient pay.

2. Patient Pay

Compare the remaining income for patient pay to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Example--Facility Spenddown Liability Greater Than Medicaid Rate, Less Than Private Cost of Care

EXAMPLE #26: (Using July 2000 figures)
Mr. L is an institutionalized spouse who applied for Medicaid in July. He was admitted to the facility the prior December. He has a monthly CSA benefit of $1,900 and a monthly Seminole Indian payment of $200. He has Medicare Parts A & B and Federal Employees Health Insurance which costs him $75 per month. He last lived outside the facility in a Group III locality.

His wife, Mrs. L, still lives in their home with their dependent child age 20 years. Mrs. L has income of $500 per month from CSA. Their child has no income. Mr. L's income exceeds the CNNMP 300% SSI income limit. His MN eligibility is determined for July. The MN determination results in a spenddown liability of $1,555:

$1,900	monthly MN income (Seminole Indian payment excluded)
- 20	exclusion
1,880	countable MN income
- 325	MN limit for 1 (Group III)
$1,555	spenddown liability for month

The facility's Medicaid rate is $45 per day, or $1,395 for a month. The private pay rate is $80 per day. By projecting the month's Medicaid rate, he does not meet his spenddown in July. He has no old bills. He is placed on a monthly spenddown of $1,555 for each month in the 12-month certification period beginning July 1.

On July 31, he submits expenses for July. The worker verifies that his resources were below the limit in July. His spenddown liability of $1,555 is compared to $2,480, the private rate for July ($80 per diem x 31 days). Because the private cost of care for July is greater than his spenddown liability for July, he met his spenddown in July. He is eligible for the full month of July. On August 1, the worker enrolls him in Medicaid with coverage beginning July 1 and ending July 31.

His patient pay is determined. The community spouse and family member allowances are calculated first:

$1,406.25	monthly maintenance needs standard
+ 0	no excess shelter allowance
1,406.25	MMMNA (minimum monthly maintenance needs allowance)
- 500.00	community spouse's gross income
$ 906.25	community spouse monthly income allowance

$1,406.25	monthly maintenance needs standard
- 0	child's income
1,406.25	amount by which standard exceeds child's income
÷ 3	
$ 468.75	child's family member monthly income allowance

$1,900.00	CSA income
+ 200.00	Seminole Indian payment (not excluded for patient pay)
2,100.00	total patient pay gross income
- 30.00	personal needs allowance
- 906.25	community spouse monthly income allowance
- 468.75	family member allowance
695.00	
- 45.50	noncovered Medicare Part B premium
- 75.00	noncovered health insurance premium
$ 574.50	remaining income (July)

The facility's Medicaid rate for July is $1,395. Because Mr. L's remaining income for patient pay is less than the Medicaid rate for July, his patient pay for July is $574.50.

From his July income of $2,100, he must pay the patient pay of $574.50. He has $1,525.50 left with which to meet his personal needs ($30), pay the community spouse and family member allowances, and pay his Medicare and health insurance premiums, a total of $1,525.50. In accordance with Section 1924 of the Social Security Act, Medicaid will assume responsibility for $980.50 of his spenddown liability ($1,555 - 574.50 patient pay = $980.50).

D. Example—Facility Spenddown Liability Greater Than Medicaid Rate and Private Cost of Care

EXAMPLE #27: (Using July 2000 figures)
Mrs. Bee is an institutionalized individual who files an initial application for Medicaid on July 6. She has a monthly SSA benefit of $2,000 and a monthly private pension payment of $500. She has Medicare Parts A & B and private Medicare supplement health insurance which costs her $100 per month. Mrs. Bee last resided outside the facility in a Group II locality. Her spouse, Mr. Bee, still lives in their home. He has income of $1,800 per month from CSA. Mrs. Bee's income exceeds the CNNMP 300% SSI income limit.

Her MN eligibility is determined for July. The MN determination results in a spenddown liability of $2,230:

$2,000.00	SSA
+ 500.00	monthly private pension
2,500.00	total monthly income
- 20.00	exclusion
2,480.00	countable MN income
- 250.00	MN limit for 1 (Group II)
$2,230.00	spenddown liability for month

The facility's Medicaid rate is $55 per day, or $1,705 for a month. By projecting the month's Medicaid rate, she does not meet her spenddown. She is placed on a monthly spenddown for each month in the 12-month certification period beginning July 1. On August 2, she submits expenses for July. The private facility rate is $70 per day, or $2,170 for July (31 days). The private cost of care, $2,170, is less than her spenddown liability of $2,230. Therefore, the worker must complete a day by day calculation to determine Mrs. Bee's spenddown eligibility for July:

$2,230.00	spenddown liability 7-1
- 140.00	private pay rate for 7-1 & 7-2 @ $70 per day.
2,090.00	spenddown balance on 7-3
- 145.50	45.50 Medicare + 100.00 health ins. premium paid 7-3
- 1,890.00	private pay for 27 days @ $70 per day 7-3 through 7-29
54.50	spenddown liability balance at beginning of 7-30
- 70.00	private pay for 7-30
$ 0	spenddown met on 7-30

Mrs. Bee met her spenddown on July 30. On August 3, the worker enrolls her in Medicaid with a begin date of July 1 and end date of July 31. To determine her patient pay, the community spouse monthly income allowance is calculated:

$1,406.25	monthly maintenance needs standard
+ 525.00	excess shelter allowance
1,931.25	MMMNA (minimum monthly maintenance needs allowance
- 1,800.00	community spouse's gross income
$ 131.25	community spouse allowance

Mrs. Bee's patient pay for July is calculated as follows:

$2,000.00	SSA
+ 500.00	private pension
2,500.00	gross patient pay income
- 30.00	personal needs allowance
- 131.25	community spouse allowance
2,338.75	
- 145.50	noncovered Medicare & health ins. premium
$2,193.25	remaining income (July)

Mrs. Bee's remaining income for patient pay in July is $2,193.25, which is greater than the Medicaid rate for of July $1,705. The facility can only collect the Medicaid rate; therefore, her patient pay for July is the Medicaid rate of $1,705.

From her July income of $2,500, she must pay the Medicaid rate of $1,705. Medicaid will not pay for any of her facility care in July because she is responsible for the whole Medicaid rate; Medicaid will cover all other medical services except her Medicare & health insurance premiums. She has $795 left with which to meet her personal needs ($30), pay the community spouse allowance, and pay her Medicare and health insurance premiums, a total of $306.75. She has $488.25 left from her July income. Medicaid will assume responsibility for $525 of her spenddown liability ($2,230 - 1,705 Medicaid rate = $525).

Since Mrs. Bee paid the private rate of $2,170 to the facility in July, the facility is responsible to reimburse her for the difference between the private rate and the Medicaid rate ($465). On August 25, she requests evaluation of her spenddown for August. She was reimbursed $465 on August 20, which was deposited into her patient fund account. The worker verifies that her resources exceed the Medicaid resource limit in August. The worker sends her a notice denying Medicaid for August because of excess resources, and stating that she must reapply for Medicaid if she reduces her resources and wants to be placed on spenddown again.

M1480.470 CBC - MN INSTITUTIONALIZED SPOUSE PATIENT PAY

A. Policy

When the Medicaid community-based care (CBC) institutionalized spouse has been screened and approved for waiver services and has **income less than or equal to 300% of the SSI income limit** for one person, he is eligible for Medicaid as CNNMP and entitled to Medicaid for full-month, ongoing Medicaid coverage.

An institutionalized spouse who is screened and approved for waiver services, and whose income **exceeds the CNNMP 300% SSI income limit**, is placed on a monthly spenddown. **The monthly CBC costs cannot be projected** for the spenddown budget period. The CBC costs, along with any other spenddown deductions, are deducted daily and chronologically as the costs are incurred. If the spenddown is met any day in the month, Medicaid coverage begins the first day of the month in which the spenddown is met, and ends on the last day of that month. A patient pay for the month is calculated.

Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay his personal needs, community spouse and family member allowances, and noncovered expenses. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability. Payment of part or all of the spenddown liability is permitted under Section 1924 (d) of the Social Security Act.

B. Procedures

The institutionalized spouse's spenddown eligibility was determined in section M1480.340 above. Because he met the spenddown in the month, he is enrolled in a closed period of coverage for the full month. His patient pay for the month must be determined for the month using the procedures below.

1. Calculate Available Income for Patient Pay

a. Determine Gross Monthly Patient Pay Income

Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).

b. Subtract Allowable Deductions

Deduct the following from the patient pay gross monthly income, in the following order as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

1) a personal maintenance allowance (per section M1480.430 C.),

2) a community spouse monthly income allowance, if *any* (per section M1480.430 D.),

3) a family member's monthly income allowance, if *any* (per section M1480.430 E.),

4) *any* allowable noncovered medical expenses (per section M1470.430) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of the community-based care.

5) a home maintenance deduction, if *any* (per section M1480.430 G.).

The result is the **remaining income** for patient pay.

2. Patient Pay

Compare the remaining income for patient pay to the Medicaid rate for the month. The patient pay is the lesser of the two amounts.

C. Example--CBC Institutionalized Spouse on Spenddown

EXAMPLE #28: (Using July 2000 figures)
Mr. T is an institutionalized spouse who applied for Medicaid in July. He was screened and approved for Medicaid E & D waiver services on July 1, and began receiving those services on that date. He has a monthly CSA benefit of $1,900 and a monthly Japanese-American Restitution payment of $200. He has Medicare Parts A & B and Federal Employees Health Insurance which costs him $75 per month. He last lived outside the facility in a Group III locality.

His wife, Mrs. T, lives in their home with Mr. T and their dependent child age 18 years. Mrs. T has income of $500 per month from CSA. Their child has no income. Mr. T's income exceeds the CNNMP 300% of SSI income limit. His MN eligibility is determined for July. The MN determination results in a spenddown liability of $1,555:

$1,900	monthly MN income (Japanese-American Restitution payment excluded)
- 20	exclusion
1,880	countable MN income
- 325	MN limit for 1 (Group III)
$ 1,555	spenddown liability for month

He has no old bills. He is placed on a monthly spenddown of $1,555 for each month in the 12-month certification period beginning July 1.

On July 31, he submits expenses for July. The worker verifies that his resources were below the limit in July. His spenddown liability of $1,555 is compared to $2,400, the total private rate for July ($16 per hour private rate x 5 hours per day x 31 days = $2,480). Because the private cost of CBC care for July is greater than his spenddown liability for July, he met his spenddown in July. He is eligible for the full month of July. On August 1, the worker enrolls him in Medicaid beginning July 1 and ending July 31.

His patient pay is then calculated. The community spouse and family member allowances are calculated first:

$1,406.25	monthly maintenance needs standard
+ 0	no excess shelter allowance
1,406.25	MMMNA (minimum monthly maintenance needs allowance)
- 500.00	community spouse's gross income
906.25	community spouse monthly income allowance

$1,406.25	monthly maintenance needs standard
- 0	child's income
1,406.25	amount by which standard exceeds child's income
÷ 3	
$ 468.75	family member monthly income allowance

$1,900.00	CSA income
+ 200.00	Japanese-American Restitution payment (not excluded for patient pay)
2,100.00	total patient pay gross income
- 512.00	personal maintenance allowance
- 906.25	community spouse monthly income allowance
- 468.75	family member allowance
213.00	
- 45.50	noncovered Medicare Part B premium
- 75.00	noncovered health insurance premium
$ 92.50	remaining income for patient pay

The CBC provider's Medicaid rate is $9.50 per hour, 5 hours per day or $47.50 per day, a total of $1,472.50 for July (31 days). Because Mr. T's remaining income is less than the Medicaid rate, his patient pay for July is $92.50.

From his July income of $2,100, Mr. T must pay the patient pay of $92.50. He has $2,007.50 left with which to meet his maintenance needs ($512), pay the community spouse and family member allowances, and pay his Medicare and health insurance premiums, a total of $2,007.50. In accordance with Section 1924 of the Social Security Act, Medicaid will assume responsibility for $1,462.50 of his spenddown liability ($1,555 - 92.50 patient pay = $1,462.50). Because he paid all of his income to the CBC provider in July, his resources are within the limit in August.

D. Example-CBC Institutionalized Spouse on Spenddown

EXAMPLE #29: (Using July 2000 figures)

Mrs. Bly is an aged individual who files an initial application for Medicaid on July 1. She was screened and approved for Medicaid E & D waiver services on July 1, and began receiving those services on July 1. She has a monthly SSA benefit of $2,000 and a monthly private pension payment of $500. She has Medicare Parts A & B and private Medicare supplement health insurance which costs her $100 per month. Mrs. Bly resides in a Group II locality. Her spouse, Mr. Bly, lives with her in their home. He has income of $1,800 per month from CSA. Mrs. Bly's income exceeds the CNNMP 300% of SSI income limit.

Her MN eligibility is determined for July. The MN determination results in a spenddown liability of $2,230:

$2,000.00	SSA
+ 500.00	monthly private pension
2,500.00	total monthly income
- 20.00	exclusion
2,480.00	countable MN income
- 250.00	MN limit for 1 (Group II)
$2,230.00	spenddown liability for month

She is placed on a monthly spenddown for each month in the 12-month certification period beginning July 1. On August 2, she submits expenses for July. The private CBC rate is $14 per hour, 5 hours per day or $70 per day, for a total of $2,170 for July (31 days). The private cost of care, $2,170, is less than her spenddown liability of $2,230. Therefore, the worker must complete a day-by-day calculation to determine Mrs. Bly's eligibility for July:

$2,230.00	spenddown liability 7-1
- 140.00	CBC private pay rate for 7-1 & 7-2 @ $70 per day.
2,090.00	spenddown balance on 7-3
- 145.50	45.50 Medicare + 100.00 health ins. premium paid 7-3
- 1,890.00	private pay for 27 days @ $70 per day 7-3 through 7-29
54.50	spenddown balance at beginning of 7-30
- 70.00	CBC private pay for 7-30
$ 0	spenddown met on 7-30

Mrs. Bly met her spenddown on July 30. On August 3, the worker enrolls her in Medicaid with the begin date of July 1 and end date July 31, application date July 1. To determine her patient pay, the community spouse monthly income allowance is calculated:

$1,406.25	monthly maintenance needs standard
+ 525.00	excess shelter allowance
1,931.25	MMMNA (minimum monthly maintenance needs allowance)
- 1,800.00	community spouse's gross income
$ 131.25	community spouse allowance

Mrs. Bly's patient pay for July is calculated as follows:

$2,000.00	SSA
+ 500.00	private pension
2,500.00	gross patient pay income
- 512.00	maintenance allowance
- 131.25	community spouse allowance
1,856.75	
- 145.50	noncovered 45.50 Medicare + 100.00 health ins. premium
$1,711.25	remaining income

Mrs. Bly's remaining income of $1,711.25 is greater than the Medicaid rate for July of $1,705, so her patient pay for July is the Medicaid rate of $1,705.

From her July income of $2,500, Mrs. Bly must pay the Medicaid rate of $1,705 to the CBC provider. Medicaid will not pay for any of her CBC care in July because she is responsible for the whole Medicaid rate; Medicaid will cover all other medical services except her Medicare & health insurance premiums. She has $795 left with which to meet her maintenance needs ($512), pay the community spouse allowance, and pay her Medicare and health insurance premiums, a total of $788.75. She has $6.25 left from her July income. Medicaid will assume responsibility for $525 of her spenddown liability ($2,230 - 1,705 patient pay = $525).

On August 25, she requests evaluation of her spenddown for August. She was reimbursed $465 on August 22 by the CBC provider, which was deposited into her bank account. The worker verifies that her resources exceed the Medicaid resource limit in August. The worker sends her a notice denying Medicaid for August because of excess resources, and stating that she must reapply for Medicaid if she reduces her resources and wants to be placed on spenddown again.

M1480.480 PACE – MN INSTITUTIONALIZED SPOUSE PATIENT PAY

A. Policy

An institutionalized spouse who is screened and approved for PACE services, and whose income exceeds the 300% SSI income limit, is placed on a monthly spenddown. The individual's spenddown liability and the PACE monthly rate (minus the Medicare Part D premium) establish whether the spenddown eligibility determination can be projected or must be determined retrospectively. The instructions for determining spenddown eligibility for MN institutionalized spouse PACE recipients are in M1480.340.

If the spenddown is met, Medicaid coverage begins the first day of the month in which the spenddown is met and a patient pay for the month is calculated. If spenddown eligibility is projected, the patient pay is not calculated monthly as long as the monthly PACE rate (minus the Medicare Part D premium), income and allowances remain the same. If spenddown eligibility is determined retrospectively, the patient pay is calculated month-by-month.

Medicaid must assure that enough of the institutionalized spouse's income is allowed so that the recipient can pay his personal needs, community spouse and family member allowances, and noncovered expenses. Therefore, Medicaid may pay some of the institutionalized spouse's spenddown liability. Payment of part or all of the spenddown liability is permitted under Section 1924 (d) of the Social Security Act.

B. Procedures

The institutionalized spouse's spenddown eligibility was determined in section M1480.340 above. His patient pay must be determined using the procedures below.

1. Calculate Available Income for Patient Pay

a. Determine Gross Monthly Patient Pay Income

Determine the institutionalized spouse's patient pay gross monthly income according to section M1480.330 (including any amounts excluded in determining MN countable income and the spenddown liability).

b. Subtract Allowable Deductions

Deduct the following from the patient pay gross monthly income, in the following order as long as the individual has income remaining for patient pay. If the individual has no remaining income, do not subtract further deductions.

1) a personal maintenance allowance (per section M1480.430 C.),

2) a community spouse monthly income allowance, if *any* (per section M1480.430 D.),

3) a family member's monthly income allowance, if *any* (per section M1480.430 E.),

4) *any* allowable noncovered medical expenses (per section M1470.530) including any old bills, carry-over expenses and other noncovered expenses that were used to meet the spenddown, but NOT including the cost of the community-based care.

5) a home maintenance deduction, if *any* (per section M1480.430 G.).

The result is the remaining income for patient pay.

2. Patient Pay Compare the remaining income for patient pay to the monthly PACE rate (minus the Medicare Part D premium) for the month. The patient pay is the lesser of the two amounts.

M1480.500 NOTICES AND APPEALS

M1480.510 NOTIFICATION

A. Notification Send written notices to the institutionalized spouse, the authorized representative and the community spouse advising them of:

- the action taken on the institutionalized spouse's Medicaid application and the reason(s) for the action;
- the resource determination, the income eligibility determination, and the patient pay income, spousal and family member allowances and other deductions used to calculate patient pay;
- the right to appeal the actions taken and the amounts calculated.

B. Forms to Use

1. Notice of Action on Medicaid (form #032-03-0008) The EW must send the "Notice of Action on Medicaid (Title XIX) and Children's Medical Security Insurance Plan (Title XXI Program)" to the applicant/recipient and the person who is authorized to conduct business for the applicant to notify him of the Agency's decision on the initial Medicaid application, and on a redetermination of eligibility when a recipient starts Medicaid-covered LTC services.

2. Notice of Obligation for Long-Term Care Costs The "Notice of Obligation for Long-term Care Costs" notifies the patient of the amount of patient pay responsibility. *The form is generated and sent by MMIS when the patient pay is used entered or changed.*

3. *Medicaid LTC Communi-cation Form (DMAS-225)* The *Medicaid Long-term Care (LTC) Communication Form (DMAS-225)* is used to facilitate communication between the local agency and the LTC services provider. The form may be initiated by the local agency or the provider. The form is available on *SPARK at: http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi*.

The DMAS-225:

- notifies the LTC provider of a patient's Medicaid eligibility status;
- reflects changes in the patient's level of care *or LTC provider;*
- documents admission or discharge of a patient to an institution or community-based care services, or death of a patient;
- provides other information known to the provider that might cause a change in eligibility status or patient pay amount.

Do not use the DMAS-225 to relay the patient pay amount. Providers will be able to access the patient pay amount via the verification systems available to providers.

a. When to Complete the DMAS-225

Complete the DMAS-225 at the time of eligibility determination and/or the recipient's entry into LTC. Complete a new DMAS-225 when the enrollee's eligibility status changes, such as when the recipient's Medicaid coverage is canceled or changed to limited coverage (e.g. QMB coverage).

When a change in LTC providers occurs, complete a new DMAS-225 advising the new provider of the enrollee's eligibility status and that patient pay information is available through the verification systems.

b. Where To Send the DMAS-225

Refer to M1410.300 B.3.b to determine where the form is to be sent.

4. Resource Assessment Forms

The forms used for a resource assessment when no Medicaid application is filed are described in section M1480.210 (above). The resource assessment form that is used with a Medicaid application is described in section M1480.220. Copies of the forms are included in Appendix 1 and Appendix 2 to this subchapter.

M1480.520 APPEALS

A. Client Appeals

The institutionalized spouse, the community spouse, or the authorized representative for either, has the right to appeal any action taken on a Medicaid application. The Medicaid client appeals process applies.

B. Appealable Issues

Any action taken on the individual's Medicaid **application** and receipt of Medicaid services may be appealed, including:

- spousal share determination,
- initial resource eligibility determination,
- spousal protected resource amount (PRA),
- resource redetermination,
- community spouse resource allowance (CSRA),
- income eligibility determination,
- patient pay and/or allowances calculations.

AGENCY USE ONLY	
COUNTY/CITY	DATE RECEIVED
CASE NUMBER	WORKER
CASE NAME	

MEDICAID RESOURCE ASSESSMENT REQUEST

Mr. and Mrs. _____request that an assessment be completed to determine the spousal share of countable resources using the resources listed below.

INSTITUTIONALIZED SPOUSE

Name: _____
SS#:_____

Address:_____
_____
_____

COMMUNITY SPOUSE

Name: _____
SS#:_____

Address:_____
_____
_____

Date first admitted to a medical institution:_____
Admitted from where?_____

Provide the requested information on all resources owned, partially owned, or being bought on the first day of the month the institutionalized spouse was admitted to the institution or to Medicaid-covered community-based care. Include real estate (home, land, buildings), life insurance, cash on hand, stocks or bonds, savings and checking accounts, certificates of deposits, trusts, IRA or Keogh Plans, machinery, farming equipment, cemetery plots, burial funds, prearranged funerals, cars, mobile homes, and other real personal properties. If more room is needed, please attach another sheet of paper.

Description (Type of Resource)	Owned by Whom	Where Located	Value
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

Signature:_____ Date:_____
(Spouse or Authorized Representative)

MEDICAID RESOURCE ASSESSMENT REQUEST

FORM NUMBER - 032-03-815

PURPOSE OF FORM - To provide information on resources that will enable the department of social services to assess the countable resources of a couple and to determine the spousal share.

USE OF FORM - To be completed when an assessment of resources available to an institutionalized spouse (spousal share) is requested, and a Medicaid application is not filed or requested.

NUMBER OF COPIES - Three.

DISPOSITION OF FORMS - The original is filed in the case record with the Medicaid Resource Evaluation and the Notice of Medicaid Resource Assessment. The first copy is sent to the community spouse with the Notice of Medicaid Resource Assessment. The second copy is sent to the institutionalized spouse with the Notice of Medicaid Resource Assessment. If an individual other than one of the spouses requested the assessment, a photocopy of the request is sent to the individual making the request along with a photocopy of the Notice of Medicaid Resource Assessment.

INSTRUCTIONS FOR PREPARATION OF FORM - The information in the right-hand corner will be completed by the worker when the form is received in the agency. The remainder of the form will be completed by the couple making the request or by the authorized representative acting on their behalf.

MEDICAID RESOURCE ASSESSMENT

COUNTY/CITY	CASE NUMBER
CASE NAME	
DATE INSTITUTIONALIZATION BEGAN	APPLICATION DATE

A. COUPLE'S RESOURCES AS OF _____ (Date)

RESOURCE (Description)	Owner	Countable YES	Countable NO	Countable Value	Documentation
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

B. COMPUTATION OF SPOUSAL SHARE

- ❑ Documentation of resources not supplied. Spousal share not determined.
- ❑ Documentation of resources supplied.

$_____ Total Value of Couple's Countable Resources

$_____ Spousal Share

Worker's Signature:
_____ Date:_____

MEDICAID RESOURCE ASSESSMENT

FORM NUMBER - 032-03-816

PURPOSE OF FORM - To document the resources owned by a couple, to specify which resources are exempted, which resources are counted and their countable values, and to determine the spousal share of resources.

USE OF FORM - To be completed by the local agency eligibility worker when a Medicaid Resource Assessment Request is received by the local department of social services, or when a Medicaid application is filed by an institutionalized individual who has a community spouse.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The original is filed in the case record with the Medicaid Resource Assessment and the Notice of Medicaid Resource Assessment for assessments that are not parts of applications. The first copy is sent to the community spouse with the Notice of Medicaid Resource Assessment. The second copy is sent to the institutionalized spouse with the Notice of Medicaid Resource Assessment. If an individual other than one of the spouses requested the assessment, a photocopy of the evaluation is sent to the individual making the request, along with a photocopy of the Notice of Medicaid Resource Assessment.

For assessments that are part of Medicaid applications, the evaluation form is filed in the case record with the application evaluation. A copy of the Resource Evaluation is sent to the institutionalized spouse, the community spouse, and the individual making the request if applicable, along with the Notice of Medicaid Resource Assessment and the Notification of Action on Medicaid.

INSTRUCTIONS FOR PREPARATION OF FORM - Complete the identifying information in the upper right-hand corner of the form.

A. RESOURCES

From the resources identified on the Medicaid Resource Assessment Request, list the excluded resources first; the countable value(s) can be "N/A". Provide a description of the resource, list the owner(s), check whether the resource is countable, enter the countable value when it is a countable resource, and provide appropriate documentation information. If information was not provided, and owners or countable value, etc., cannot be documented, enter "not provided" in the appropriate columns.

B. COMPUTATION OF SPOUSAL SHARE

Check the appropriate box to indicate whether documentation was or was not supplied. If documentation was supplied, enter in the first line the value of countable resources, divide that figure by two and enter on the second line the spousal share.

C. The worker must sign the form and enter the date the form was completed.

COMMONWEALTH OF VIRGINIA
DEPARTMENT OF SOCIAL SERVICES

NOTICE OF MEDICAID RESOURCE ASSESSMENT

AGENCY USE ONLY
CASE NAME
CASE NUMBER
COUNTY/CITY

☐ The resource assessment you or your authorized representative requested was completed.

The spousal share is $ _____.

Enclosed are copies of the Medicaid Resource Assessment Request you submitted and the Medicaid Resource Assessment completed by the worker.

☐ The resource assessment you or your authorized representative requested was not completed because you or your authorized representative did not provide the necessary verifications of your resources. The spousal share of your resources cannot be determined.

☐ The resource assessment you or your authorized representative requested was not completed because the institutionalization began prior to September 30, 1989.

Worker's Name	Agency Name and Address	Date Mailed

NOTICE OF MEDICAID RESOURCE ASSESSMENT

FORM NUMBER - 032-03-817

PURPOSE OF FORM - To provide notice that a resource assessment of a couple's countable resources, and the spousal share, was or was not completed.

USE OF FORM - To be prepared when the resource assessment is denied, evaluation is completed, or evaluation could not be completed.

NUMBER OF COPIES - Three.

DISPOSITION OF FORM - The original is filed in the case record with the original Medicaid Resource Assessment Request and the original Medicaid Resource Evaluation. The first copy is sent to the community spouse with the first copy of the Medicaid Resource Assessment and the first copy of the Medicaid Resource Evaluation. The second copy is sent to the institutionalized spouse with the second copy of the Medicaid Resource Assessment and the second copy of the Medicaid Resource Evaluation.

If an individual other than one of the spouses requested the assessment, a photocopy of the notice is sent to the individual making the request along with a photocopy of the Medicaid Resource Assessment.

INSTRUCTIONS FOR PREPARATION OF THE FORM - Complete the identifying information in the upper right-hand corner. Enter the name and mailing address of the individual who will receive the form.

Check the appropriate box to show if the assessment was not completed because institutionalization began before 9-30-89, or if it was not completed because documentation was not provided, or if documentation of resources was provided and the assessment was completed. If documentation was provided, enter the spousal share of the countable resources.

Enter the worker's name, address, and the date the notice is or will be mailed.

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CHAPTER M15
ENTITLEMENT POLICY & PROCEDURES
SUBCHAPTER 10

MEDICAID ENTITLEMENT

M1510 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/01/11	pages 8a, 10
TN #95	3/1/11	Table of Contents Pages 8, 11-15
TN #94	9/1/10	pages 2a, 8-8a
TN #93	1/1/10	page 6
Update (UP) #2	8/24/09	page 11
TN #91	5/15/09	page 14

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M1510.000 ENTITLEMENT POLICY & PROCEDURES

M1510.100 MEDICAID ENTITLEMENT

A. Policy

If an individual meets all eligibility factors within a month covered by the application, eligibility exists for the entire month *unless the individual became eligible by meeting a spenddown.*

1. Spenddown Met

If the applicant had excess income and met the spenddown within the month, he remains responsible for his spenddown liability and his coverage begin date cannot be any earlier than the date he met the spenddown.

2. Applicant Dies

If an applicant dies during the application process, his eligibility is determined only for the days he was alive. He must have been eligible for Medicaid while he was alive in order to be entitled to enrollment in Medicaid. Any changes in the individual's resources or income after his death do not affect the eligibility determination.

Example: An individual applies on July 23 for retroactive and ongoing Medicaid. The worker determines that the individual had excess resources(cash value of life insurance) throughout the retroactive period and the application month. The individual dies on August 5. The family asserts that he no longer owned the life insurance policies on August 5 and meets the resource requirements for the month of August. The worker determines that the individual owned the policies on the date of his death, the countable value exceeded the resource limit and he was not eligible for medical assistance on or before the date of his death.

B. SSI Entitlement Date Effect on Medicaid

SSI payments for eligible individuals are effective the first day of the month following the month in which the SSI application was filed. Medicaid coverage for eligible individuals is effective the first day of the month in which the Medicaid application is filed. When the Medicaid application is filed in the same month as the SSI application, the applicant is not eligible for Medicaid as an SSI recipient until the month in which his SSI entitlement began - the month following the application month. His eligibility for Medicaid in the application month must be determined in another covered group.

C. Procedures

The procedures for determining an eligible individual's Medicaid coverage entitlement are contained in the following sections:

- M1510.101 Retroactive Eligibility & Entitlement
- M1510.102 Ongoing Entitlement
- M1510.103 Disability Denials
- M1510.104 Foster Care Children
- M1510.105 Delayed Claims

M1510.101 RETROACTIVE ELIGIBILITY & ENTITLEMENT

A. Definitions

1. Retroactive Period

The retroactive period is the three months immediately prior to the application month. Within this retroactive period, the individual may be CN, CNNMP or MI in one or two months and MN in the third month, or any other combination of classifications.

2. Retroactive Budget Period

The "budget period" is the period of time during which an individual's income is calculated to determine income eligibility. The retroactive budget period depends on the individual's covered group.

B. Policy

An application for Medicaid or Auxiliary Grants (AG) is also an application for retroactive Medicaid coverage whenever the applicant reports that he/she received a Medicaid-covered service in retroactive period. Eligibility for retroactive coverage is determined at the same time as the ongoing eligibility is determined, using the same application.

If the applicant reports receipt of a hospital service within the month immediately preceding the application month, the application date is within 30 days of the hospital service, and the applicant is not eligible for retroactive Medicaid, the applicant's eligibility for SLH must be determined.

When an applicant reports that he/she, or anyone for whom he/she is applying, received a Medicaid covered service in any one of the three retroactive months, determine the applicant's eligibility for all three retroactive months, regardless of the service date. Determine nonfinancial, resource and income eligibility for each month in the retroactive period.

C. Budget Periods By Classification

1. CN, CNNMP, MI

The retroactive budget period for categorically needy (CN), categorically needy non-money payment (CNNMP) and medically indigent (MI) covered groups (categories) is one month.

CN, CNNMP or MI eligibility is determined for each month in the retroactive period, including a month(s) that is in a prior spenddown that was not met. Do not determine eligibility for a retroactive month that was included in a previous Medicaid coverage period; the applicant has already received Medicaid for that month.

NOTE: There is never any retroactive eligibility or entitlement as a Qualified Medicare Beneficiary (QMB) only. An individual who is eligible as Special Low-income Medicare Beneficiary (SLMB) or Qualified Disabled & Working (QDWI) can have retroactive coverage as an SLMB or QDWI.

2. Medically Needy (MN)

In the retroactive period, the **MN budget period is always all three months** in the retroactive period. Unlike the CN, CNNMP or MI, the retroactive MN budget period may include a portion of a prior Medicaid coverage or

spenddown period, and may also include months in which he is eligible as CN, CNNMP or MI.

D. Verification

The applicant must verify all eligibility requirements in a retroactive month in order to be eligible for Medicaid coverage in that month.

An individual who provides proof of application for an SSN, after he applies for medical assistance, meets the application for SSN requirement in the three months retroactive to his medical assistance application.

If the applicant fails to verify any required eligibility factor for a retroactive month, coverage **for that month** must be denied because of failure to verify eligibility. If he verifies all eligibility factors for the other months in the retroactive period, he may be eligible for CN, CNNMP or MI retroactive coverage for those months.

EXAMPLE #1: Ms. A applied for Medicaid for herself and her children on July 8. She reported receiving a Medicaid covered service in each retroactive month. The retroactive period is April 1 through June 30. She currently receives Unemployment Compensation; she lost her job in May. She provided all required verification for May and June, but did not provide income verification for April. Their application was approved for MI Medicaid coverage beginning May 1; April coverage was denied because of failure to verify income for April.

1. Excess Income In One or More Retroactive Months

When an applicant has excess income in one or more of the retroactive months, he must verify that he met the nonfinancial and resource requirements in the month(s). He must verify the income he received in **all 3** retroactive months in order to determine his MN income or spenddown eligibility in the retroactive month(s).

If he fails to verify income in all three months, he CANNOT be eligible as medically needy in the retroactive period. His application for the retroactive months in which excess income existed must be denied because of failure to provide income verification for that month(s). However, coverage for the retroactive month(s) in which he was eligible as CNNMP or MI must be approved.

EXAMPLE #2: (Using July 200*6* figures)
A parent of a child under age 19 applies for Medicaid in April. She requests retroactive coverage for the child's medical bills incurred in January, February and March, *including a hospital stay in February*. She also has unpaid medical bills (old bills) from December. The retroactive period is January - March.

The eligibility worker determines that the child met all the Medicaid nonfinancial requirements in the retroactive period, and that the countable income of $3,250 per month in January and February exceeded the F&C, MI and the MN income limits. The income of $800 starting March 1 is within the F&C MI income limit. The parent verifies that the resources in January, February were within the MN resource limit, but does not verify the March resources because the income is within the MI income limits.

The application is approved for retroactive coverage as MI beginning March 1 and for ongoing coverage beginning April 1. The child's spenddown liability is calculated for January and February. The eligibility worker deducts the old bills and the incurred medical expenses, and a spenddown liability remains. The retroactive *Medicaid* coverage is denied for January and February *because the spenddown was not met.*

2. Excess Income In All 3 Retroactive Months

When excess income existed in all classifications in all 3 retroactive months, the applicant must verify that he met all eligibility requirements in all 3 months. If he fails to verify nonfinancial, resource or income eligibility in any of the retroactive months, the retroactive period cannot be shortened and he CANNOT be placed on a retroactive spenddown. His application for retroactive coverage must be denied because of excess income and failure to provide eligibility verification for the retroactive period.

EXAMPLE #3: (Using July 200*6* figures)
A parent of a child under age 19 applies for Medicaid in April. She requests retroactive coverage for the child's medical bills incurred in January, February and March, *including a hospital stay in March*. The retroactive period is January – March.

The worker verifies that the child met all the Medicaid nonfinancial requirements in the retroactive period, and that their countable income of $3,250 in January, February and March exceeded the F&C MI and the MN income limits. The worker verifies that their resources in January and February were within the MN resource limits, but is unable to verify the resources for March.

The application is denied for retroactive coverage as MI *Medicaid* because of excess income and denied for MN *spenddown* because of failure to provide resource verification for *all months in* the retroactive period.

E. Disabled Applicants

If the applicant was not eligible for SS or SSI disability benefits during the retroactive period and the recipient alleges he/she was disabled during the retroactive period, follow the procedures in M0310.112 for obtaining an earlier disability onset date.

F. Excess Resources in Retroactive Period

If the applicant had excess resources during part of the retroactive period, retroactive resource eligibility exists only in the month(s) during which the resources were at or below the limit at any time within the month. The applicant's eligibility must be denied for the month(s) during which excess resources existed during the entire month.

EXAMPLE #4: (Using July 200*6* figures)
Mr. A applied for Medicaid for himself on July 8. He reported receiving a Medicaid covered service in each retroactive month; *no hospital service was received*. The retroactive period is April 1 through June 30. He currently receives SS disability benefits of $1500 per month and received SS disability of $1500 monthly during the retroactive period. He is not eligible for Medicare Part A. His verified resources exceeded the MN limit in April and part of May; the resources were reduced to below the MN limit on May 20. He met the retroactive spenddown on April 5. His application was approved for retroactive MN coverage beginning May 1, and April coverage was denied because of excess resources.

G. Income Determination

Countable income for the applicant's unit is that income which was actually received in the three months prior to the application month.

1. Monthly Determination for CN/CNNMP & MI

When an individual in the family unit meets a CN, CNNMP or MI covered group, compare each month's countable income to the appropriate CN/CNNMP or MI income limit for the month. When the countable income is within the CN, CNNMP or MI income limit in the month, the CN, CNNMP or MI individual meets the income eligibility requirement for that retroactive month. Enroll the eligible CN, CNNMP or MI unit member(s) **for that month(s) only**, using the appropriate CN, CNNMP or MI covered group program designation.

2. Medically Needy (MN)

When the family unit's countable income exceeds the CN, CNNMP or MI income limit in one or more of the retroactive months, and all other

Medicaid medically needy eligibility factors are met in that month(s), determine if the unit meets the MN income limit for the **3-month** retroactive budget period.

When the unit's countable income exceeds the MN limit for 3 months, place the unit on a spenddown for the month(s) in which excess income existed. See subchapter M1330 for retroactive spenddown eligibility determination policy and procedures.

H. Retroactive Entitlement

Retroactive coverage can begin the first day of the third month prior to application month if all eligibility requirements are met.

NOTE: A QMB is never eligible for retroactive coverage as a QMB-only.

The applicant is entitled to Medicaid coverage for only the month(s) in which all eligibility factors were met. If all factors except income were met in all the retroactive months, then the applicant is placed on spenddown for the retroactive period. **See subchapter M1330 to determine retroactive spenddown eligibility.**

1. Retroactive Coverage Begin Date

If the applicant is eligible for retroactive coverage, he is enrolled effective the first day of the month in which he met all eligibility factors. When excess income existed in a retroactive month(s), entitlement begins the date the retroactive spenddown was met.

2. Retroactive Coverage End Date

The Medicaid recipient's retroactive Medicaid coverage expires after the last day of the retroactive month(s) in which he was entitled to Medicaid.

3. Example

EXAMPLE #5: Mr. B applied for Medicaid for himself on July 8. He reported receiving a Medicaid covered service in each retroactive month. The retroactive period is April 1 through June 30. He met all eligibility requirements in the retroactive period. He is entitled to retroactive Medicaid coverage beginning April 1 and ending June 30.

M1510.102 ONGOING ENTITLEMENT

A. Coverage Begin Date

Ongoing Medicaid entitlement for all covered groups except the medically indigent Qualified Medicare Beneficiary (QMB) group **begins the first day of the application month** when all eligibility factors are met at any time in the month of application. Exceptions:

- when an applicant has excess income;
- when the applicant is eligible only as a medically indigent qualified Medicare beneficiary (QMB); *or*
- *when the applicant is age 21-64 years and is admitted to an institution for treatment of mental diseases (IMD).*

1. Applicant Has Excess Income

When all eligibility requirements are met except for income, entitlement begins the date the spenddown is met. Only medically needy applicants can be eligible after meeting a spenddown. See subchapter M1330 to determine retroactive spenddown eligibility.

2. QMB Applicant

Entitlement to Medicaid for a medically indigent Qualified Medicare Beneficiary (QMB) begins the first day of the month **following** the month in which the individual's QMB eligibility is determined.

3. SLMB and QDWI

Ongoing entitlement for the Special Low Income Medicare Beneficiary (SLMB) and the Qualified Disabled and Working Individuals (QDWI) MI covered groups is the first day of the application month when all eligibility factors are met at any time in the month of application.

4. Applicant Age 21-64 Is Admitted To Ineligible Institution

An applicant who is age 21-64 years and who is admitted to an IMD or other ineligible institution (such as a jail) in a month is NOT eligible for Medicaid while he is a patient in the IMD (or is residing in the ineligible institution). If otherwise eligible for Medicaid in the application month, his entitlement to Medicaid begins the date he is discharged from the ineligible institution in the month.

EXAMPLE #6: Mr. A is a 50 year old man who applies for Medicaid at his local agency on October 1, 2006. He receives Social Security disability benefits. He was admitted to Central State Hospital (an IMD) on October 20, 2006, and was discharged on November 2, 2006, back to his home locality. The agency completes the Medicaid determination on November 5 and finds that he is eligible for Medicaid in October 2006 and ongoing, except for the period of time he was in Central State Hospital.

The worker enrolls him in Medicaid for a closed period of coverage beginning October 1, 2006, and ending October 20, 2006. The worker also enrolls him in an ongoing period of Medicaid coverage beginning November 2, 2006.

5. Applications From CSBs For IMD Patients Ages 21-64 Years

A patient who is age 21 years or older but is less than 65 years and who is in an institution for treatment of mental diseases (IMD) is not eligible for Medicaid while in the IMD. Local agencies will take the **applications received from the CSBs** for *Department of Behavioral Health and Developmental Services (DBHDS*) IMD patients who will be discharged within 30 days and process the applications within the established time frames. Eligibility will be determined based on the type of living arrangement to which the patient will be discharged. If eligible, do not enroll the patient until the date the patient is discharged from the IMD.

If the patient is discharged from the facility and the patient meets all eligibility factors, the agency will enroll the patient effective the date of discharge.

EXAMPLE #6a: Mr. A is a 50 year old patient at Central State Hospital (an IMD). He receives Social Security disability benefits. The CSB sends

his local agency a Medicaid application which is received on August 18. The facility's statement notes that he will be discharged on September 17 to ABC Nursing Home, a nursing facility. The agency completes the determination on August 27 and finds that he will be eligible once he is discharged to the nursing facility.

The agency does not enroll Mr. A until the discharge is confirmed. The CSB case manager calls the agency on September 21 and informs the agency that the patient was discharged to the ABC Nursing Home on September 18. The patient is enrolled in Medicaid with a begin date of September 18.

B. Coverage End Date

Medicaid entitlement ends the last day of the month in which the recipient fails to meet all of the Medicaid eligibility requirements, unless the recipient is an MI pregnant woman or is age 21-64 and admitted to an IMD or other ineligible institution (see below).

Medicaid coverage is canceled on the last day of the month in which the agency determines that the recipient no longer meets the eligibility requirements IF the agency can send an advance notice to the recipient at least 11 days before the last day of the month. If the agency cannot send the notice at least 11 days before the end of the month, coverage is canceled effective the last day of the next month.

1. MI Pregnant Woman

For an eligible MI pregnant woman, entitlement to Medicaid continues after eligibility is established regardless of any changes in family income, as long as she meets the pregnant category (during pregnancy and the 60-day period following the end of pregnancy) and all other non-financial criteria.

2. Individual Age 21-64 Admitted to Ineligible Institution

a. Entitlement - applicants

For a Medicaid enrollee age 21-64 years, entitlement to Medicaid begins on the first day of the application month and ends on the date following the date he is admitted to an IMD or other ineligible institution. When enrolling the individual in the MMIS, enter the begin date and the end date of coverage.

b. Cancel procedures for ongoing enrollees

Cancel coverage as soon as possible after learning of the enrollee's admission to an ineligible institution. **DO NOT cancel coverage retroactively.** Cancel coverage in the MMIS effective the *current* date *(date* the *worker enters the* cancel transaction in MMIS*)*, using cancel reason code "008."

c. Notice

An Advance Notice of Proposed Action is not required. Send a Notice of Action to the enrollee or his authorized representative informing him of the cancel date and the reason.

3. Spenddown Enrollees

Medicaid entitlement ends on the last day of the last month in the spenddown budget period, unless the individual's or family's circumstances change before that date.

C. Ongoing Entitlement After Resources Are Reduced

When an applicant has excess resources throughout the application month, he is not eligible for Medicaid for the month of application. An applicant who reduces excess resources during the month of application or a subsequent month before action is taken on the application may become eligible in the month in which the value of his resources is reduced to, or below, the Medicaid resource limit. In order to reduce resources, the resources must actually be expended and the expenditure documented. (For example: a receipt, a canceled check, or a bank statement).

Reduction of resources is an asset transfer and must be evaluated under asset transfer policy (subchapter M1450).

When excess resources are reduced, entitlement to ongoing Medicaid may begin no earlier than the first day of the month in which the resources were reduced to the Medicaid limit. When retroactive coverage is requested, policy in M1510.101 above must be followed.

M1510.103 DISABILITY DENIALS

A. Policy

When an individual concurrently applies for SSI or SS and Medicaid as disabled, and either the DDS or the Social Security Administration (SSA) denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

When an individual applies for Medicaid as disabled or concurrently applies for SS/SSI and Medicaid as disabled, and DDS denies disability, the local social services department must deny the Medicaid application because the disability requirement is not met.

B. Procedures

1. Subsequent SSA/SSI Disability Decisions

The SSA disability decision takes precedence over a DDS decision (DDS will make a decision before SSA if SSA does not take action within the 90-day Medicaid application processing time). If SSA denies disability and the decision is appealed and subsequently reversed, reopen and re-evaluate the denied Medicaid application *as long as the disability onset date is prior to or no later than 90 days from the date of application.*

2. Use Original Application

The original application is used as long as the application was denied because the individual was not disabled and the subsequent disability onset date is *no later than* 90 days *from the date of* application.

3. Entitlement

If the re-evaluation determines that the individual is eligible, the individual's Medicaid entitlement is based on the Medicaid application date including the retroactive period if all eligibility requirements were met during the retroactive period. However, eligibility as a disabled individual

cannot begin prior to the disability onset date when the disability onset date falls after the application date.

4. Redetermination Required When More Than 12 Months Have Passed

If, based upon the re-evaluation, the individual is determined to be eligible and more than 12 months have passed since the application was filed, complete a redetermination to determine whether or not the individual remains eligible.

5. Spenddown

If, based upon the re-evaluation, the individual is determined not eligible but met the requirements in Chapter M13 for placement on a spenddown, *a first prospective and additional 6 month spenddown budget period are established to cover the period of time between the date of application and the date action is taken on his case.*

A new application is not required for each 6 month spenddown budget period leading up to the date of processing; however, verification of all income and resources for those time periods must be obtained.

M1510.104 FOSTER CARE CHILDREN

A. Policy

Entitlement begins the first day of the month of commitment or entrustment IF a Medicaid application is filed within 4 months of the commitment or entrustment date.

If the Medicaid application is filed more than 4 months after entrustment or commitment, entitlement begins the first day of the application month if retroactive coverage is NOT requested.

B. Retroactive Entitlement

If the Medicaid application is filed within 4 months of entrustment or commitment, retroactive eligibility exists only if the child met another covered group and all other Medicaid eligibility requirements in the

retroactive period. If the Medicaid application is filed more than 4 months after entrustment or commitment, retroactive entitlement as a foster care child exists in the 3 months prior to Medicaid application. Entitlement cannot go back more than 3 months prior to the Medicaid application month.

M1510.105 DELAYED CLAIMS

A. When Applicable

Medicaid will not pay claims from providers that are filed more than 12 months after the date the service was provided, unless the reason for the delayed filing was a delay in the enrollee's eligibility determination and enrollment. If the applicant is eligible for Medicaid and the coverage begin date is 12 months or more prior to the month during which the enrollee is enrolled on the Medicaid computer, the agency must write a letter for the applicant to give to all medical providers who will bill Medicaid for services provided over 1 year ago.

B. Eligibility Delay Letter Requirements

The letter must:

- be on the agency's letterhead stationery and include the date completed.
- be addressed to the "Department of Medical Assistance Services, Claims Processing Unit."
- state the enrollee's name and Medicaid recipient I.D. number.
- state that "the claim for the service was delayed for more than one year because eligibility determination and enrollment was delayed."

C. Procedures

The "eligibility delay" letter and a sufficient number of copies must be given to the enrollee to give to each provider who provided a covered medical service to the recipient over one year ago. The provider must attach the letter to the claim invoice in order to receive Medicaid payment for the service. If the date the letter was prepared by the agency is not included on the letter, the claim will be denied. A sample eligibility delay letter *is available on the local agency intranet at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi*.

M1510.200 NOTICE REQUIREMENTS

A. Policy

Federal regulations in 42 CFR 431.206 through 431.214 require the agency to inform every applicant or enrollee in writing

- of his right to a hearing;
- of the method by which he may obtain a hearing; and
- that he may represent himself or use legal counsel, a relative, a friend or other spokesperson.

The agency must provide the information required above at the time of any action affecting his claim for Medicaid benefits.

B. Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs

The "Notification of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs" (Form 032-03-008) must be used to notify the applicant:

- that his application has been approved and the effective date(s) of his Medicaid coverage.
- that retroactive Medicaid coverage was approved and the effective dates.
- that his application has been denied including the specific reason(s) for denial.
- that retroactive Medicaid coverage was denied, including the specific reason(s) for denial.
- of the reason for delay in processing his application.
- of the status of his request for reevaluation of his application in spenddown status.

When the application was filed by the applicant's authorized representative, a copy of the notification must be mailed to the applicant's authorized representative.

1. MI Children or Pregnant Women

When the application of a medically indigent child or pregnant woman is denied because of excess income, the denial notice ("Notice of Action on Medicaid and Family Access to Medical Insurance Security Plan (FAMIS) Programs ") must state the reason for denial. The notice must also include the *resource questions pages from the* "Application For Benefits" form *or the form "Eligibility Review Part B,"* and must advise the applicant of the following:

a. that he/she may complete and *return the enclosed form* for *a* Medicaid spenddown *to be evaluated*, and

b. *if the information is returned* within 10 days of this notice, the medically indigent application date will be used as the Medicaid spenddown application date.

2. Qualified Medicare Beneficiaries

a. Excess resources

When a Qualified Medicare Beneficiary's (QMB's) application for medically indigent Medicaid coverage is denied because of excess resources, the denial notice must state that the applicant is not eligible for Medicaid because of excess resources.

b. Excess income

1) If the QMB's resources are within the medically indigent limit but are over the medically needy limit, and the income exceeds the medically indigent limit, the notice must state that the applicant is not eligible for QMB Medicaid because of excess income, and is not eligible for

MN spenddown because of excess resources. The notice must specify the dollar amount of the appropriate MN resource limit.

2) If the QMB's resources are within the MN income limit, and income exceeds the MI limit, the notice must state that the applicant is not eligible for full-benefit Medicaid because of excess income, but that the applicant can become eligible by incurring medical or dental expenses that equal or exceed his excess income. The notice must specify the spenddown amount, the spenddown period begin and end dates, and include a copy of the Spenddown Fact Sheet.

3. Retroactive Entitlement Only or Limited Period of Entitlement

There are instances when an applicant is not eligible for ongoing Medicaid coverage but is eligible for retroactive benefits, or when a change in the applicant's situation during the application process results in the applicant being eligible for only a limited period of time. Only one "Notice of Action on Medicaid and FAMIS" (Form 032-03-008) is sent to the applicant covering both actions. The begin and end dates of Medicaid coverage and the reason(s) for ineligibility must be included on this notice.

4. Example #7 Limited Period of Entitlement

A Medicaid application was filed on December 30. The client inherited real property on January 30. The agency processed the application on February 5 and determined the client was eligible for Medicaid for the months of December and January, but was ineligible for additional coverage beginning February because the countable value of the inheritance caused excess resources. One notice is sent to the applicant stating that his Medicaid application was approved beginning December 1 and ending January 31, and that he was denied coverage after January 31 because of excess resources (real property).

M1510.300 FOLLOW-UP RESPONSIBILITIES

M1510.301 THIRD PARTY LIABILITY (TPL)

A. Introduction

Medicaid is a “last pay” program and cannot pay any claim for service until the service provider has filed a claim with the recipient’s liable third parties such as health insurance companies or legally liable person. The procedures depend on the type of third party liability (TPL) the recipient has.

B. Private Health Insurance

Information on *an eligible individual’s* private health insurance coverage must be obtained and recorded in the case record and in the MMIS. This must include the company name (code number for the TPL file), the policy number, and the begin date of coverage. *This information does NOT require verification.*

Health insurance policy or coverage changes must be updated in the eligibility record and *the MMIS* TPL file.

1. Verification Required - Policy or Coverage Termination

Verification of the date the health insurance policy and/or a coverage type terminated is required. The verification of the termination date can be a written letter from, or verbal statement by, the insurance company that states the termination date. If verification is obtained, the worker is to ***end-date*** *the TPL coverage in MMIS (note: do not delete the TPL from MMIS).*

Absent receipt of documentation showing that the TPL coverage has ended, it must be left open in MMIS and cannot be ended by the worker. If the worker is unable to obtain verification of the coverage termination date from the insurance company or the enrollee/authorized representative, the worker is to notify DMAS that the enrollee's TPL coverage was terminated, but verification cannot be obtained. The notification should be sent via e-mail to: tplunit@dmas.virginia.gov. If it is determined that TPL coverage no longer exists, the coverage will be closed in MMIS by DMAS staff.

2. HIPP

If an applicant or enrollee reports that he or a family member is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan, he or she must be given a HIPP Fact Sheet which provides a brief description of the program and the contact information for the HIPP Unit at DMAS. The HIPP Fact Sheet is available on-line at: http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi.

Changes to TPL coverage in MMIS for HIPP participants can only be made by the HIPP Unit at DMAS. Call the HIPP Unit at 1-800-432-5924 when changes to the TPL information in MMIS are needed.

C. Medicare

For persons age 65 or over, for persons under age 65 who have received SSA or Railroad Retirement benefits because of disability for 24 consecutive months, and for persons with chronic end-stage renal disease, the Department of Medical Assistance Services has a buy-in agreement with Medicare to provide to those eligible individuals who are also eligible for Medicare the medical services available under Medicare, Part B (Title XVIII of the Social Security Act) through payment of the Part B premium.

When the recipient has to pay a Medicare Part A premium, Medicaid will pay the Part A premium for

- all QMBs; the "dually-eligible" (those who are eligible in a CN, CNNMP or MN covered group and also are QMB), and the QMB-only (those QMBs who are not eligible for Medicaid in another covered group);
- Qualified Disabled and Working Individuals (QDWI).

1. Buy-In Procedure

The Centers for Medicare and Medicaid Services(CMS) maintains a current list of individuals for whom the State is paying the Part B premiums. The list is updated on a monthly basis by adding newly enrolled individuals and deleting those no longer eligible. Before CMS will admit an individual to the buy-in list for Part B coverage, the individual must have established his eligibility for Medicare. His name and claim number, if one has been assigned, must be identical to the information in the SSA files. A difference between the name and number on the MMIS and in the SSA files results in a mismatch and rejection of Part B premium coverage.

2. Medicare Claim Numbers

Only two types of claim numbers correctly identify an individual's entitlement to Medicare coverage: a Social Security claim number or a Railroad Retirement claim number.

a. SSA claim numbers consist of a nine-digit number followed by a letter, or a letter and numerical symbol. The most common symbols are T, M, A, B, J1, K1, D, W, and E.

b. RR annuity-claim numbers have a letter (alpha) prefix followed by a six or nine digit number. The most common prefixes are A, M, H, WCD, NCA, CA, WD, WCH, and PD.

c. Certain letters following nine digit numbers identify an individual as an SSI recipient and are not acceptable as a Medicare claim number. These claim symbols are AI, AS, BC, BI, BS, DC, DI, and DS.

3. Procedures for Obtaining Claim Numbers

a. Requesting Medicare Card

Each Medicaid applicant who appears to qualify for Medicare must be asked if he has applied for Medicare. Those that have applied and are eligible have received a white card with a red and a blue stripe at the top, with his name as it appears in the SSA files and the assigned claim number on the card. The name as it appears and the claim number must be included in the TPL section of the MMIS eligibility file maintained by the Department of Medical Assistance Services.

b. Applicants Who Cannot Produce a Claim Number

In the event the applicant either does not have a Medicare card or does not know his claim number, inquire SSA via the SVES (State Verification Exchange System) using the applicant's own SSN.

If the applicant has never applied for Medicare, complete the Referral to Social Security Administration Form DSS/SSA-1 (form #032-03-099) and write in, "Buy-In" on the upper margin. Mail the form to the Social Security Office serving the locality in which the applicant resides. The SSA office will provide the correct claim number if the individual is on their records. Should the (local/area) SSA office have no record of an application for Medicare, a representative will contact the applicant to secure an application.

Should the applicant be uncooperative (not wish to apply) or be deceased, the Social Security Office will contact the local social services department and ask that agency to file the Medicare application in his behalf. A local department of social services must also submit an application for Medicare on behalf of an individual who is unable or unwilling to apply. When the local department must file a Medicare application, the local Social Security office will advise the local department of the procedure to follow.

4. Buy-in Begin Date

Some individuals have a delay in Buy-in coverage:

Classifications	Buy-in Begin Date
Category Needy Cash Assistance	1st month of eligibility
ABD MI (includes dually-eligible)	1st month of eligibility
Categorically Needy Non-money Payment and Medically Needy who are dually-eligible (countable income < 100% FPL and Medicare Part A)	1st month of eligibility
Categorically Needy Non-money Payment and Medically Needy who are not dually-eligible (countable income > 100% FPL or no Medicare Part A)	3rd month of eligibility

If the medically needy coverage begin date is other than the first day of a month, Buy-in is effective the first day of the month in which the 60th day after the begin date occurs.

D. Other Third Party Liability

When the agency identifies another third party which has responsibility to pay for a recipient's medical bill, the agency must report the third party to:

Department of Medical Assistance Services
Third Party Liability Section
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Examples of other third parties include liability insurance settlements, trust funds established for the recipient's medical care, awards resulting from liability lawsuits, and persons ordered by the court to pay for the recipient's medical care.

E. Pursuing Third Party Liability and Medical Support

In order to continue to be eligible for Medicaid, an individual who is required to assign rights to, and cooperate in, pursuing medical support and third party liability must continue to cooperate with the local agency and DMAS. See subchapter M0250 for details.

M1510.302 SOCIAL SECURITY NUMBERS

A. Policy

Applicants must provide the Social Security number (SSN) of any person for whom they request Medicaid, or must apply for a Social Security number if he/she does not have one. An individual who is applying only for others and is not applying for himself is not required to provide an SSN for himself.

When an individual has applied for an SSN and is determined eligible for medical assistance, the worker must take follow-up action to obtain the individual's SSN.

B. Procedures

See subchapter M0240 for the SSN application follow-up procedures required after enrolling an eligible individual who has applied for an SSN.

M1510.303 PATIENT PAY INFORMATION

A. Policy

After an individual in long-term care is found eligible for Medicaid, the recipient's patient pay must be determined. When the patient pay amount is initially established or when it is changed, the worker enters the information in MMIS. MMIS sends the "Notice of Obligation for Long-Term Care Costs" to the enrollee or the enrollee's authorized representative.

B. Procedure

When patient pay increases, the MMIS "Notice of Obligation for Long-Term Care Costs" is sent in advance of the date the new amount is effective.

CHAPTER M15
ENTITLEMENT POLICY & PROCEDURES
SUBCHAPTER 20

MEDICAID ELIGIBILITY REVIEW

M1520 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	Table of Contents pages 1-7g pages 11-13 pages 21-24
TN #95	3/1/11	pages 6a, 7, 21, 22
TN #94	9/1/10	Table of Contents pages 3, 4b, 5, 6-6a, 10 Appendix 1 removed.
UP #4	7/1/10	page 4
TN #93	1/1/10	pages 3, 4b, 5-6, 10, 15 pages 21, 22
Update (UP) #2	8/24/09	pages 1, 2, 13, 14, 17, 18
Update (UP) #1	7/01/09	page 3

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M1520.000 MEDICAID ELIGIBILITY REVIEW

M1520.001 GENERAL PRINCIPLE

A. Policy

A Medicaid recipient's eligibility must be partially reviewed whenever the agency becomes aware of any change in the enrollee's circumstances that might affect the enrollee's continued Medicaid eligibility.

An annual review of all of the enrollee's Medicaid eligibility requirements is called a "renewal." A renewal of the enrollee's eligibility must be completed at least once every 12 months. *The renewal should be initiated in the 11th month to ensure timely completion of the renewal.*

When a Medicaid enrollee no longer meets the requirements for his current covered group, prior to cancelling his coverage, *he must be evaluated in all covered groups for which he may meet the definition. If the individual is not eligible for full benefit Medicaid coverage and is not eligible as a Medicare beneficiary, he must be evaluated for Plan First, unless he has declined that coverage.*

1. Negative Action Requires Advance Notice

When a change is reported that impacts eligibility or a renewal is completed and the enrollee is no longer eligible, the Advanced Notice of Proposed Action must be sent to the enrollee before the enrollee's benefits can be reduced or his eligibility can be terminated (see M1520.401).

2. Renewal Approval Requires Notice

When a change is reported and eligibility continues, no notice is necessary. When a renewal is completed and eligibility continues, the Notice of Action is used to inform the enrollee of continued eligibility and the next scheduled renewal.

3. Voter Registration

If the individual reports a change of address in person, voter registration application services must be provided (see M0110.300 A.3).

B. Procedures For Partial Review and Renewals

The policy and procedures in this subchapter are contained in the following sections:

- the requirements for **partial reviews** are in section M1520.100;
- the requirements for **renewals** are in section M1520.200;
- the policy and procedures for **canceling** a enrollee's Medicaid coverage or reducing the enrollee's Medicaid services (benefit package) are in section M1520.400;
- the policy and procedures for **extended Medicaid coverage** are in section M1520.500;
- the policy and procedures for **transferring cases** within Virginia are in section M1520.600.

M1520.100 PARTIAL REVIEW

A. Enrollee's Responsibility

Enrollees must report changes in circumstances which may affect eligibility and/or patient pay within 10 days from the day the change is known. For enrollees participating in the Health Insurance Premium Payment (HIPP) Program, changes that may affect participation in HIPP must also be reported to the DMAS HIPP Unit within the 10 day timeframe.

B. Eligibility Worker's Responsibility

The eligibility worker has a responsibility for keeping a record of changes that may be anticipated or scheduled, and for taking appropriate action on those changes. The worker can set a follow-up review in the MMIS for anticipated changes. Examples of anticipated changes include, but are not limited to, the receipt of an SSN, receipt of SSA benefits and the delivery date for a pregnant woman.

Appropriate agency action on a reported change must be taken within 30 days of the report. If the enrollee reports any changes requiring verifications, such as changes in income or resources, or an asset transfer for enrollees receiving LTC services, send the enrollee a checklist requesting the necessary verifications, and allow at least 10 calendar days for the information to be returned. Document the information and evaluation in the case record.

1. Changes That Require Partial Review of Eligibility

When changes in an enrollee's situation are reported by the enrollee or when the agency receives information indicating a change in an enrollee's circumstances (i.e. SSI purge list, reported transfer of assets), the worker must take action to partially review the enrollee's continued eligibility.

A reported increase in income and/or resources can be acted on without requiring verification, unless a reported change causes the individual to move from a limited-benefit covered group to a full-benefit covered group. The reported change must be verified when it causes the individual to move from a limited-benefit covered group to a full-benefit covered group.

2. Changes That Do Not Require Partial Review

When changes in an enrollee's situation are reported or discovered, such as the enrollee's SSN and card have been received, the worker must document the change in the case record and take action appropriate to the reported change in the appropriate computer system(s).

Example: The Medicaid enrollee who did not have an SSN, but applied for one when he applied for Medicaid, reports by calling the worker that he received his SSN. The worker records the telephone call and the enrollee's newly assigned SSN in the case record, verifies the SSN via SPIDeR and enters the enrollee's verified SSN in MMIS and ADAPT.

3. HIPP

The eligibility worker must provide the enrollee with a copy of the HIPP FACT Sheet when it is reported that he or a family member is employed more than 30 hours per week and is eligible for coverage under an employer's group health plan. The HIPP Fact Sheet is available on-line at: http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi. The eligibility worker must report to the HIPP Unit at DMAS any changes in an enrollee's situation that may affect the premium payment. *The worker may report changes by e-mail to hipp@dmas.virginia.gov. This e-mail address is for use by the local agency staff only. See M0130.200 G for additional information about HIPP requirements.*

4. Program Integrity

The Medicaid eligibility of enrollees is subject to periodic review through the program integrity process (such as Medicaid Quality Control and the DMAS Recipient Audit Unit). It may be necessary for program integrity staff to request information, such as income verification, from the enrollee. The enrollee will be notified in writing and given a reasonable amount of time, as determined by the program integrity staff, to provide the information.

Should the enrollee not provide the requested information to the program integrity staff within the specified time, program integrity staff will notify the eligibility worker, and the worker must take action to follow up by requesting the appropriate verifications and/or sending advance notice, if necessary, to cancel coverage due to the inability to determine continued eligibility. An individual's failure to provide information to program integrity staff does not affect any future Medicaid applications.

C. Covered Group Changes

1. Newborn Child

When a child is born to a Medicaid-eligible woman (including an emergency services alien certified for Medicaid payment for labor and delivery), the only information needed to enroll the child in Medicaid (Child Under One covered group) is the child's name, gender and date of birth.

This information may be reported through any reliable means, such as the hospital where the child was born, the medical practitioner, or the mother's managed care organization. The agency may not require that only the mother make the report.

An eligibility determination for a child born to a Medicaid eligible pregnant woman (including an emergency services alien certified for Medicaid payment for labor and delivery) is not required until the month in which the child turns one year old, unless there is an indication that the child no longer meets the Virginia residency requirements in M0230. If the child continues to reside in Virginia, an application and an eligibility determination must be completed prior to MMIS cut-off in the month the child turns one year old.

2. Child Turns Age 6

When a child who is enrolled as an MI child turns age 6, the child's Aid Category (AC) in MMIS will automatically be changed to 092 or 094. No action is required when the child is enrolled as AC 092. If the child is enrolled as AC 094, a partial review must be completed to determine if the child has creditable health insurance coverage. If the child does not have creditable health insurance, no additional action is required. If the child has creditable health insurance, the eligibility worker must cancel the child's enrollment in AC 094 effective the end of the month and reinstate coverage in AC 092 effective the first day of the following month. Do not use change transactions to move a child to or from AC 094.

3. F&C Enrollee Becomes Entitled to SSI

When an individual who is enrolled in a Families and Children (F&C) covered group becomes entitled to SSI, the enrollee must be given the opportunity to provide information regarding ownership interest in countable real property for eligibility in the SSI Medicaid covered group. Contact the individual by telephone, inquire about any ownership interest in real property, and document the case record regarding the individual's statement. If the enrollee cannot be reached by telephone, send the Application/Redetermination for Medicaid for SSI Recipients to request the information.

If the individual reports no ownership interest in countable real property, take action to change the individual's AC to the appropriate SSI Medicaid AC. Because full coverage continues, no notice is required.

If the SSI individual reports ownership of countable real property, request verification of all countable resources. If verification is provided, determine eligibility in the SSI Medicaid covered group. If eligible, change the AC to the appropriate SSI Medicaid AC. Otherwise, the individual remains enrolled as an F&C enrollee as long as F&C eligibility continues.

See M0320.201 for information regarding eligibility requirements for the SSI Medicaid covered group.

4. **SSI Medicaid Enrollee Becomes a Qualified Severely Impaired Individual (QSII) – 1619(b)**

When an SSI Medicaid enrollee loses eligibility for an SSI money payment due to receipt of earned income, continued Medicaid eligibility under the Qualified Severely Impaired Individual (QSII) -1619(b) covered group may exist. A partial review to determine the individual's 1619(b) status via the State Verification Exchange System (SVES) *or* the State Online Query-Internet system (SOLQ-I) *must be completed*.

To identify a 1619(b) individual, check the "Medicaid Test Indicator" field on the SOLQ-I or SVES screen. If there is a code of A, B, or F, the individual has 1619(b) status. The eligibility worker must change the AC to the appropriate AC.

D. **Child Discharged From A Psychiatric Residential Treatment Facility**

Children who receive Medicaid-covered treatment in a psychiatric residential treatment facility may receive a special benefit package through the Children's Mental Health Program following discharge from the facility. Effective July 1, 2010, children receiving Children's Mental Health Program services after discharge from a psychiatric residential treatment facility continue to be eligible for Medicaid without the need for an eligibility review. When determining the Medicaid eligibility of these children, each child is considered an assistance unit of one (1) as long as the child continues to receive Children's Mental Health Program services.

1. Notification to LDSS

The discharge planner with the psychiatric residential treatment facility will send a Children's Mental Health Program Pre-Release Referral (form DMAS-800) to the agency. The referral will identify the child, the proposed date of discharge, and the proposed placement in the community. Transitional services care coordinators may download the official form from the DMAS web site, http://www.dmas.virginia.gov.

2. Agency Responsibility

Upon receipt of the Children's Mental Health Program Pre-Release Referral, the agency will document in the case record that the child has been approved for Children's Mental Health Program services. The child continues to be an assistance unit of one (1) for Medicaid eligibility purposes as long as the child continues to receive Children's Mental Health Program services.

Unless a change is subsequently reported that may impact eligibility, the child's Medicaid eligibility is not reviewed until the next annual renewal is due. A copy of the completed referral form must be kept in the case record.

E. Child Moves From Parental Home

When an enrolled child moves out of the parental home but is still living in Virginia, do not cancel Medicaid coverage solely on the basis of the move, and do not require a new application. Complete a partial review to determine the child's continuing eligibility if any changes in income, such as the child becoming employed, are reported.

1. Case Management

The necessary case management actions depend on the child's age and whether or not the child has moved to an arrangement in which an authorized representative is necessary.

a. Child Age 18 years or Under 18 and Living with a Relative

If the child is age 18, he may be placed in his own Medicaid case if he was previously on a case with other enrollees. If the child is under age 18 and moved in with an adult relative, the child may be placed on a case with the relative and the relative authorized to conduct Medicaid business on behalf of the child.

b. Child Under Age 18 years Living with Non-relative

When a child under age 18 moves to the home of a non-relative adult without legal custody, the non-relative adult does not have to be an authorized representative to report changes in the child's situation. However, the worker cannot discuss the case or send the non-relative adult a copy of the child's Medicaid card unless the person is authorized to handle the Medicaid business for the child. Follow the procedures in M1520.100 E.2 through E.4 below.

2. MMIS Enrollment

a. MMIS Case Number

The child's MMIS member ID number does not change, but the child's Member ID number must be moved to an MMIS base case number in the child's name as case head, if the person with whom the child is living does NOT have authority to act on the child's behalf.

b. MMIS Demographics Comment Screen

On the child's MMIS Demographics screen, enter a Comment that will inform staff that the person with whom the child lives cannot be given information from the child's MMIS records. Type a message in the Comment screen that says "information from the case cannot be shared with (the name of the person with whom the child lives) because he/she is NOT authorized to receive the information."

c. Renewal Date

If establishing a new MMIS case for the child, enter the child's existing renewal date from his former MMIS case. If moving the child to the adult relative's already established MMIS case, the child's renewal date will be the adult relative's case renewal date only if this action does not extend the child's renewal date past one year.

d. Medicaid Card

A new Medicaid insurance ID card is only generated when the enrollee's name, SSN or gender changes, or when a worker requests a replacement ID card.

Changing the child's address or MMIS case number does not generate a new card. The worker must request a replacement card in MMIS if one is needed. The existing card will be voided when the replacement is issued.

3. Obtain Authorization from Parent Prior to Renewal

Prior to the next scheduled renewal, the agency should try to obtain an authorization from the parent to allow the agency to communicate with the adult. However, as long as the parent has not formally lost custody of the child, the parent is still the responsible party and can transact the Medicaid business if he is capable and willing, or until there is a guardian/custodian established. If the parent cannot or will not designate an authorized representative, refer the case to the agency's Family Services Unit is so that guardianship can be established per M0120.200 C.

4. Renewal

Follow the rules in M0120.200, which apply to both applications and renewals. If the adult is a relative, the adult can complete the renewal for the child. If the adult is a non-relative and not an authorized representative, then the adult cannot complete the child's renewal. If the child's parent cannot or will not complete the renewal, a referral to the agency's Family Services Unit is needed to pursue guardianship.

F. Recipient Enters LTC

An evaluation of continued eligibility must be done when a Medicaid enrollee begins receiving Medicaid-covered long-term care (LTC) services. When the re-evaluation is done, complete and send all required notices to the enrollee/authorized representative, and send a DMAS-225 to the provider (see M1410.300).

Note: To determine the enrollee's Medicaid eligibility as an institutionalized individual, a pre-admission screening may be required (see M1420.100).

1. Partial Review Required

If an annual renewal has been done within the past 6 months, a partial review to address factors pertinent to receipt of LTC, such as asset transfer, spousal resource assessment, etc., must be completed. If the enrollee reports any changes requiring verifications, such as changes in income or resources, or an asset transfer, send the enrollee a written request for the necessary verifications, and allow at least 10 calendar days for the information to be returned. Document the renewal information and evaluation in the case record. Send all required notices (see M1410.300).

If the individual is already enrolled in a full benefit Medicaid covered group other than the ABD with Income $\leq$ 80% FPL covered group, do not change the AC. If the individual is enrolled as $\leq$ 80% FPL, the individual must be evaluated for eligibility in one of the covered groups for institutionalized individuals (i.e. income $\leq$ 300% of SSI). Follow the procedures in M1460 to determine the appropriate covered group/AC for the individual.

2. Renewal Required

If an annual renewal has not been done within the past 6 months, a complete renewal must be completed (see M1520.200). A new application is not required; complete a telephone interview renewal or a paper-based renewal. For individuals age 19 years and older, use the Medicaid Redetermination for Long-Term Care form (#032-03-369), available on SPARK at: http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi. For children under age 19, use the Families & Children Medicaid and FAMIS Plus Renewal Form (#03-032-018), available on SPARK at http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi

3. SSI Recipients

For an SSI recipient who has no community spouse and owns no countable real property, verify continued receipt of SSI through SOLQ-I or SVES, obtain information regarding asset transfer from the enrollee or authorized representative, and document the case record. As long as the individual continues to receive SSI, do not change the AC. If the individual loses SSI, evaluate his Medicaid eligibility in other covered groups. See M1430.104 for additional information regarding an SSI recipient who enters a nursing facility.

4. Individual on a Spenddown

When an individual on a spenddown enters LTC, his Medicaid eligibility must be determined using the procedures in subchapter M1460.

An individual on a spenddown in an assistance unit with a spouse and/or children becomes a separate assistance unit when he enters LTC. The spouse's and/or children's spenddown liability is recalculated to reflect a decrease in assistance unit size. See M1350.220 for additional information.

5. Married Institutionalized Individuals with a Community Spouse

Rules for determining Medicaid eligibility for married institutionalized recipients who have a community spouse are found in subchapter M1480.

M1520.200 RENEWAL REQUIREMENTS

A. Policy

The agency must evaluate the eligibility of all Medicaid enrollees, with respect to circumstances that may change, at least every 12 months. *Each renewal must be authorized by an eligibility worker or supervisor, although administrative staff may assist in the gathering of information.*

1. Required Verifications

An individual's continued eligibility for Medicaid requires verification of income for all covered groups and resources for covered groups with resource requirements. Blindness and disability are considered continuing unless it is reported that the individual is no longer blind or disabled.

***2.* SSN Follow Up**

If the enrollee's Social Security Number (SSN) has not been assigned by *the* renewal *date*, the worker must obtain the enrollee's assigned SSN at renewal in order for Medicaid coverage to continue. See subchapter M0240 for detailed procedures for obtaining the SSN.

3. Evaluation and Documentation

An evaluation of the information used to determine continued eligibility must be completed and included in the case record. *For ex parte renewals, the Record of Ex Parte Medicaid Renewal (#032-03-0740) is recommended. For contact-based renewals, either a paper renewal form or the Record of Telephone Interview for Medicaid Renewal (#032-03-0741), available on SPARK at http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi must be used to document the case record.*

The enrollee must be informed of the findings of the renewal and the action taken using the Notice of Action when continued eligibility exists. The Advance Notice of Proposed Action must be used when there is a reduction of benefits or termination of eligibility.

4. Voter Registration Requirement

The National Voter Registration Act of 1993 (NVRA) requires local social services agencies to offer Medicaid enrollees an opportunity to apply to register to vote at each renewal (redetermination) of eligibility (see M0110.300.A.3).

5. **12-Month Renewal Period**

Renewals must be completed prior to cut-off in the 12th month of eligibility. The first 12-month period begins with the month of application for Medicaid.

Subsequent renewals must be completed by the MMIS cut-off date no later than 12 months following the month *in which* the last renewal *was filed/initiated.* Monthly annual renewal lists are generated by the *VDSS Data Warehouse using MMIS data.* These *reports* notify eligibility workers of enrollees due *and overdue* for renewal.

6. **Scope of Renewals**

The scope of renewals is limited to information that is necessary to determine ongoing eligibility and that relates to circumstances that are subject to change, such as income and resources. Verification of information that is not subject to change, such as date of birth and Social Security Number (SSN), is not required at renewal, *unless it has not been verified previously*.

7. ***Types of Renewals***

There are two types of Medicaid eligibility renewals: non-contact based (ex-parte) and contact-based (telephone interview or paper-based). The type of renewal required depends on the enrollee's covered group requirements and availability of information necessary to determine continued eligibility. Whenever the necessary renewal information is available to the worker through data verification sources and policy permits, the client is not to be contacted and an ex parte renewal is to be completed. When an ex parte renewal is not possible, contact the individual by telephone or in writing.

For all types of Medicaid eligibility renewals, the agency must make all reasonable efforts to obtain relevant information from Medicaid files and other sources (subject to confidentiality requirements).

a. **Ex Parte Renewal**

An ex parte renewal is an internal review of eligibility based on *information* available *to the agency*. By relying on information available, the agency avoids unnecessary and repetitive requests for information from individuals and families that can add to administrative burdens, make it difficult for individuals and families to retain coverage, and cause eligible individuals and families to lose coverage. *The procedures for completing an ex parte renewal are in M1520.200 B, below.*

Individuals in the SSI Medicaid covered group must have an ex parte renewal unless they have reported ownership of non-excluded real property prior to the renewal.

When the ex parte process is used, a contact–based renewal, either through a telephone interview or paper form, must be completed at least once every five years.

b. Telephone Interview Renewal Process

If an ex parte renewal cannot be done, the eligibility worker may conduct a telephone interview renewal, either in conjunction with the renewal for other benefits or for Medicaid only. The procedures for completing a telephone renewal interview are in M1520.200 C below.

c. Renewal Using a Paper Form

If ongoing eligibility cannot be established through an ex parte renewal *and a telephone renewal interview is not feasible,* the agency must provide the individual the opportunity to present additional or new information on a paper renewal form and *to present* verifications necessary to determine ongoing eligibility. *The procedures for completing a renewal when a paper form is used are in section M1520.200 D, below.*

The following Medicaid renewal forms are available on SPARK at http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi:

- The Families & Children Medicaid and FAMIS Plus Renewal Form (#03-032-0187);
- The ABD Medicaid Renewal Form (#03-032-0186) ;
- *The BCCPTA Redetermination Form (#032-03-0653), for woman enrolled in the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) covered group.*
- The Medicaid Application/Redetermination for Long-Term Care (#032-03-0369), available at: http://spark.dss.virginia.gov/divisions/bp/me/forms/longterm_care.cgi, for individuals *receiving LTC services;*
- The Eligibility Review Part A (#032-03-729A) and Eligibility Review Part B (#032-03-729B) for individuals required to complete them for another benefit program.

B. Ex Parte Renewal *Process*

Local departments of social services are **required** to conduct renewals of ongoing *Medicaid* eligibility through *the* ex parte renewal process when:

- *the local agency has access to on-line systems information for verifications necessary to determine ongoing eligibility and/or income verifications obtained for other benefit programs, and*
- *the enrollee's covered group is not subject to a resource test.*

1. F&C Ex Parte Renewal Procedures

a. Use Available Information

The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family, and *must* make efforts to align renewal dates for all programs. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, information from SSA through SVES *or* SOLQ-I *and information from* child support and child care files.

*The eligibility worker is to take every opportunity to renew Medicaid eligibility when information is reported/verified that will allow a renewal of eligibility to be completed. For example, w*hen an ongoing Medicaid enrollee applies for SNAP or TANF or reports a change in income, use the income information obtained to complete an early *ex parte* Medicaid renewal and extend the Medicaid renewal for another 12 months.

b. Income Verification

The *eligibility* worker must document the date and method used to obtain the *verification* information (viewed *pay stub dated xx/xx/xxxx*, telephone *call on xx/xx/xxxx date*, etc.), the type of verification, the source and a description of the information. Income verification *that is* no older than 6 months old may be used unless the agency has reason to believe it is no longer accurate. It is not necessary to retain a copy of income verifications in the case record. If the renewal is not processed *and documented* in ADAPT, the documentation must be in the case record.

An enrollee who has previously reported $0 income must provide written confirmation of income at each renewal. If the agency has not obtained written confirmation for another program (e.g. SNAP), do not complete an ex parte renewal when an enrollee has reported $0 income. $0 income statements must be no more than 30 days old to be used. If written confirmation was provided for another program, it cannot be used if it is more than 30 days old.

2. Renewal *Procedures* For SSI Recipients and 1619(b) Individuals

a. Review Case Record

An ex parte renewal for an SSI recipient (*including an LTC recipient with no community spouse)* who has reported no *ownership interest in* countable real property can be completed by verifying *the individual's* continued receipt of SSI through SVES or SOLQ-I and documenting the case record. The ex parte process cannot be used for an SSI recipient who owns non-ex*cluded* real property. He is subject to a resource evaluation and the agency has no internal means to verify all his resources.

For a 1619(b) individual, check the Medicaid Test Indicator field in SVES or SOLQ-I to verify there is a code of A, B or F.

The case record must also contain documentation that the individual reported no ownership interest in countable real property, either on the application form or on a subsequent renewal form. If the case record does not contain documentation that the individual reported no ownership interest in real property, a contact-based (telephonic or paper form) renewal is to be completed at the next annual renewal.

b. Individual Loses SSI or 1619(b) Status

If the individual is no longer an SSI recipient or no longer has 1619(b) status and the information needed to determine continued eligibility is not known to the agency, *a contact-based (telephone interview or paper form)* renewal must be completed and necessary verifications obtained to evaluate the individual's eligibility in all other covered groups prior to canceling his Medicaid coverage.

C. *Telephone Interview Renewal Procedures*

When an ex parte renewal cannot be completed for an enrollee in any covered group, the eligibility worker may contact the enrollee by telephone. When a renewal is completed by telephone, no renewal form is sent to the enrollee, and the enrollee's signature is ***not*** *required. Send the enrollee a written request for the necessary verifications, and allow at least 10 calendar days for the information to be returned.* ***If an enrollee reports $0 income from any source, obtain a written statement indicating that he has no income.***

The renewal information and evaluation must be documented in the case record. The enrollee must be informed of the findings of the renewal.

D. ***Paper Renewal Procedures***

When a Medicaid renewal form is *used*, the form must be sent to the enrollee no later than the 11th month of eligibility. The worker can complete the renewal form and send it to the enrollee to sign and return ,or the worker can mail the form to the enrollee for completion. Allow at least 10 calendar days for receipt of the necessary verifications; additional time may be allowed *at the enrollee's* request. The specific information requested and the deadline for receipt of the verification must be documented *in the case record*.

E. ***Disposition of Renewal***

1. Renewal Completed

Notify the enrollee in writing of the findings of the renewal and the action taken. When eligibility continues, use the Notice of Action, and include the month and year of the next scheduled renewal. When the individual is no longer eligible, use the Advance Notice of Proposed Action and include spenddown information, if applicable. When there is a reduction of benefits, use the Advance Notice of Proposed Action and include the month and year of the next scheduled renewal.

***2.* Renewal Not Completed**

If information necessary to redetermine eligibility is not available through online information systems that are available to the agency and the enrollee has been asked but has failed to provide the information, the renewal must be denied and the coverage cancelled due to the inability to determine continued eligibility. *Action cannot be taken to cancel coverage until after the deadline for the receipt of verifications has passed, except for situations when the deadline falls on a weekend or holiday.*

3. Action Taken After Cutoff but Prior to Cancellation Date

When the enrollee fails to return the renewal form and verifications by the requested date and cutoff falls on a weekend or holiday, cancel the individual's coverage on the last business day before Medicaid cutoff, and send advance notice of the cancellation to the enrollee. However, if the early cancel action is taken, LDSS must *re-evaluate* the renewal if the individual provides the necessary information by the last day of the month in which the renewal is due.

If the individual's is determined eligible, the LDSS must reinstate the individual's coverage and send a notice to the individual notifying him of the reinstatement, *his* continued coverage *and the next renewal month and year. If the re-evaluation determines that the enrollee is not eligible, send a Notice of Action indicating the correct reason for the cancellation (e.g. countable income exceeds the limit).*

***F*. Special Requirements for Certain Covered Groups**

1. Pregnant Woman

Do not initiate a renewal of eligibility of an MI pregnant woman, or a pregnant woman in any other covered group, during her pregnancy. Eligibility in a pregnant woman covered group ends effective the last day of the month in which the 60th day following the end of the pregnancy occurs.

When eligibility in a pregnant woman covered group ends, *prior to the cancellation of her coverage,* determine if the woman meets the definition for another Medicaid covered group (see M0310.002). If the woman meets the definition of a full-benefit covered group, or *for limited coverage under Plan First,* determine if an ex parte renewal can be completed or if a renewal form is required and take appropriate action.

If the woman does not meet the definition and/or the income requirements for another full-benefit covered group, *determine her eligibility in the limited benefit Plan First covered group using the eligibility requirements in M0320.302.*

If the woman is eligible for Plan First, reinstate her coverage in Plan First and send the Advance Notice of Proposed Action indicating that she has been enrolled in Plan First. On the notice, state that if she does not wish to remain covered by Plan First, to contact the eligibility worker and request that the coverage be cancelled. Include a Plan First Fact Sheet, available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi, with the Advance Notice of Proposed Action.

Do not use change transactions to move an individual between full and limited coverage.

2. **Newborn Child Turns Age 1**

An application for a child enrolled as a Newborn Child Under Age 1 must be filed before MMIS cut-off in the last month in which the child meets the Newborn Child Under Age 1 covered group and must include:

- an application (see M0120.300)
- SSN or proof of application
- verification of income
- verification of resources for the MN child.

3. ***MI*** **Child Under Age 19—*Income Exceeds FAMIS Plus Limit***

Eligibility of children in the MI Child Under Age 19 (FAMIS Plus) covered group must be renewed at least once every 12 months.

When an enrolled FAMIS Plus child no longer meets the MI income limits, *ADAPT will* evaluate the child for the Family Access to Medical Insurance Security Plan (FAMIS).

If the worker must determine eligibility outside ADAPT, use the eligibility requirements in chapter M21. If the child is eligible for FAMIS, send the family an Advance Notice of Proposed Action that Medicaid will be cancelled effective the last day of the month in which the 10-day advance notice expires and the FAMIS coverage will begin the first day of the month following the Medicaid cancellation. Use cancel reason “042” when the child loses eligibility in Medicaid and is reinstated in FAMIS and there is no break in coverage.

Do not use change transactions to move a child between Medicaid and FAMIS. If the child is not eligible for FAMIS, the worker must provide an opportunity for the child to be evaluated as medically needy prior to sending an advance notice and canceling the child's Medicaid coverage. *It is not necessary to obtain a new application. The necessary information regarding resources can be obtained using either Review Form Part B or the resource section of the Application for Benefits.*

4. **FAMIS Plus Child Turns Age 19**

When a FAMIS Plus child turns age 19, redetermine the child's continuing Medicaid eligibility in other covered groups, *outside ADAPT.*

If information in the case record indicates that the child is disabled or may be disabled, verify the child's SSI benefits through SVES or SOLQ-I. If the child does not receive SSI, complete a referral to Disability Determination Services (DDS) following the procedures in M0310.112. The referral to DDS must be made at least 90 calendar days prior to the child's 19th birthday *to allow the disability determination to be made prior to the child's 19th birthday.*

If the child does not meet the definition for another covered group, determine the child's eligibility in Plan First *using the eligibility requirements in M0320.302. If the child is eligible for Plan First, reinstate coverage in Plan First and send the Advance Notice of Proposed Action indicating that he has been enrolled in Plan First. On the notice, state that if he does not wish to remain covered by Plan First, to contact the eligibility worker and request that the coverage be cancelled. Include a Plan First Fact Sheet, available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/facts.cgi, with the Advance Notice of Proposed Action.*

5. **Child Under 21 Turns Age 21**

When an *individual who is enrolled in the* Child Under Age 21 *covered group turns* 21, *redetermine his continuing Medicaid eligibility in other covered groups, including Plan First.*

6. **IV-E FC & AA *Children and* Special Medical Needs Children From Another State**

The renewal of Medicaid coverage for Title IV-E foster care or adoption assistance children and non-IV-E special medical needs adoption assistance children requires only the following information:

- verification of continued IV-E eligibility status or non-IV-E special medical needs status,
- the current address, and
- any changes regarding third-party liability (TPL).

This information can be obtained from agency records, the parent or the Interstate Compact office from another state, when the child's foster care or adoption assistance agreement is held by another state. A renewal form is not required. The information must be documented in the case record.

7. **Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA)**

The BCCPTA Redetermination Form (#032-03-653), is used to redetermine eligibility for the BCCPTA covered group. The form is available on *SPARK* at: http://spark.dss.virginia.gov/divisions/bp/me/forms/index.html. The enrollee must provide a statement from her medical provider verifying continued treatment for breast or cervical cancer. There are no Medicaid financial requirements for the BCCPTA covered group.

8. **Hospice Covered Group**

At the annual renewal for an individual enrolled in the Hospice covered group (AC 054), the worker must verify the enrollee's continued election and receipt of hospice services, *in addition to determining continued Medicaid eligibility.*

9. **Qualified Individuals**

Coverage for individuals enrolled in the Qualified Individuals (QI) covered group (AC 056) is automatically cancelled effective December 31 of the current year. However, coverage for QIs can be renewed annually provided that there is no break in Medicaid eligibility.

Renewals for all QIs are due by December 31 of each year. On or after November 1 of each year, send the ABD Medicaid Renewal Form (#032-03-0186) to all individuals currently enrolled in the QI covered group. Follow the ABD Medicaid renewal procedure to request verifications and complete the evaluation.

a. Renewal form returned BEFORE December 31st

If the individual remains eligible for QI coverage, do not act *do not* change the renewal date in MMIS prior to December 31. On or after January 1 of the following year, reinstate the QI coverage in MMIS, effective January 1. Change the renewal date in MMIS to December 31 *of the current year*. Send a Notice of Action on Medicaid and FAMIS (form #032-03-0008) indicating that the individual's coverage continues and the date of the next renewal.

b. Renewal form returned AFTER December 31st

If the renewal form is not returned by December 31st the individual must submit a new application for Medicaid. The MMIS-generated cancellation notice will serve as the 10-day advance notice for cancellation of the individual's QI coverage.

G. LTC

The ex parte renewal process is used for institutionalized individuals who receive SSI and have no countable real property. It can also be used for other enrollees when the local agency has access to on-line information for verifications necessary to determine ongoing eligibility and/or income verifications obtained for other benefit programs and the covered group has no resource test.

For all others, the eligibility worker may complete a telephone interview renewal or a paper-based renewal. For individuals age 19 years and older, use the Medicaid Redetermination for Long-Term Care form. For children under age 19, use the Families & Children Medicaid and FAMIS Plus Renewal Form.

Send the enrollee a written request for the necessary verifications, and allow at least 10 calendar days for the information to be returned. Document the renewal information and evaluation in the case record. Send all required notices (see section 1410.300).

The patient pay must be updated in MMIS at least every 12 months, even if there is no change in patient pay. Send the provider a DMAS-225 when there has been a change in circumstances resulting in a change in eligibility. If there has been no change in circumstances, do not send a DMAS-225 to the provider.

M1520.400 MEDICAID CANCELLATION OR SERVICES REDUCTION

M1520.401 NOTICE REQUIREMENTS

A. Policy

Following a determination that eligibility no longer exists or that the enrollee's Medicaid services must be reduced, the Advance Notice of Proposed Action must be sent to the enrollee at least 10 days plus one day for mail, before action is taken to cancel or reduce Medicaid coverage. If the action to cancel or reduce benefits cannot be taken in the current month due to MMIS cut-off, then the action must be taken by MMIS cut-off in the following month. The Advance Notice of Proposed Action must inform the enrollee of the last day of Medicaid coverage.

The Advance Notice of Proposed Action is available on *SPARK* at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi.

B. Change Results in Adverse Action

1. Services Reduction

When information is secured that results in a reduction of Medicaid services to the enrollee or a reduction in the Medicaid payment for the enrollee 's services (when the patient pay increases), the "Advance Notice of Proposed Action" must be sent to the enrollee at least 10 days plus one day for mail, before the adverse action is taken.

If the enrollee requests an appeal hearing before the effective date, the enrollee may choose to have eligibility continued at the current level of services until a decision is reached after a hearing. In the event the decision is adverse to the enrollee, the amount Medicaid paid on the services being appealed that were received by the recipient during the continuation is subject to recovery by the Department of Medical Assistance Services (DMAS). If the enrollee requests an appeal hearing before the effective date of the action and the DMAS Appeals Division notifies the local agency that the enrollee's coverage must be reinstated during the appeal process, reinstate the enrollee's coverage in the MMIS. **Do not reinstate coverage until directed to do so by the DMAS Appeals Division.**

Medicaid coverage at the prior level is not continued when a request for appeal is filed on or after the effective date of the action.

2. Adverse Action Resulting from Computer Matches

When adverse action is taken based on information provided by computer matches from any source, such as IEVS, the Virginia Employment Commission (VEC) or SAVE, notice must be mailed at least ten (10) days before the effective date of the action, excluding the date of mailing and the effective date.

3. Matches That Require Advance Notice

The following list indicates some of the computer match sources which require a ten (10) day advance notice *when, after the worker reviews the individual's eligibility in light of the match information, the enrollee is determined ineligible:*

Match Source	Notification Period
Internal Revenue Service (IRS) unearned income files	10 days
Beneficiary and Earnings Data Exchange (Bendex)	10 days
State Data Exchange (SDX)	10 days
Enumeration Verification System (SSN)	10 days
Systematic Alien Verification For Entitlements (SAVE)	10 days
Department of Motor Vehicles (DMV)	10 days
Virginia Employment Commission (VEC)	10 days
Benefit Exchange Earnings Record (BEERS)	10 days
Public Assistance Reporting Information System (PARIS)	*10 days*

C. Procedures

1. Action Appealed

Adverse action must not be taken if the recipient requests an appeal hearing before the effective date of the action. The DMAS Appeals Division will notify the local agency whether to continue coverage during the appeal. **Do not reinstate coverage until directed to do so by the DMAS Appeals Division.**

If the recipient requests an appeal hearing before the effective date, the recipient may choose to have eligibility continued at the current level of services until a decision is reached after a hearing. In the event the decision is adverse to the recipient, the amount Medicaid paid on the services being appealed that were received by the recipient during the continuation is subject to recovery by the Department of Medical Assistance Services (DMAS).

When notification is received from DMAS that the agency's proposed adverse action was sustained, the recipient's eligibility must be terminated effective the date of the receipt of that letter. No further advance notice to the recipient is necessary since he/she is also informed of DMAS' decision.

2. Death of Recipient

The eligibility worker must take the following action when it is determined that an enrollee is deceased:

If the enrollee has an SSN, the worker must verify the date of death. The worker must run a SVES *or SOLQ-I* request to verify the date of death. SVES will display an "X" and the date of death in the "SSN VERIFICATION CODE" field on Screen 1.

If the recipient does not have an SSN, or if SOLQ-I or SVES does not return information showing that the recipient is deceased, contact the parent/caretaker relative or authorized representative to obtain the date of death. Information from a medical professional/facility is also acceptable.

The worker must document the case file. Send adequate notice of cancellation to the estate of the enrollee at the enrollee's last known address and to any authorized representative(s) using the "Notice of Action on Medicaid."

Cancel coverage in MMIS using cancel code "001." The effective date of cancellation is the date of death.

3. End of Spenddown Period

When eligibility terminates at the end of a six-month spenddown period, advance notice is not required. The individual is notified of the limited period of spenddown eligibility on the Notice of Action sent at the time the spenddown application is approved. Explanation of this limitation and information relative to re-application is provided at the time of the spenddown eligibility determination and enrollment.

M1520.402 CANCELLATION ACTION OR SERVICES REDUCTION

A. Introduction

1. MMIS Transaction

An enrollee's coverage must be canceled in MMIS prior to the date of the proposed action. The change to the MMIS enrollee file must be made after system cut-off in the month the proposed action is to become effective. For example, if the Notice of Action specifies the intent to cancel coverage on October 31, a change to MMIS is made prior to cut-off in October.

In the event the proposed action is not taken, the enrollee's coverage must be immediately reinstated. If the enrollee files an appeal prior to the proposed date of action, the DMAS Appeals Division will notify the agency if the enrollee's coverage should be reinstated.

2. Reason "012" Cancellations

When information is received from DMAS that a case is canceled for cancel reason "012", the local social services department must determine if the cancellation is valid. When cancellation is not valid, the case must be re-enrolled immediately.

When the cancellation is valid, the local department must mail the individual an adequate notice of cancellation using the NOA. Adequate notice consists of specifying the date the cancel action took place, which is the date the notice is mailed, in the section marked "Other" on the notification form.

Cancel actions done by DMAS staff or MMIS are reported in the Client Information Document (CID) report available on *SPARK* at: https://securelocal.dss.virginia.gov/reports/benefits/vammis/index.cgi.

M1520.403 ENROLLEE REQUESTS CANCELLATION

A. Introduction

An enrollee may request cancellation of his *and/or his children's medical assistance* coverage *at any time. The request can be verbal or written.*

B. Written Request

A written withdrawal request must be placed in the case record.

C. Verbal Request

A verbal request for withdrawal can be accepted only from the enrollee or case head, or his authorized representative. A verbal request must be documented in the case record with the date and time the withdrawal request was received, the name of the person who made the withdrawal request, and the signature and title of the agency staff person who took the call.

D. Worker Action

When the enrollee requests cancellation of Medicaid, the local department must send a **Notice of Action** to the enrollee no later than the effective date of cancellation. Advance notice is not required when the enrollee requests cancellation.

E. Notice Requirements

On the notice:

- check the "other" block and list the reason as "Medicaid coverage cancelled at the enrollee's request,"
- include the effective date of cancellation and instruct the enrollee to discontinue using the card after that date, and
- instruct the enrollee to retain the Medicaid card for future use in case coverage is reinstated within the next 12 months (the system will generate a new card after 12 months).

Cancel Medicaid coverage in MMIS using the cancel reason *code* "004."

M1520.500 EXTENSIONS OF MEDICAID COVERAGE

A. Policy

Medicaid recipients may be eligible for an extended period of Medicaid coverage when the family meets all the requirements for the Low Income Families with Children (LIFC) covered group except income.

LIFC families who received Medicaid in 3 of the last 6 months and who became ineligible for Medicaid due to increased income from child and/or spousal support may be eligible for a 4-month extension.

LIFC families who received Medicaid in 3 of the last 6 months and who became ineligible for Medicaid due to an increase in earnings may be eligible for a 12 months extension. Earnings could increase because of a new job, a raise in the rate of pay or more hours are being worked.

NOTE: Children must first be evaluated for Medicaid eligibility in the MI Child Under Age 19 (FAMIS Plus) covered group and if eligible, enrolled using the appropriate MI Child Under Age 19 AC. If ineligible as MI, the child must be evaluated for the Medicaid extensions. If ineligible for the Medicaid extensions, the child must be evaluated for FAMIS. If ineligible for FAMIS, the family must be given an opportunity for a medically needy determination prior to the worker taking action to cancel the Medicaid coverage.

B. Procedure

The policy and procedures for the four-month extension are in section M1520.501 below.

The policy and procedures for the twelve-month extension are in section M1520.502 below.

M1520.501 FOUR-MONTH EXTENSION

A. Policy

An LIFC Medicaid family is entitled to four additional months of Medicaid coverage after they lose Medicaid LIFC eligibility when the following conditions are met:

- The family received Medicaid as LIFC in at least three of the six months immediately preceding the month in which they became ineligible for LIFC;
- The family lost eligibility solely or partly due to receipt of or increased child or spousal support income; and
- All other Medicaid eligibility factors except income are met.

B. Procedures

1. Received in Error

For purposes of this subsection, "received Medicaid as LIFC" does not include received Medicaid erroneously. Therefore, a family unit who received Medicaid erroneously during 3 or more of the 6 months *before* the month of ineligibility does **not** qualify for the Medicaid extension.

2. New Family Member A new member of the family unit is eligible for Medicaid under this provision if he/she was a member of the unit in the month the unit became ineligible for LIFC Medicaid. However, even if a baby was not born as of that month, a baby born to an eligible member of the unit during the 4-month extension is eligible under this provision because the baby meets the categorically needy non-money payment newborn child under age 1 covered group.

3. Moves Out of State Eligibility does not continue for any member of the family unit who moves to another state.

4. Coverage Period Medicaid coverage will continue for a period of four months beginning with the month in which the family became ineligible for LIFC Medicaid because of support income.

5. Aid Category Cases eligible for this four-month extension are categorically needy non-money payment. A Medicaid-Only application and case are recorded statistically. The aid category (AC) for the recipients in the unit remains "081" for an LIFC family unit with one parent or caretaker-relative or "083" for a two-parent family unit.

6. Case Handling Those cases closed in a timely manner must be held in a suspense file until the fourth month after the LIFC Medicaid cancellation month. At that time, action must be taken to evaluate continuing Medicaid eligibility.

If all eligibility factors are met, the children in the case may continue eligible as MI or medically needy. Make the appropriate AC changes to the enrollee's MMIS record.

The caretaker's Medicaid coverage must be canceled if he/she does not meet a Medicaid covered group. An appropriate "Advance Notice of Proposed Action", form 032-03-018 must be sent to the recipient if the caretaker or the case is no longer eligible for Medicaid.

M1520.502 TWELVE-MONTHS EXTENSION

A. Policy An LIFC Medicaid family is entitled to six additional months, with possible extension to twelve months, of Medicaid coverage after they lose Medicaid LIFC eligibility when the following conditions are met:

- The family received Medicaid as LIFC in at least three of the six months immediately preceding the month in which they became ineligible for LIFC;
- The family lost eligibility solely or partly due to receipt of or increased income from earnings or expiration of $30 + one-third or $30 earned income exclusion; and
- All other Medicaid eligibility factors except income are met.

The family consists of those individuals living in the household whose needs and income were included in determining the LIFC Medicaid

eligibility of the assistance unit at the time that the LIFC Medicaid eligibility terminated. It also includes family members born, adopted into, or returning to the family after extended benefits begin who would have been considered a member of the unit at the time the LIFC Medicaid eligibility terminated.

The earned income of family members added after the family loses LIFC Medicaid eligibility must be counted to determine gross family income.

B. Eligibility Conditions

The following conditions must be met:

1. Received LIFC Medicaid in 3 of 6 Months

The family received LIFC Medicaid in at least 3 of the 6 months immediately before the month in which the family became ineligible for LIFC. *Months during which the family received Extended Medicaid are not considered months in which the family received LIFC Medicaid.*

2. Cancel Reason

LIFC Medicaid was canceled solely because of:

- the caretaker/relative's new employment,
- the caretaker/relative's increased hours of employment,
- the caretaker/relative's increased wages of employment, or
- expiration of any assistance unit member's $30 plus 1/3, or $30, earned income disregard.

3. Has A Child Living in Home

The family continues to have at least one child under age 18, or under age 19 if in school, living in the home.

4. No Fraud

The family has not been determined to be ineligible for LIFC Medicaid because of fraud any time during the last six months in which the family received LIFC Medicaid.

C. Entitlement & Enrollment

Entitlement does not continue for any member of the unit who moves to another state.

Enrollees receiving this extension are categorically needy non-money payment aid category (AC) "081" for an LIFC family unit with one parent or caretaker-relative or "083" for a two-parent family unit.

1. Determining Extension Period

Medicaid coverage will continue for six months beginning with the first month the family is not eligible for LIFC Medicaid because of excess income due to any unit member's expiration of the $30 plus 1/3 or $30 earned income disregard, or due to the increased earnings of the caretaker/relative. Extension for an additional 6-month period is possible if the reporting and financial requirements are met (below).

a. New/increased Earnings Not Reported Timely

When the new/increased earnings were not reported so that action to cancel LIFC Medicaid could be taken in a timely manner, the extension period begins the month following the month the assistance unit would have last received LIFC Medicaid if reported timely.

For example, if the increased earnings were received in April, but were not reported or discovered until a review of eligibility in June, the 12-month period begins with May, the first month the family's LIFC Medicaid should not have been received. The screening period to determine if the family unit received LIFC Medicaid in at least 3 of the six months immediately preceding the month in which the unit became ineligible for LIFC Medicaid will be November to April.

b. Simultaneous Income Changes

In situations where an earned income case has simultaneous income changes which cause LIFC Medicaid ineligibility, such as new or increased earned income plus an increase in support, the eligibility worker must determine if the case would have been ineligible due to new or increased earnings or loss of the disregards. This requires that the eligibility worker recalculate the LIFC income eligibility only considering the increased earned income or loss (expiration) of the disregards.

1) If the family would have been ineligible for one of these reasons, it will be considered the reason for LIFC Medicaid ineligibility and the family is eligible for the 12-month Medicaid extension.

2) If, however, the family would have continued to be eligible for LIFC Medicaid if the only change had been increased earnings or expiration of the disregards, the other changes which occurred simultaneously will be the reason for LIFC Medicaid ineligibility. The family is **not** eligible for the Medicaid extension.

2. Extension Ends

Entitlement to Medicaid under this extension period terminates at the end of the first month in which the family unit ceases to include a child under age 18 or under age 19 if in school, the family unit fails to comply with the reporting requirements in D below, or at the end of the extension period.

The child(ren)'s eligibility for Medicaid in another covered group or for FAMIS must be determined prior to canceling the child(ren)'s Medicaid coverage. An "Advance Notice of Proposed Action" must be sent prior to canceling extended Medicaid coverage.

D. Notice and Reporting Requirements

1. LIFC Medicaid Cancellation Month

When LIFC Medicaid is canceled, the unit must be notified of its entitlement to extended Medicaid coverage for six months, and that

Medicaid coverage will terminate if the child(ren) in the family turns age 18, or turns age 19 if the child is in school. *Use the Notice of Extended Medicaid Coverage form that is posted on SPARK at: http://spark.dss.virginia.gov/divisions/bp/files/me/forms/general/032-03-0728-04-eng.doc.*

a. Instructions to Family

The family unit must be instructed to retain verifications of all earnings received during each month of the extension and attach verifications of the first three-month period's earnings to the agency by the 21st day of the fourth month in the extension period. The names of the three months in the three-month period must be written out on the notice form and the *earnings* report form.

b. Notices

The instructions to the family are on the Notice of Extended Medicaid Coverage and *on* the *second page of the notice which is the* Medicaid Extension Earnings Report. *The 2-page form is posted on SPARK at: http://spark.dss.virginia.gov/divisions/bp/files/me/forms/general/032-03-0728-04-eng.doc.*

c. MMIS Data Entry

After the worker sends the initial Extended Medicaid notice, the worker enters a Follow-up Code and Follow-up Date (the begin date of the extension) on the Case Data screen in MMIS. MMIS will automatically generate subsequent notices and earnings reports to the family. The MMIS Extended Medicaid procedures are contained in Chapter I of the MMIS Users' Guide for DSS.

2. Third Month of Extension

In the third month of extension, the unit must be notified that it must return the Medicaid Extension Earnings Report, with the earnings verifications attached, to the agency by the 21st of the following month (the fourth month).

This notice will be sent automatically by *MMIS* if the correct Follow-up Code and effective date of the 12-month extension are entered on the *Case Data screen in MMIS.* If the *Follow-up C*ode and *Follow-up Date* are **not** entered correctly or in a timely manner, the agency must manually send the notice.

The notice will state that if the earnings report and verifications are not received by the 21st day of the fourth month, Medicaid coverage will be canceled effective the last day of the sixth month, and that the family will not be eligible for any additional Medicaid extension.

3. Fourth Month of Extension

If the first three-month period's report is not received by the 21st day of the fourth month, the family is not eligible for the additional six-month extension. Medicaid must be canceled effective the last day of the sixth month in the extension period.

a. Notice Requirements

MMIS will send the advance notice and automatically cancel coverage at the end of the sixth month if the initial Follow-up Code and Date were entered correctly, and the code is **not** updated because the report was not received on time. If the code was not entered correctly, the agency must manually send the *Advance Notice of Proposed Action* and must cancel the family's coverage in *MMIS* after the Medicaid cut-off date in the fifth month. The effective date of cancellation will be the last day of the sixth month in the extension period.

b. Determine Child(ren)'s Eligibility

The child(ren)'s eligibility for Medicaid in another covered group or for FAMIS must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income, including earned and unearned income. If the child is eligible, change the child's enrollment to the appropriate aid category **before the cut-off date** of the sixth extension month. If not eligible, leave the child's enrollment (the case Follow-up Code and Follow-up Date fields) as it is and *MMIS* will cancel the child's coverage.

If the child(ren)'s eligibility is not reviewed by the **cut-off date** of the sixth extension month, *MMIS* will cancel coverage. The agency must reopen the child(ren)'s Medicaid if the child(ren) is determined eligible and must notify the recipient of the reopened coverage.

c. Report Received Timely

If the first three-month period's report is received by the 21st day of the fourth month, and the family continues to include a child, entitlement to extended Medicaid continues. The Follow-up Code must be changed *on the MMIS* Case *Data screen* when the report is received in order for *Extended* Medicaid to continue. No action is taken on the first three-month period's earnings.

4. Sixth Month of Extension

In the sixth month of extension, the unit must be notified that it must return the "Medicaid Extension Earnings Report" for the previous three-month period (the fourth through the sixth month), with the earnings verifications for those three months attached, to the agency by the 21st day of the seventh month of extension.

The notice must state that if this three-month period's report and verifications are not returned by the 21st day of the seventh month, Medicaid coverage will be canceled effective the last day of the eighth month of extension.

MMIS will automatically send this notice if the Follow-up Code in the base case information is correct. If it is not correct, the agency must manually send this notice.

5. Seventh Month of Extension

If the second three-month period's report and verifications are not received by the 21st of the seventh month, the family's Medicaid coverage must be canceled after an Advance Notice of Proposed Action is sent. *MMIS* will send the advance notice and automatically cancel coverage if the report is not received on time and the code is not changed.

Medicaid coverage must be canceled unless the family establishes good cause for failure to report on a timely basis. Examples of good cause for failure to report timely are:

- illness or injury of family member(s) who is capable of obtaining and sending the material;

- agency failure to send the report notice to the family in the proper month of the extension.

a. Determine Child(ren)'s Eligibility

The child(ren)'s eligibility for Medicaid in another covered group or for FAMIS must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income, including earned and unearned income. If the child is eligible, change the child's enrollment to the appropriate aid category before the **cut-off date** of the eighth extension month. If not eligible, leave the child's enrollment (the base case Follow-up Code and Follow-up Date fields) as it is and MMIS will cancel the child's coverage.

If the child(ren)'s eligibility is not reviewed by the **cut-off date** of the eighth extension month, MMIS will cancel coverage. The agency must then reopen coverage and notify the recipient if the child is subsequently found eligible.

b. Cancellation Effective Date

Cancellation is effective the last of the eighth month of extension.

c. Report Received Timely

If the second three-month period's report is received by the 21st of the seventh month, change the case Follow-up Code in MMIS immediately upon receipt of the report and verifications. The family will continue to be eligible for extended Medicaid coverage unless:

1) no child under age 18, or under age 19 if in school, lives with the family;

2) the caretaker/relative had no earnings in one or more of the previous three months, unless the lack of earnings was due to:
   - the caretaker/relative's involuntary lay-off,
   - the business closed,
   - the caretaker/relative's illness or injury,
   - other good cause (such as serious illness of child in the home which required the caretaker/relative's absence from work);

3) the family unit's average gross monthly **earned** income (earned income only; unearned income is not counted) less costs for child care that was necessary for the employment of the caretaker/relative, during the preceding three-month period exceeds the 185% Federal Poverty Level (FPL) appropriate to the family unit size.

See subchapter M0710, Appendix 7, for the 185% FPL income limits.

d. Calculate Family's Gross Earned Income

1) The "family's" gross earned income means the earned income of all family unit members who worked in the preceding three-month period. "Gross" earned income is total earned income before any deductions or disregards. All earned income must be counted, including students' earned income, JTPA earned income, children's earned income, etc. No exclusions or disregards are allowed.

1) Child care costs that are "necessary for the caretaker/relative's employment" are expenses that are the responsibility of the caretaker/relative for child care that if not provided would prevent the caretaker/relative from being employed.

2) To calculate average gross monthly income:

- add each month's cost of child care necessary for the caretaker/relative's employment; the result is the three-month period's cost of child care necessary for the caretaker/relative's employment.

- add the family unit's total gross earned income received in each of the 3 months; the result is the family's total gross earned income.

- subtract the three-month period's cost of child care necessary for the caretaker/relative's employment from the family's total gross earned income.

- divide the remainder by 3; the result is the average monthly earned income.

- compare the average monthly earned income to the monthly 185% FPL for the appropriate number of family unit members.

e. Family No Longer Entitled To Extended Medicaid

1) If the family is not entitled to further Medicaid coverage because of one of the reasons in item 5.c. above, each family member's eligibility for Medicaid in another covered group must be determined before canceling coverage.

Contact the recipient and request current verification of the family's total income, including earned and unearned income. If eligible, change the enrollment to the appropriate aid category before cut-off in the eighth extension month.

2) If the family is ineligible because of excess income, cancel Medicaid coverage. If any of the ineligible family members meet a medically needy covered group definition, send an Application for Benefits to the family giving them the opportunity to apply for spenddown.

3) If any of the family members are eligible for FAMIS or FAMIS MOMS, enroll them in FAMIS or FAMIS MOMS, and transfer the case to the FAMIS Central Processing Unit (CPU).

f. Family Remains Entitled To Extended Medicaid

If the family remains eligible for *Extended Medicaid*, no action is required until the ninth month of extension, except to be sure that the Follow-up Code was updated in the computer when the income report was received.

6. Ninth Month of Extension

In the ninth month of extension, the unit must be notified that it must return the "Medicaid Extension Earnings Report" with earnings verifications attached, for the previous three-month period (seventh through ninth month) to the agency by the 21st day of the tenth month of the extension.

The notice must state that if the report and verifications are not returned by 21st day of the tenth month, Medicaid coverage will be canceled effective the last day of the eleventh month of extension.

MMIS will automatically send this notice if the correct *Follow-up* Code is in the base case information on the computer. If it is not *correct*, the local agency must manually send this notice.

7. Tenth Month of Extension

If the third three-month period's report and verifications are not received by the 21st of the tenth month, the family's Medicaid coverage must be canceled after an advance notice is sent. *MMIS* will automatically cancel coverage and send the advance notice if the report is not received on time and the Follow-up Code is not changed.

Medicaid coverage must be canceled unless the family establishes good cause for failure to report timely (see 5. above for good cause).

a. Determine Child(ren)'s Eligibility

If the report is not received on time, the child(ren)'s eligibility for Medicaid in another covered group or for FAMIS must be determined before canceling coverage. Contact the recipient and request current verification of the family's total income. If eligible, change the child(ren)'s enrollment to the appropriate aid category before the **cut-off date** of the eleventh extension month. If not eligible, leave the child's enrollment (the base case Follow-up Code and Follow-up Date fields) as it is and *MMIS* will cancel the child(ren)'s coverage.

If the child(ren)'s eligibility is not reviewed by the **cut-off date** of the eleventh extension month, *MMIS* will cancel coverage. The agency must then reopen coverage and notify the recipient if the child(ren) is *subsequently* found eligible.

b. Cancellation Effective Date

Cancellation is effective the last day of the eleventh month of extension.

c. Report Received Timely

If the third three-month period's report is received by the 21st of the tenth month, change the case Follow-up Code in *MMIS* immediately upon receipt of the report and verifications. The family continues to be eligible for Medicaid unless one of the items in 5.c. above applies. Calculate the family's income using the procedures in 5.d. above.

d. Family No Longer Entitled To Extended Medicaid

1) If the family is not entitled to **extended** Medicaid coverage, review their eligibility for Medicaid in another category or for FAMIS or FAMIS MOMS. If not eligible, cancel Medicaid after sending the **Advance Notice of Proposed Action**. Cancellation is effective the last day of the eleventh month of extension.

2) If the family is ineligible because of excess income, cancel Medicaid coverage. **Send the Advance Notice of Proposed Action**. If any of the ineligible family members meet a medically needy covered group definition, send an Application for Benefits to the family giving them the opportunity to apply for spenddown.

3) If any of the family members are eligible for FAMIS or FAMIS MOMS, enroll them in FAMIS or FAMIS MOMS and transfer the case to the FAMIS Central Processing Unit (CPU).

e. Family Remains Entitled To Extended Medicaid

If the family remains entitled to Extended Medicaid coverage, a redetermination of the family's Medicaid eligibility must be completed by the Medicaid cut-off in the twelfth month.

8. Twelfth Month of Extension

Before Medicaid cut-off in the twelfth month, complete the family's redetermination. *MMIS* will automatically cancel coverage and send the advance notice after cut-off of the twelfth month, if the Follow-up Code was updated correctly. Therefore, for any of the family members that remain eligible for Medicaid or FAMIS-FAMIS MOMS, the AC and the Follow-up Code must be changed before cut-off of the twelfth month.

If any of the family members are eligible for FAMIS or FAMIS MOMS, enroll them in FAMIS or FAMIS MOMS and transfer the case to the FAMIS Central Processing Unit (CPU).

For family members who are not eligible for Medicaid or FAMIS-FAMIS MOMS, **send the Advance Notice of Proposed Action** and cancel Medicaid effective the last day of the twelfth month.

If any of the ineligible family members meet a medically needy covered group definition, send an Application for Benefits to the family giving them the opportunity to apply for spenddown.

M1520.600 CASE TRANSFERS

A. Introduction

Applications and ongoing cases are transferred only when the individual retains residence in Virginia.

B. Nursing Facility and Assisted Living Facility (ALF)

When an applicant/recipient is admitted to a nursing facility or an ALF from a community living arrangement, the case is not transferred, but remains with the Virginia locality in which the individual last lived outside of an institution. Community living arrangements do not include medical facilities, ALFs or group homes with four or more beds.

When an applicant/recipient is discharged from a nursing facility or ALF to a community living arrangement not in the Virginia locality that had responsibility for the individual's case while he was in the nursing facility or ALF, the case is transferred to the new locality.

C. DBHDS Facilities

The procedures for transfer of Medicaid cases of ABD patients admitted to or discharged from Department of Behavioral Health and Developmental Services (DBHDS) facilities are in subchapter M1550. F&C cases are not transferred to the DBHDS facilities.

D. Cases From DMAS FAMIS Plus Unit FIPS 976 - *Receiving LDSS Responsibilities*

The Medicaid cases approved by the DMAS FAMIS Plus Unit, FIPS 976, must be transferred to the local department of social services (LDSS) where the recipient lives. Medicaid cases are **not** transferred from local agencies **to** the DMAS FAMIS Plus Unit (FIPS 976).

1. Confirm Receipt

The receiving LDSS must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the DMAS FAMIS Plus Unit.

2. Do Not Review Eligibility

Do not review eligibility for cases transferred from the DMAS FAMIS Plus Unit for eligibility until

- a change is reported that potentially impacts the individual's non-financial or financial Medicaid eligibility, or
- the annual renewal is due.

3. Entering Case in ADAPT

When *entering* the case into ADAPT, use the gross monthly income for each individual in the FAMIS Plus assistance unit who has income, to ensure that the income determination made by the FAMIS Plus Unit is captured. On the ADAPT income screen, use the "Monthly" code for frequency even if the income is received more or less frequently. Complete instructions for entering a case transferred from the FAMIS Plus Unit into ADAPT are available at: http://spark.dss.virginia.gov/divisions/bp/me/training/index.cgi.

4. LDSS Not Responsible for Any Errors

LDSS will not be held responsible for errors found if the case is pulled for a program integrity review or audit as long as (1) no partial review or annual renewal was completed since the case transfer and (2) the annual renewal is not overdue.

E. Cases From Outstationed Workers

Medicaid applications taken and Medicaid cases approved by outstationed workers, such as the workers stationed at the University of Virginia (UVA) or the workers at Medical College of Virginia (MCV) hospitals, must be transferred to the LDSS where the applicant/enrollee lives. Medicaid cases and applications are **not** transferred from LDSS **to** outstationed workers.

1. Confirm Receipt

The receiving LDSS must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the outstationed worker.

2. Review Eligibility

LDSS workers must review (partial review) the Medicaid eligibility determination in approved cases transferred from an outstationed worker, and must take any necessary corrective action.

3. Corrective Action

If an eligibility error(s) is found, do not send the case back. Correct the error(s), send the notice to the case head if required, and refer the case to the LDSS supervisor for possible contact with the outstationed worker's supervisor.

F. Local Agency to Local Agency

When a Medicaid applicant/enrollee (including a Medicaid CBC waiver services enrollee) moves from one locality to live in a community living arrangement (not a medical facility, an ALF, or group home with 4 or more beds) in another locality within the state of Virginia, the following procedures apply:

1. Sending Locality Responsibilities

a. Case Renewal Cannot Be Overdue

The sending locality must make certain the case is current and complete before transferring the case. If the annual renewal has been completed within the past 10 months, a partial review based on known information, as to whether or not the recipient will meet a covered group and the income and resource limits in the new locality, must be completed before transferring the case.

If the annual renewal is due in the month the LDSS plans to transfer the case or the following month, the renewal must be completed before transferring the case.

Exception: When the Medicaid case is in ADAPT and SNAP is active in the ADAPT case, the SNAP case transfer rules override the Medicaid policy that the Medicaid renewal cannot be overdue. The ADAPT case must be transferred immediately to the new locality, even if the Medicaid renewal is overdue, due in the transfer month or due in the following month to comply with the SNAP case transfer rule.

b. When Renewal Must Be Completed Before Transferring

If the sending LDSS must complete the renewal before transferring the case, the Sending LDSS must keep the case record to complete the renewal.

The sending locality must update the enrollees' MMIS records as follows to assure managed care continuity:

1) Case Data screen - change the case address to the case's new address. Do not change the Case FIPS or Caseworker number because the sending LDSS worker retains responsibility for the case until the renewal is completed.

2) Enrollee Demographics screen, Enrollee FIPS – change each enrollee's Enrollee FIPS to the new address's FIPS code.

When the renewal is completed and the enrollee remains eligible, transfer the ADAPT case (if in ADAPT) or update the enrollee's MMIS Case FIPS to the enrollee's locality of residence and update the Caseworker number to M0000. Send the paper case record to the enrollee's locality of residence with a completed Case Record Transfer Form.

c. Do Not Transfer Ineligible Cases

If the annual renewal or the partial review finds that eligibility no longer exists for one or all enrollees in the case, the agency must take the necessary action, including advance notice to the individuals, to cancel the ineligible individuals' coverage. Only eligible enrollees' cases are transferred.

d. Transfer Eligible Enrollees/Cases

If the renewal or the partial review indicates that the enrollee(s) will continue to be eligible for Medicaid in the new locality, the sending locality must update the ADAPT case, if the case is in ADAPT, or MMIS if the case is not in ADAPT. The sending locality must prepare the "Case Record Transfer Form" and forward it with the case record to the LDSS in the new locality of residence.

e. Transfer Pending Medicaid Applications

Pending applications must be transferred to the new locality for an eligibility determination.

f. Foster Care & Adoption Assistance

Foster care and adoption assistance Medicaid cases are not transferred unless custody or responsibility for services and/or payment is transferred.

g. Sending Transferred Cases

The eligibility record must be sent by certified mail, delivered personally and a receipt obtained or, at the agency's discretion, the case may be sent via the courier pouch.

2. Receiving Locality Responsibilities

a. Confirm Receipt

The receiving agency must confirm receipt of the case by completing the Case Record Transfer Form and returning the copy to the sending agency.

b. Process Pending Applications

When a pending application is transferred, the receiving agency makes the eligibility determination and takes all necessary action, including sending the notice and enrolling eligible individuals in MMIS.

c. Review Eligibility

LDSS workers must review (partial review) the Medicaid eligibility determination for cases transferred from other LDSS and must take any necessary corrective action.

d. Corrective Action

If an eligibility error(s) is found or the case is overdue for renewal, do not send the case back. Correct the error(s), and/or complete the renewal, send the notice to the case head if required, and refer the case to the LDSS supervisor for possible contact with the sending agency's supervisor.

F. Spenddown Cases

Cases in spenddown status (denied or canceled and placed on a spenddown) must be transferred when the applicant notifies the agency that he/she has moved to a new Virginia locality.

1. Sending Locality Responsibilities

Within 10 working days of notification that the applicant has moved, the case must be transferred to the new locality, using the "Case Record Transfer Form." The sending agency must:

- inform the applicant of the receiving agency's name, address, and telephone number;
- deduct all known spenddown items from the spenddown balance on the worksheet before sending the case record;
- note the spenddown period and balance on the case transfer form.

2. Receiving Locality Responsibilities

The receiving locality logs the case record on file, but does not open it statistically. The receiving locality must review the spenddown to determine if a recalculation based on a different income limit is required.

If the spenddown is met, the application is recorded statistically as taken, approved, and added to the caseload at that time.

G. *Receiving LDSS Case Management Procedure*

To identify and manage transferred Medicaid cases, use the report titled "Caseworker Alpha Case/Enrollee Listing." This report is posted in the Data Warehouse, MMIS Reporting, Medicaid Management Reports. It is updated on or about the 22nd of each month.

Most LDSS agencies and the DMAS FAMIS Plus Unit transfer cases in MMIS to Worker Number "M000" or "M0000." To identify transferred Medicaid cases, check the locality's report for Worker Number "M000" and "M0000." If the receiving LDSS uses another worker or caseload number for transferred-in cases, and the sending locality or DMAS FAMIS Plus Unit knows about the worker/caseload number for transfer cases, also check for cases in that worker number.

CHAPTER M15
ENTITLEMENT POLICY & PROCEDURES
SUBCHAPTER 50

DMHMRSAS FACILITIES

CHAPTER M15
ENTITLEMENT POLICY & PROCEDURES
SUBCHAPTER 50
DEPARTMENT OF BEHAVIORAL HEALTH AND DEVELOPMENTAL SERVICES (DBHDS) FACILITIES

M1550 Transmittal Changes

Changed With	Effective Date	Pages Changed
TN #96	10/01/11	Appendix 1, page 1
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TN #91	05/15/09	Appendix 1

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M1550.000 *DBHDS* FACILITIES

M1550.100 GENERAL PRINCIPLES

A. Introduction

The Department of Social Services' Division of Benefit Programs has five eligibility workers, called Medicaid Technicians, located in four *Department of Behavioral Health and Developmental Services (DBHDS)* facilities to determine the patients' eligibility for Medicaid. The Medicaid Technicians function like a local department of social services (LDSS) agency. Medicaid cases may be transferred to and from the Medicaid Technicians.

B. Procedures

This subchapter contains a list and a brief description of the *DBHDS* facilities (M1550.200), a directory of the Medicaid Technicians (M1550.300, and procedures for handling cases of Medicaid applicants/recipients admitted to or discharged from a *DBHDS* facility (M1550.400).

M1550.200 *DBHDS* FACILITIES

A. Introduction

Three types of medical facilities are administered by *DBHDS*: training centers, psychiatric hospitals, and a general hospital with nursing facility beds. Below is a brief description of each type of facility.

1. Training Centers

Training centers are medical facilities for patients diagnosed as mentally retarded (institutions for the mentally retarded). Training centers provide either or both intermediate and skilled nursing care. Some patients receiving intermediate care may be employed and have earned income.

Normally, patients in the training centers are disabled, but some are children who have not been determined disabled. Patients of any age in a training center may be Medicaid eligible if they meet all nonfinancial and financial Medicaid eligibility requirements.

The State training centers and locations are:

- Central Virginia Training Center (CVTC) – Madison Heights
- Southside Virginia Training Center (SSVTC) – Petersburg
- Northern Virginia Training Center (NVTC)– Fairfax
- Southeastern Virginia Training Center (SEVTC) – Chesapeake
- Southwestern Virginia Training Center (SWVTC) – Hillsville

2. Psychiatric Hospitals

Psychiatric hospitals are medical facilities – institutions for the treatment of mental diseases – which provide care and services to mentally ill patients. There are two types of psychiatric hospitals: intensive psychiatric and psychiatric/chronically mentally ill. These hospitals may have patients of any age, although two of them are dedicated to geriatric patients and one serves only adolescents.

Patients in psychiatric hospitals may be Medicaid eligible only if they are

- under age 21 years (if treatment began before age 21 and continues, they may be eligible up to age 22), or
- age 65 years or older,

and they meet all non-financial and financial Medicaid eligibility requirements.

The following are psychiatric hospitals, offering differing levels of care:

a. Eastern State Hospital – Williamsburg
b. Central State Hospital – Petersburg
c. Western State Hospital – Staunton
d. Northern Virginia Mental Health Institute – Falls Church
e. Southern Virginia Mental Health Institute – Danville
f. Southwestern Virginia Mental Health Institute – Marion
g. Piedmont Geriatric Hospital – Burkeville
h. Catawba Hospital – Catawba
i. Commonwealth Center for Children and Adolescents (CCCA) – Staunton (formerly Dejarnette Center)

CCCA is a psychiatric hospital for adolescents between the ages of 4 and 18. Children are provided schooling, counseling and medication. Most children have not been determined disabled. A child in CCCA can be Medicaid-eligible if the child meets all nonfinancial and financial Medicaid eligibility requirements.

2. General Hospital

General hospitals are medical facilities which provide care and services to acutely physically ill patients in the *DBHDS* facilities. The general hospitals may have patients of any age. There are general hospital acute care units within Eastern State and Western State Hospitals, and the Hiram Davis Medical Center general hospital located on the campus of Central State Hospital in Petersburg. Hiram Davis provides medical and surgical treatment for patients from any *DBHDS* facility. Hiram Davis also has some beds certified for nursing facility level of care.

Patients in the general hospitals may be Medicaid eligible if they meet all non-financial and financial Medicaid eligibility requirements.

M1550.300 MEDICAID TECHNICIANS

The Medicaid Technicians share responsibilities for the *DBHDS* facilities assigned to their caseloads. See M1550, Appendix 1, for the chart listing the Medicaid Technicians, their supervisor, addresses, telephone numbers and caseload assignment.

M1550.400 CASE HANDLING PROCEDURES

A. Introduction

Effective July, 1994, the Aged, Blind or Disabled (ABD) Medicaid cases handled by local departments of social services and cases of patients in *DBHDS* facilities will be transferred between the facility and the local DSS agency when the individual leaves a community to enter a *DBHDS* facility or leaves the *DBHDS* facility to live in a community. Case transfer policy in M1520.600 is applicable.

NOTE: Transfer procedures are applicable only to individuals who are eligible in an ABD covered group. The Medicaid case of a child eligible in a Families and Children (F&C) covered group who is a patient in a *DBHDS* facility is the responsibility of the local department of social services (LDSS) in which the child last resided. If the child is not currently a Medicaid recipient, an application for Medicaid may be made with the LDSS in the locality in which the child last resided.

Persons between the ages of 21 (or 22 if treatment began before age 21) and 65 are not eligible for Medicaid while they are patients in an institution for treatment of mental diseases (IMD) or tuberculosis.

B. Procedures

Use the policy and procedures contained in the subchapters below when an individual is:

- admitted to a *DBHDS* facility (M1550.401),
- discharged from a *DBHDS* facility to a community living arrangement (M1550.402),
- discharged from a *DBHDS* facility to an assisted living facility (ALF) (M1550.403), and
- discharged from a *DBHDS* facility to a nursing facility or Medicaid Community-based Care (CBC) waiver services (M1550.404).

M1550.401 ADMISSION TO *DBHDS* FACILITIES

A. Introduction

When a Medicaid recipient is admitted to a *DBHDS* facility from a community living arrangement, follow the procedures in this section. The procedures for an ABD recipient differ from those for an F&C recipient

B. Local Social Services

1. ABD Recipient

When an ABD recipient has been admitted to a *DBHDS* facility, the eligibility worker must determine if it is appropriate to transfer the case. Do not transfer the Medicaid case of an individual between the ages of 21 and 65 if the individual is admitted to an IMD since he or she cannot be Medicaid eligible while in the institution. The Medicaid case of such an individual must be closed.

If the recipient is not in the *DBHDS* facility for 30 days, the local EW must complete the DMAS-*225* for the patient's stay in the facility, and must send it to the facility's Reimbursement office.

After the ABD recipient has been in the facility for 30 days, transfer the Case to the appropriate Medicaid Technician in the appropriate *DBHDS* facility. **Do not close the case.**

2. F&C Recipient

IF the patient being admitted is an individual eligible in a Families and Children (F&C) category, the case will NOT be transferred to the *DBHDS* facility, but will be retained by the LDSS. The individual will be considered temporarily absent from the home and will continue to be eligible in the F&C category as long as all non-financial and financial requirements are met.

C. *DBHDS* Reimbursement Office

Send a DMAS-*225* to the Medicaid Technician to advise of name of the patient, date of admission, facility, etc. The technician will take the following steps.

1. Inquire MEDPEND

The Technician will inquire through MEDPEND and Medicaid Management and Information System (MMIS) to see if the patient has a pending Medicaid application or is enrolled in Medicaid. If a pending case is found in MEDPEND and the Medicaid Technician has not received the case, the Medicaid Technician will contact the eligibility worker (EW) in the LDSS which holds the patient's case and advise the EW that the recipient has been admitted to the facility. Pending applications must have eligibility determined with 45-90 days as per policy. The Medicaid Technician will request that the case be transferred immediately.

2. Active Case Found

If inquiry into MMIS indicates an active Medicaid case and the Medicaid Technician has not received the case, the Medicaid Technician will contact Medical Records at the end of 30 days to determine if the patient is still in the facility.

- If the patient is still in the facility, the Medicaid Technician will request that the case be transferred.

- If the patient has left the facility before the end of the 30 day period, the Medicaid Technician will advise the EW in the local agency that the individual has left the facility. Reimbursement will send the DMAS-*225* to the local EW for completion.

3. No Active Case Found

If the patient has neither a pending application nor an active Medicaid case and Medicaid eligibility needs to be pursued, Reimbursement must submit a completed Application For Benefits on behalf of the patient, providing as much information as possible. Attach any verifications available and send to the Medicaid Technician.

D. Medicaid Technician

When a DMAS-*225* is received from Reimbursement, search MEDPEND and MMIS systems. NOTE: If the patient is between the ages of 21 and 65 and in an IMD, he or she cannot be Medicaid eligible while in the IMD. For other patients admitted, including those admitted as respite or emergency admissions, use the following procedures:

1. Pending Case in MEDPEND

If a pending case is found in MEDPEND, contact the local agency shown holding the case. Advise them that the recipient is now a patient in the facility and request that the pending case be transferred immediately, since an eligibility determination must be made within 45/90 days. When a determination is completed, notify the agency according to policy. Send the Notification of Action on Medicaid to the Reimbursement office and a copy of the notice to the patient's authorized representative.

2. Active Case in MMIS

If an active case is found in MMIS, follow-up 30 days from the date the patient entered the facility. Contact Medical Records to determine if the patient is still in the facility.

a. If so, ask the EW in the LDSS holding the case to transfer the case.

b. If the patient has left the facility at the time of the 30 day follow-up, advise the EW of that information; return the DMAS-*225* to Reimbursement indicating that patient's eligibility must be determined by the local agency because the patient was not in the facility for 30 days.

3. Transfer Case Received

When an active case is received in transfer, a full redetermination must be done in order to determine if the patient continues to be eligible for Medicaid based on his or her current status using policy for institutionalized ABD individuals. After the redetermination is completed, update the MMIS and send appropriate notification according to policy. Send appropriate notice to Reimbursement office and a copy to the patient's authorized representative.

4. No Pending or Active Case

If neither a pending application nor an active Medicaid case is found, open a case using a completed Application for Benefits submitted by the Reimbursement Office on behalf of the patient.

a. If a case number is found in MEDPEND or MMIS, use that case number to establish the hospital case.

b. If no case number is found in MEDPEND or MMIS, but there is an inactive case in the facility, use the facility case number.

c. Send all notification required by policy to Reimbursement with a copy to the authorized representative for the patient.

5. Patient Discharged

If the patient is discharged before spending 30 days in the facility and the application is received after discharge, immediately forward the case to the appropriate local DSS agency for processing.

M1550.402 PATIENTS DISCHARGED FROM *DBHDS* FACILITIES

A. Introduction

When a Medicaid recipient in a *DBHDS* facility will be discharged from the facility, follow the procedures in the following sections:

- for patients discharged to a community living arrangement, see this section M1550.402;
- for patients discharged to an assisted living facility (ALF), see section M1550.403;
- for patients discharged to a nursing facility, see section M1550.404.

B. *DBHDS* Discharge Planner/Social Worker/ Reimbursement

For Medicaid patients who do not receive SSI, contact the Social Security Administration (SSA) within 15 days of discharge to apply for SSI. If a patient's SSI has been decreased while in the institution, advise SSI of the patient's discharge so that, if appropriate, his or her SSI may be increased.

Medicaid cases of patients discharged to a living arrangement which is not an assisted living facility (ALF) or nursing facility will be transferred to the LDSS in which he or she will be living.

C. Reimbursement Office

Send the DMAS-*225* to the Medicaid Technician and DMAS to advise of the date the patient will leave the facility.

D. Medicaid Technician

The Medicaid case of a Medicaid enrollee discharged to a living arrangement which is not an ALF or nursing facility will be transferred to the LDSS in the locality where he or she will be living.

Do a desk review of all cases to be transferred to an LDSS, **but do NOT determine if the recipient will be eligible in the locality.**

Update the MMIS. Enter the new city/county code on the case, new address, and change worker number to M0000.

Forward the case containing all original Medicaid information, any verification provided by discharge planner and/or Reimbursement office, and the DMAS-*225*, via certified mail to the appropriate LDSS.

E. Eligibility Worker in LDSS

When the case is received, do a full redetermination to determine the recipient's continued eligibility for Medicaid in his or her new circumstances.

Send the Case Record Transfer Form to the Medicaid Technician to notify the Technician of disposition of the transfer.

M1550.403 PATIENTS DISCHARGED TO ALF

A. Introduction

When a patient in a *DBHDS* facility will be discharged to an assisted living facility (ALF), follow the procedures in this section.

B. *DBHDS* Discharge Planner/Social Worker/ Reimbursement

The Medicaid case of a patient who will be discharged to enter an ALF will be transferred to the LDSS in the Virginia locality in which the Medicaid recipient last resided outside of an institution.

1. Medicaid Patient Discharge to ALF

For patients being discharged to an ALF who are Medicaid eligible in the *DBHDS* facility, complete an Application For Benefits to apply for Auxiliary Grants (AG) and a Uniform Assessment Instrument. Attach copies of any verifications, a copy of the Community Placement Plan, the DMAS-*225* and the DMAS-96. Send the completed forms to the LDSS immediately.

The Discharge Planner should not request information from the Medicaid case, but should complete the Application For Benefits providing the latest information available on the patient. The Medicaid Technician should also be given a copy of the Community Placement Plan and the DMAS-*225* for the Medicaid case.

The Medicaid Technician will transfer the Medicaid case to the LDSS. However, the AG application form should be sent immediately to the appropriate LDSS in order to expedite processing, with a note that the patient's Medicaid case is being transferred to them. **The application must be received by the LDSS in the month of the patient's entry to the ALF in order for an AG payment to be made for that month, if eligible; no retroactive payments are made for AG.**

2. Patient Not On Medicaid, Discharged to ALF

For patients being discharged to an ALF who are not Medicaid eligible in the *DBHDS* facility, but for whom a AG/Medicaid application needs to be pursued, complete an Application For Benefits providing the latest known information on the patient, and a UAI. Attach copies of any verifications available, a copy of the Community Placement Plan, the DMAS-*225* and the DMAS-96.

Applications for patients being discharged to an ALF must be sent to the LDSS in the locality in which the patient last resided prior to entering the *DBHDS* facility. If admission to the *DBHDS* facility was from the out of state but the patient intends to remain in Virginia, the application must be sent to the LDSS in the Virginia locality in which the ALF is located. **Do not send any information to the Medicaid Technician located in the *DBHDS* facility.**

The application must be received by the LDSS in the month of the patient's entry to the ALF in order for payment to be made for that month, if eligible; there are no retroactive payments made for AG.

C. Medicaid Technician

Do a desk review of all cases to be transferred to a LDSS, **but do NOT determine if case will be eligible in the locality.** Update the MMIS. Enter new city/county code, new address, and change worker number to M0000.

Forward the case containing all original Medicaid information, any verifications provided by discharge planner/Reimbursement office, and DMAS-*225*, via certified mail to the appropriate LDSS.

D. Eligibility Worker in LDSS

When the case is received, do a full redetermination to determine the recipient's continued eligibility for Medicaid and, if appropriate, eligibility for Auxiliary Grants, in his or her new circumstances. Send the Case Record Transfer Form to the Medicaid Technician to notify the Technician notify the Technician that the case was received by the agency.

M1550.404 PATIENTS DISCHARGED TO NURSING FACILITY/CBC

A. Introduction

When a patient in a *DBHDS* facility will be discharged to a nursing facility or to a community living arrangement with Medicaid CBC waiver services, follow the procedures in this section.

B. *DBHDS* Discharge Planner/ Social Worker/ Reimbursement

1. Patient Not On Medicaid

If the patient was not Medicaid-eligible in the *DBHDS* facility but Medicaid eligibility in the patient's new circumstances needs to be determined, the Discharge Planner, Social Worker, Reimbursement, patient or the patient's authorized representative may complete an Application For Benefits and send it to the appropriate LDSS.

Applicants for patients being discharged to a nursing facility must be sent to the LDSS in the locality in which the patient last resided prior to entering the *DBHDS* facility. If admission to the *DBHDS* facility was from out of state but the patient intends to remain in Virginia, the application form must be sent to the Virginia locality in which the nursing facility is located.

Applications for patients being discharged to a community living arrangement with Medicaid CBC waiver services must be sent to the locality in which the patient will reside.

2. Medicaid Patient

If the patient was Medicaid eligible in the facility, provide the Medicaid Technician a copy of the Community Placement Plan, the DMAS-*225* and any other information necessary to transfer the Medicaid case record.

C. Reimbursement Office

Send the DMAS-*225* to the Medicaid Technician and DMAS to advise them of the date the patient will leave the facility.

D. Medicaid Technician

The Medicaid case of an eligible individual discharged to a nursing facility or CBC will be transferred to the LDSS in the locality in which he or she last resided outside of an institution.

Do a desk review of the case to be transferred to the LDSS. Update the MMIS with the new city/county code, new address, and change the worker number to M0000.

Forward the case containing all original Medicaid information, any verification provided by the discharge planner and/or Reimbursement office, and the DMAS-*225*, via certified mail to the appropriate LDSS. Note on the Case Transfer Form that this case is a nursing facility or CBC waiver case so that the receiving agency will be alerted to take immediate action.

E. Eligibility Worker in LDSS

When the case is received, do a full redetermination to determine the recipient's continued eligibility for Medicaid in his or her new circumstances.

Send the Case Record Transfer Form copy to the Medicaid Technician to notify the Technician that the case was received by the agency.

DBHDS Facilities
Medicaid Technicians

NAME	LOCATION	WORK TELEPHONE	CASELOAD
Brenda Wolhfert, Supervisor (T006)	Central Virginia Training Center Medicaid Office Madison Heights, VA Mail to: P. O. Box 1098 Lynchburg, VA 24505	434-947-2754 cell 434-906-0024 FAX-434-947-2114	CVTC-caseload-A-L
Mary Lou Spiggle (T003)	Central Virginia Training Center Medicaid Office Madison Heights, VA Mail to: P. O. Box 1098 Lynchburg, VA 24505	434-947-6256 FAX-434-947-2114	CVTC-caseload-M-Z PGH-caseload-all WSH-caseload-all NVMHI-caseload-all SVMHI-caseload-all
Debra J. Quesenberry (T002)	Catawba Hospital Medicaid Office P. O. Box 200 Catawba, VA 24070	540-375-4350 FAX-540-375-4383	Catawba-caseload-all NVTC-caseload-all *HDMC*-caseload-all
Frances Jones (T004)	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0841 FAX-276-782-9732	SWVTC-caseload-all ESH-caseload-A-O SSVTC-caseload-A-G
Vickie C. Simmons (T005)	Southwestern Virginia Mental Health Institute 340 Bagley Circle Marion, VA 24354	276-783-0842 FAX-276-782-9732	SEVTC-caseload-all ESH-caseload-P-Z SSVTC-caseload-H-Z SWVMHI-caseload-all

NOTE: Because the Medicaid Technicians handle various hospitals in their caseloads, LDSS staff should send transferred case records directly to the Medicaid Technician who requested the case record. In the case record transfer request, the Medicaid Technician will give specific instructions about where to send the case record.

DBHDS Facilities:

FIPS	Facility Initials and Full Name
997	Catawba – Catawba Hospital
990	CVTC – Central Virginia Training Center
994	ESH – Eastern State Hospital
988	NVMHI – Northern Virginia Mental Health Institute
986	NVTC – Northern Virginia Training Center
993	PGH – Piedmont Geriatric Hospital
985	SEVTC – Southeastern Virginia Training Center
989	SSVTC – Southside Virginia Training Center
983	SVMHI – Southern Virginia Mental Health Institute
992	SWVMHI – Southwestern Virginia Mental Health Institute
984	SWVTC – Southwestern Virginia Training Center
991	WSH – Western State Hospital
996	*HDMC*-Hiram Davis Medical Center

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M1600.00 APPEALS PROCESS

M1610.100 PURPOSE AND SCOPE

A. Legal Base

The Social Security Act requires that the State Plan for Medical Assistance provide individuals affected by the administration of the Medical Assistance Program an opportunity for a fair hearing. The act establishes the right of any individual to appeal and receive a fair hearing before the administering agency, the Department of Medical Assistance Services (DMAS), when DMAS or any of its designated agents:

- takes an action to terminate, deny, suspend, or reduce benefits,
- fails to take an application for medical assistance,
- fails to act on an application for medical assistance with reasonable promptness, or
- takes any other action that adversely affects receipt of medical assistance.

The State law governing the State/Local Hospitalization (SLH) program requires that DMAS use the Medicaid applicant/*enrollee* appeals and hearings procedures for SLH applicants and *enrollees*. The procedures in this Chapter also apply to SLH appeals.

B. Participants

The DMAS Appeals Division provides the Hearing Officer who makes arrangements for the fair hearing. The Appeals Division is separate and apart from operational divisions and units within and outside of DMAS. The Division provides a neutral forum for appeals. The Hearing Officer is an impartial decision-maker who will conduct hearings, decide on questions of evidence, procedure and law, and render a written final decision. The Hearing Officer is one who has not been directly involved in the initial adverse action which is the issue of the appeal.

The local agency taking the action being appealed, including *Disability Determination Services (DDS)* disability decisions, and the appellant (the individual appealing some aspect of his entitlement to medical assistance or its scope of services) or his representative must participate in the hearing. *Most hearings will be conducted by telephone.*

C. Ex Parte Communication

Ex parte communication with the Hearing Officer is strictly prohibited. *Ex parte communication is any off-the-record communication (oral or written) between the Hearing Officer and an interested party outside the presence of the other parties to the proceeding during the life of the appeal proceeding.*

The Hearing Officer cannot discuss the substantive issues of an appeal with anyone outside of the hearing. Therefore, it is not appropriate to contact the Hearing Officer to discuss the agency's action prior to or after the hearing.

Any information provided to the Hearing Officer must be provided to all parties of the proceeding. However, as noted in M1620.100, it is appropriate to notify all parties to the appeal when an action is taken by an agency to resolve the issue of the appeal. Communication is also allowed for procedural issues such as scheduling hearings, canceling hearings, and indicating a desire to withdraw an appeal.

D. Notification and Rights

At the time of application or redetermination, and at the time of any action or proposed action affecting eligibility for medical assistance, medical services or patient pay, every applicant for and *enrollee* of medical assistance shall be informed in writing of his right to a hearing. He shall also be notified of the method by which he may obtain a hearing, and of his right to represent himself at the hearing or to be represented by an authorized representative such as an attorney, relative, friend, or other spokes*person*.

M1620.100 LOCAL AGENCY CONFERENCE

A. Time Limits

A dissatisfied applicant or *enrollee* must be given the opportunity to request a local agency conference. *If a conference is requested, it must be* scheduled within 10 working days of receiving *the* request.

B. Conference Procedures

At the conference, the applicant/*enrollee* must be:

- given an explanation of the action.
- allowed to present any information to support his disagreement with the action.
- allowed to represent himself or be represented by an authorized representative such as a legal counsel, friend, or relative.

C. Failure to Request a Conference

The applicant's or enrollee's failure to request a conference does not affect his right to appeal within 30 days and does not affect his right to continued eligibility if he appeals prior to the effective date of the action.

D. The Conference & Right to Appeal

The local agency conference must <u>not</u> be used as a barrier to the individual's right to a fair hearing.

E. Decision Notification

The local agency conference may or may not result in a change in the agency's decision to take the action in question, however an agency can reverse its decision at any time between making the original decision and when a decision is rendered by the Hearing Officer.

If the agency's decision is not to take the adverse action indicated on the notice, the applicant or enrollee must be informed in writing. The agency must send a new notice regarding the changed action. A copy of the new notice must be sent to the DMAS Appeals Division.

If the agency's decision is to stand by its action, the applicant/*enrolle*e must be i*nformed,* but written notice of this decision is not required.

F. Conference Decision

If the applicant/enrollee is not satisfied with the agency action following the conference and wants to request a fair hearing, he must be given that opportunity. See M1630.100 C. below. The applicant/enrollee may request an appeal before or after the conference. Participation in a conference does not extend the 30 day time limit for requesting an appeal.

M1630.100 APPEAL REQUEST PROCEDURES

A. Appeal Definition

An appeal is a request for a fair hearing. The request must be *a clear, written* expression by an applicant or *enrollee*, his legal representative (such as a guardian, conservator, or person having power of attorney), or his authorized representative acting at his request, of a desire to present his case to a higher authority. It may be a letter or a completed "Medicaid/SLH/FAMIS Appeal Request Form."

B. Where to File an Appeal

Appeals must be sent to the:

Department of Medical Assistance Services
Appeals Division, *11th Floor*
600 East Broad Street
Richmond, Virginia 23219

Appeals may also be faxed to (804) 371-8491.

C. Assuring the *Right* to Appeal

The *right to* appeal must not be limited or interfered with in any way. When requested to do so, the agency *must* assist the *applicant/enrollee* in preparing and submitting his request for a fair hearing.

D. Appeal Time Standards

A request for *an appeal* must be made within 30 days of receipt of notification that Medicaid *coverage* or medical services has been denied, terminated, reduced, adversely affected, or that it has not been acted upon with reasonable promptness.

Notification is presumed received by the applicant/*enrollee* within three days of the date the notice was mailed, unless the applicant/*enrollee* substantiates that the notice was not received in the three-day period through no fault of his/her own.

An appeal request shall be deemed to be filed timely if it is mailed, faxed, or otherwise delivered to the DMAS Appeals Division before the end of last day of filing (30 days plus 3 mail days after the date the agency mailed the notice of adverse action). The date of filing will be determined by:

- *the postmark date,*
- *the date of an internal DMAS receipt date-stamp, or*
- *the date the request was faxed or hand-delivered.*

In computing the time period, the day of the act or event from which the period of time begins to run shall be excluded, and the last day included. If the time limit would expire on a weekend or state or federal holiday, it shall be extended until the next regular business day.

The DMAS will, at its discretion, grant an extension of the time limit for requesting *an appeal* if failure to comply with the time limit is due to a good cause such as illness of the appellant or his representative, failure to have been notified of the right to appeal, delay due to the postal service or to an incorrect address, or other unusual or unavoidable circumstances.

M1640.100 CONTINUED COVERAGE PENDING APPEAL DECISION

A. Appeal Validation

Following receipt of a written request for a hearing, the DMAS Appeals Division will determine whether the request *is valid. A valid* appeal is one that *involves* an action over which the DMAS has hearing authority, and that is received within the required time limit or extended time limit. During the process of validating an appeal request, a representative of the DMAS may contact the agency to request a copy of the notice of the adverse action. Upon receipt of such a request, the agency must immediately send a copy of the notice to the DMAS Appeals Division.

When an appeal is *determined to be valid, the DMAS will send official notification to the agency and identify the issue and Hearing Officer.*

B. Coverage May Continue

When an appeal is received and validated, the DMAS Appeals Division decides if Medicaid coverage must continue and notifies the agency. The agency should not continue coverage due to the appeal until it has been contacted by the Appeals Division. Upon being informed, by telephone or correspondence, that the *enrollee* is eligible to receive continued coverage, the agency must reinstate coverage immediately.

An *enrollee*'s Medicaid coverage must continue until a final appeal decision is made when an appeal hearing is requested prior to the effective date of the action stated on the "Advance Notice of Proposed Action". *In the case of a patient pay adjustment, the patient pay obligation must return to the amount that was effective prior to the change shown on the "Notice of Obligation for Long Term Care Costs" that is the subject of the appeal.*

C. *When Continued Coverage Does Not Apply*

*Coverage **will not** continue when:*

- an appeal hearing is requested on or after the effective date of action;
- an *enrollee* does not dispute the facts used by the local agency, but is appealing the policy on which the agency based its action;
- at the hearing, the Hearing Officer determines that the sole issue of the appeal is disagreement with existing State or Federal policy or law and that no facts are disputed. The Hearing Officer will *promptly* notify

the *enrollee* or his representative and the agency in writing that continued Medicaid coverage must terminate immediately. The agency *must* terminate the *enrollee*'s Medicaid immediately, using cancel reason "015" effective the date of the hearing.

D. Recovery of Continued Coverage Costs

When the Hearing Officer upholds the agency's action, the cost of medical care received during the period of continued coverage may be recovered by the DMAS. (See M1670.100)

M1650.100 PRE-HEARING ACTIONS

A. Invalidation

A request for an appeal may be invalidated if it was not filed within the time limit imposed or if it was not filed by the applicant/enrollee or an authorized representative.

1. Appeal Not Filed Timely

If DMAS determines that the appellant has failed to file a timely appeal, DMAS shall notify the appellant or the appellant's representative of the opportunity to show good cause for the late appeal.

If there is no response, or if after evaluating the response, the Hearing Officer determines that the reason for failing to file a timely appeal does not meet good cause criteria, the appeal request will be considered invalid.

2. Factual Dispute of Timeliness

If a factual dispute exists about the timeliness of the request for an appeal, the Hearing Officer shall receive testimony and evidence at the hearing prior to receiving testimony and evidence about the substantive issue of the appeal. A decision on the timeliness issue will be made prior to a determination of whether to make a decision about the substantive issue of the appeal.

3. When Individual Filing Appeal Is Not the Appellant

If the individual filing the appeal is not the appellant or an authorized representative of the appellant, DMAS will request that the appellant and/or representative provide proof of authorization to represent the appellant. If proof is not provided, the appeal request will be considered invalid.

B. Administrative Dismissal

A request for an appeal may be administratively dismissed without a hearing if the appellant has no right to a hearing. DMAS will administratively close an appeal case in the following situations:

1. No Adverse Action Taken

If DMAS learns that no adverse action was taken prior to the date of the appeal request, the appeal will be closed.

2. Disability Decision Rescinded By DDS

If the appellant's Medicaid application is returned to a pending status because the Disability Determination Services analyst rescinds the denial of disability, the appeal will be closed.

3. Withdrawn

If the appellant requests that the appeal be withdrawn, the appeal will be closed by the DMAS Appeals Division.

- *The appellant must sign a statement clearly indicating that he wishes to withdraw his appeal. The statement or form must be mailed or faxed to the DMAS Appeals Division. Verbal notification to the LDSS by the appellant to withdraw an appeal is **not** sufficient.*

- *The Hearing Officer will close the appeal and send a letter to the appellant with a copy to the LDSS.*

4. Abandoned *If the appellant or his representative fails to appear at the scheduled hearing, and does not reply within 10 days to the Hearing Officer's request for an explanation that meets good cause criteria, or if the appellant does reply and the Hearing Officer decides that the reply does not meet good cause criteria, the appeal will be closed as "abandoned."*

5. Administratively Resolved *If, upon reevaluation by the LDSS, the appellant's coverage is reinstated to the full amount of coverage that was in effect prior to closure or reduction of benefits, the appeal will be closed as administratively resolved.*

***NOTE**: The agency should not assume that a reinstatement automatically ends the appeal. The Appeals Division will decide whether to terminate the appeal. The agency will receive a copy of final letters for administrative closures.*

C. Judgment on the Record *If the Hearing Officer determines from the record that the agency's action was clearly in error and that the case should be resolved in the appellant's favor, he shall issue a judgment on the record instead of holding a hearing. The Hearing Officer will provide the local agency with a clear explanation of the reason(s) for issuing a judgment on the record and which actions must be taken by the local agency to correct the case. The decision to issue a judgment on the record is at the Hearing Officer's discretion.*

D. Remand to the Agency Prior to the Hearing *If the Hearing Officer determines from the record that the case might be resolved in the appellant's favor if the agency obtains and develops additional information, documentation, or verification, he may remand the case to the agency for action consistent with the Hearing Officer's written instructions. The agency must complete the remand evaluation within 30 days or 45 days as applicable.*

M1660.100 SCHEDULING THE HEARING

A. Scheduling and Location *The Hearing Officer will select a date and time for the hearing. Typically, hearings are scheduled three weeks in advance.*

For eligibility issues, hearings will be held at the local agency. The applicant/enrollee will be at the agency. The Hearing Officer will conduct the hearing by telephone unless the appellant requests a face-to-face hearing.

B. Confirmation Letter *The schedule letter is mailed to the appellant or representative, and a copy is mailed to the agency.*

The schedule letter contains information about summary due dates and other pertinent information.

If the agency representative can not be available on the date and time selected by the Hearing Officer, he/she must notify the DMAS as soon as possible and request an alternate date and time for the hearing.

M1670.100 LOCAL AGENCY APPEAL SUMMARY

A. ***Agency Appeal Summary Form***

Once a hearing has been scheduled, the agency must complete an "Agency Appeal Summary," form #032-03-805 *available at:* http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi.

B. ***Send to Appeals Division and Appellant***

At least ten days prior to the hearing, the agency must send one copy of this form to each of the following:

- Department of Medical Assistance Services
  Appeals Division, *11th Floor*
  600 East Broad Street
  Richmond, Virginia 23219.

- The appellant or his authorized representative.

The agency must keep a copy of the appeal summary and all relevant documentation, including applications and notices, for its records.

M1680.100 THE HEARING PROCEDURE

A. Hearing Procedure

The hearing will be conducted in an informal manner. Formal rules of evidence do not apply in these proceedings. The appellant is entitled to guarantees of fair hearings established in Goldberg v. Kelly, 397 US 245 (1970). The proceedings will be governed by the following rules:

1. Record

The Hearing Officer will swear-in all hearing participants who will be presenting evidence or facts and will record the hearing proceedings.

2. Appellant

The appellant will present his own case or have it presented by an authorized representative. He will be allowed to bring witnesses, establish all pertinent facts and circumstances, advance any testimony or evidence, and question witnesses.

3. Agency Representatives

The local DSS agency worker who took the action being appealed and/or the worker's supervisor should be present at the hearing. The local agency may be represented by its county or city attorney. The agency has the authority to ask its county or city attorney to attend the hearing.

When the action being appealed is a disability decision made by the DDS, a representative from DDS must be present at the hearing. When the action being appealed is a denial of a medical or dental covered service, a representative from DMAS or its contractor who made the decision must be present at the hearing.

4. Opportunity to Examine Documents

The appellant or his representative must be given the opportunity to examine all documents and records to be used at the hearing, at a time before the hearing or during the hearing. Copies of case record information must be made available free of charge to the appellant at his request.

B. Hearing Officer Evaluation and Decision

1. Evaluation

Following the hearing, the Hearing Officer prepares a decision taking into account the summary prepared by the agency or medical provider involved, evidence provided by the appellant or his representative, and additional information provided by the *agency. The* Hearing Officer evaluates all evidence, researches laws, regulations and policy, and decides on the *accuracy of the agency's action.*

2. Hearing Officer Decision

Examples of the Hearing Officer's decisions include, but are not limited to:

a. Sustain

When the Hearing Officer's decision upholds the agency's action, *the decision is "sustained."*

b. Reverse

When the Hearing Officer's decision overturns the agency's *action, the decision is "reversed."*

c. Remand

When The Hearing Officer sends the case back to the agency for additional evaluation, *the decision is "remanded." The Hearing Officer's decision* will include instructions that must be followed when completing the remand evaluation.

3. Failure to Provide Requested Information

If the local department of social services denies an application because of failure to provide requested information, the hearing will address:

- whether or not the applicant was given appropriate notification of what was needed for the eligibility determination; and
- whether or not the applicant was given sufficient time to submit the information requested.

a. Sustained

If the local department of social services followed correct procedures (see M0130.200) and the applicant brings the requested information to the hearing, the action of the local department of social services will be sustained and the applicant will be required to file a new application.

b. Remanded

If the Hearing Officer determines that the local department of social services did not follow appropriate procedures, the case may be remanded for appropriate action.

If the Hearing Officer determines that the local department of social services did not follow correct procedures, and the applicant brings the relevant information to the hearing, the case may be remanded for an eligibility determination using the original application date.

C. Local Agency Action

The decision of the Hearing Officer is the final administrative action taken on the appeal. The local agency must comply with the Hearing Officer's decision.

1. Agency Action - Sustained Cases

If the Hearing Officer's decision *is to sustain the agency's action, and coverage was continued during the appeal process*, the case must be closed without an additional notice to the *enrollee* from the local agency. The Hearing Officer's decision letter to the appellant is the appropriate official notice of cancellation.

The local agency must take action to close the case in the Medicaid computer using cancel reason "015"effective the date the agency receives the decision.

2. Agency Action - Remanded Cases

a. Do Not Send Documents to Hearing Officer

If the Hearing Officer's decision is to remand the case to the local agency, the local agency must not send documentation of the evaluation or a copy of the remand notice to the Hearing Officer.

b. Enrollment Actions

If the Hearing Officer's decision is to remand the case for further evaluation and coverage was continued during the appeal process, coverage must be continued until the local agency completes the evaluation and makes a new decision.

If the remand evaluation results in the appellant's continuous eligibility, the local agency must notify the appellant of his/her continuing eligibility for coverage.

If the remand evaluation results in the appellant's continuous eligibility and coverage was NOT continued during the appeal process, the local agency must reinstate coverage back to the original termination date (no break in coverage) and notify the appellant of his continued eligibility.

If the remand evaluation results in the appellant's ineligibility and coverage was continued during the appeal process, the *enrollee's coverage* must be *canceled* at the completion of the evaluation, and the appellant must be notified.

c. Take Action in 30-45 Days

The agency must complete the remand evaluation within 30 days or 45 days as applicable.

3. Agency Action-Reversed Cases

Following a Hearing Officer's decision to reverse an agency's action to deny, reduce, or terminate coverage, the agency must reinstate coverage retroactive to the date of closure or month of application (including retroactive coverage months, if applicable).

M1690.100 RECOVERY OF BENEFITS PAID DURING APPEAL

A. Applicable Circumstances

The Medicaid Program may recover expenses paid on behalf of appellants whose Medicaid coverage was continued during the appeal process, when the agency's proposed action is upheld by the Hearing Officer.

DMAS will be responsible for recovering these expenses from the appellant, not the service provider. The appellant will be notified, after the hearing decision is made, of how much money if any is owed to the Medicaid Program.

B. Recovery Period

Medicaid expenditures for services received from the original effective date of the proposed adverse action (as stated on the notice) until the actual cancellation of Medicaid coverage or payment will be recovered.

CHAPTER M17

MEDICAID FRAUD AND *NON-FRAUD* RECOVERY

M17 Changes

Changed With	Effective Date	Pages Changed
TN #94	09/01/10	Title Page Table of Contents pages 1-7 Appendix 1 Appendix 2
TN #93	01/01/10	page 3

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M1700 MEDICAID FRAUD AND NON-FRAUD RECOVERY

M1700.100 INTRODUCTION

A. Administering Agency

The Department of Medical Assistance Services (DMAS) *investigates and accepts referrals regarding* fraudulent and *non-fraudulent* erroneous payments made by the Medicaid Program. DMAS *has the authority to* recover any payment erroneously made for services received by a Medicaid recipient or former Medicaid recipient. Recovery *may* be made from the recipient or the recipient's income, assets, or estate, unless such property is otherwise exempted from collection efforts by State or Federal law or regulation.

B. Utilization Review

Recipients' utilization of all covered services is monitored regularly by DMAS. Whenever utilization of services is unusually high, claims for services are reviewed for medical necessity. If some services are *determined* not *to be* medically necessary, the recipient will be contacted by the DMAS Recipient Monitoring Unit.

DMAS also reviews hospital claims prior to payment to determine if the 21-day limit is exceeded or if the length of stay regulations are met. All provider claims are reviewed and audited after payment.

M1700.200 FRAUD

A. Definitions

Fraud is defined as follows:

"Whoever obtains, or attempts to obtain, or aids and abets a person in obtaining, by means of a willful false statement or representation, or by impersonation, or other fraudulent device, assistance or benefits from other programs designated under rules and regulations of the State Board of Social Services or State Board of Health to which he is not entitled, or fails to comply with the provisions of 63.2-522, 32.1-321.1, 32.1-321.2,.1-112, shall be deemed guilty of larceny..." (Code of Virginia, §63.1-124).

"If at any time during the continuance of assistance there shall occur any change, including but not limited to, the possession of any property or the receipt of regular income by the recipient, in the circumstances upon which current eligibility or amount of assistance were determined, which would materially affect such determination, it shall be the duty of such recipient immediately to notify the local department of such change, and thereupon the local board may either cancel the assistance, or alter the amount thereof." (Code of Virginia, §63.1-112).

B. DMAS *Authority*

1. Recipient Fraud

DMAS has sole *authority over* cases of suspected Medicaid fraud when eligibility for a public assistance payment is not involved (Medicaid only cases). The local department of social services (LDSS) *shall* refer all Medicaid cases involving suspected fraud to the DMAS Recipient Audit Unit, 600 E. Broad Street, Suite 1300, Richmond, Virginia 23219, using the Notice of Recipient Fraud/Non-Fraud *Recovery (form #DMAS 751R)*located on SPARK at *http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi*.

The information listed below shall be provided, *using the following format:*

- *confirmation that ongoing eligibility has been reviewed (in relation to the allegation) with evaluation results attached;*
- reasons for and exact dates of ineligibility for Medicaid;
- the recipient's name and Medicaid *enrollee identification* number;
- the recipient's Social Security Number;
- applicable Medicaid applications or review forms for the referral/ineligibility period;
- address and telephone number of any attorney-in fact, authorized representative, or other individual who assisted in the application process;
- relevant covered group, income, resource, and/or asset transfer documentation for *the time period in question*;
- any record of communication between the agency and the client or representative, such as case narratives, letters, and notices; and
- information obtained from the agency's fraud investigation, including names and addresses of knowledgeable individuals for testimony and/or interviews.

2. ***Fiscal Threshold Removed***

The fiscal threshold for Administrative Non-fraud Recovery (previously $300) has been removed. There is no fiscal threshold of any case with criminal intent to defraud Medicaid.

In order to determine the amount of the loss of Medicaid funds related to the enrollee's Temporary Assistance for Needy Families (TANF) Medicaid eligibility, *the local agency must submit a Medicaid Claims Request (see Appendix 1 to this chapter) to DMAS and obtain the amount of the loss. The local agency should allow a three-week turnaround for the documents. There may be exceptional circumstances when claims can be provided within a shorter time, i.e., expedited trial dates. Once the information is received and the agency determines that it will not make a joint TANF/Medicaid criminal prosecution referral, the local agency must send to DMAS the Notice of Recipient Fraud/Non-Fraud Recovery. DMAS will determine if administrative non-fraud recovery is appropriate and request restitution.*

For those cases where Medicaid claims only include Managed Care Organization (MCO) capitation fees, the MCO Capitation Fees Recovery Form will be included with the claims and the custodian certificate (see Appendix 2 to this chapter). The MCO Capitation Fees Recovery Form provides an explanation of the MCO capitation fees submitted and paid as claims on the recipient's behalf during the recovery period. The TANF/Medicaid related claims information should be included with this form.

2. **Provider Fraud**

Cases of suspected fraud involving enrolled providers of medical services to Medicaid recipients *shall* be referred to the Medicaid Fraud Control Unit in the Office of the Attorney General, *and a* copy *of the referral correspondence shall be* sent to the Provider Review Unit, Department of Medical Assistance Services.

3. **Suspected Fraud Involving Recipients of Public Public Assistance** ***Cash Payments***

a. Auxiliary Grant (AG) Cases

Individuals who receive AG payments also receive Medicaid coverage. Cases of suspected fraud involving AG payments are the responsibility of the local department of social services. For AG cases, the *LDSS shall determine whether the enrollee would have been eligible for Medicaid had he not been receiving AG. If the individual was eligible for Medicaid solely due to his AG eligibility, the agency shall determine the period of ineligibility for Medicaid. The LDSS shall report any period of* ineligibility. *The* DMAS Recipient Audit Unit *will determine* the amount of Medicaid payments made.

The amount of misspent Medicaid funds *shall* be included in the AG fraud case, whether the action results in prosecution or in voluntary restitution. The final disposition on all money payment fraud cases *shall* be communicated to the Recipient Audit Unit, DMAS, no later than 5 business days after disposition for inclusion in federal reporting.

b. *Cases in which Medicaid is received with TANF*, SNAP, GR, *Energy Assistance*, etc.

For suspected fraud involving cases *with combined Medicaid* and TANF, Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps), General Relief (GR), *Energy Assistance*, or other such assistance which does not directly relate to the provision of Medicaid, the local agency *shall* notify the Recipient Audit Unit of the agency's action on the other assistance case so that Medicaid *may* take concurrent action, if necessary.

C. Medicaid Ineligibility Following Fraud Conviction

1. Period of Eligibility

An individual *who* has been convicted of Medicaid fraud *is* ineligible for Medicaid for a period of 12 months beginning with the month of fraud conviction. Action to cancel the individual's Medicaid coverage *shall* be taken in the month of conviction or in the month the agency learns of the conviction, using cancel reason 014 (42 United States Code §1320a-7b.(a)(6)(ii); 12 Virginia Administrative Code 30-10-70).

2. Who is Ineligible

a. TANF or Families and Children (F&C) Cases

Only the parent/caretaker of a TANF/Medicaid or F&C Medicaid case *is* ineligible for Medicaid when the parent/caretaker has been convicted of Medicaid fraud. The TANF payment *made to* the caretaker *on a child's behalf shall* not be affected.

b. Aged, Blind, Disabled (ABD) or Pregnant Women Cases

In an ABD or pregnant woman case, only the individual found guilty of Medicaid fraud will be ineligible. If only one spouse of a married couple is convicted, the eligibility of the innocent spouse is not affected

3. Family Unit

If both spouses of an eligible couple are found guilty of fraud, neither is eligible for Medicaid. If only one member of a family unit is convicted of fraud, only that member's Medicaid coverage is canceled. The fraud conviction does not affect the composition of the family unit or the treatment of the family unit's income or resources. The convicted individual is included in the family unit according to Medicaid policy, but is not eligible for Medicaid coverage and is not enrolled.

M1700.300 NON-FRAUD RECOVERY

A. Definition

The Virginia State Plan for Medicaid defines Non-Fraud Recovery as: "Investigation by the local department of social services of situations involving eligibility in which there is no reason to suspect that there has been deliberate misrepresentation by an applicant/recipient with intent to defraud." These cases are referred to DMAS when there is reason to suspect that an overpayment has occurred. (42 CFR§431)**.**

B. Recovery of *Erroneous Payments*

DMAS has the authority to investigate cases and recover expenditures made for services received by ineligible enrollees without fraudulent intent. *Examples of* when recovery of expenditures *is* possible include, but are not limited to:

- eligibility errors due to recipient misunderstanding,
- agency errors, or
- medical services received during the appeal process, *if* the agency's cancellation action is upheld.

C. Recovery of Correctly Paid Funds

Within specific restrictions, DMAS may recover funds correctly paid for medical services received by eligible recipients.

1. Deceased Recipient's Estate

Under federal regulations and state law, DMAS may make a claim against a deceased enrollee's estate when the recipient was age 55 or over. The recovery *may* include any Medicaid payments made on his/her behalf. This claim *may* be waived if there are surviving dependents. **(42 CFR §433.36; Va. Code §32.1-326.1 and 32.1-327).**

Section 1917(b)(1)(C)(ii) of the Social Security Act was amended by the Deficit Reduction Act of 2005 to exempt assets disregarded under a "qualified" Long-term Care (LTC) Partnership Policy from estate recovery, as defined in clause (iii) of 1917(b)(1)(C). The same amount of assets that was disregarded in the Medicaid eligibility determination for an individual under an LTC Partnership Policy will be protected during estate recovery.

2. Uncompensated *Asset* Transfers

DMAS may seek recovery when a Medicaid enrollee transferred *assets* with an uncompensated value of more than $25,000. The transferees (recipients of the transfer) are liable to reimburse Medicaid for expenditures up to the *amount of funds spent on the enrollee or the amount of the* uncompensated *asset transfer, whichever is less*. The *asset* transfer must have occurred within 30 months of the recipient (transferor) becoming eligible for or receiving Medicaid. **(Va. Code §20-88.02).**

D. Insurance Settlements and Similar Recoveries

Settlements related to personal injuries are a form of third party liability (TPL). When a Medicaid enrollee has received an insurance settlement or similar settlement from a law suit related to a medical condition or injury, DMAS may seek recovery of any amount of medical assistance expended on the enrollee prior to the receipt of the settlement. Generally, the insurance company notifies DMAS of the settlement; however, if an agency discovers that an enrollee received a settlement, the agency shall report it to DMAS. An insurance settlement that is sent directly to a recipient, in his name only, should be reviewed for its impact on the recipient's eligibility.

***E.* LDSS Referral**

When an agency discovers a Medicaid case involving property transfers, the Notice of Medicaid Fraud/Non-fraud Recovery *shall* be completed and sent to:

Department of Medical Assistance Services
Supervisor, Recipient Audit Unit
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

or the form may be faxed to 804-371-8891.

For cases involving estate recoveries and/or TPL (insurance-related) recoveries, the completed recovery form shall be sent to:

Department of Medical Assistance Services
Attn: Third Party Recovery Unit
600 East Broad Street, Suite 1300
Richmond, VA 23219

or the form may be sent by e-mail to TPLunit@dmas.virginia.gov.

M1700.400 RESPONSIBILITY OF THE LDSS

A. *VDSS/LDSS Responsibilities in Loss Prevention Efforts*

VDSS Medicaid operates under an interagency agreement with *DMAS* which lists specific responsibilities *of VDSS and, by extension, the LDSS, for active participation in loss prevention efforts. The responsibilities of the LDSS fall under the interagency agreement and are neither optional nor discretionary for the LDSS. VDSS shall supervise the programmatic activities of the LDSS to ensure compliance.*

B. *LDSS Requirements*

It is the responsibility of LDSS to determine and review ongoing or current recipient eligibility. ***The DMAS RAU does not determine ongoing recipient eligibility, but rather reviews recipient eligibility in relation to allegations of fraud****. LDSS shall participate in the identification, tracking, and correction of eligibility errors. LDSS shall:*

1. Report Individuals

Report to DMAS *RAU* every known instance relating to a non-entitled individual's use of Medicaid services, regardless of the reason for non-entitlement *including, but not limited to:*

- Instances where evidence *of* fraud may exist;
- *Errors involving eligibility discovered by the LDSS in which there is no reason to suspect that there has been deliberate misrepresentation by an applicant/recipient with intent to defraud;*
- *Eligibility errors discovered by the LDSS, independent of other audit or quality control functions, including cases in which the individual was enrolled incorrectly, added in error, not cancelled timely, allowed to remain on Medicaid during the conviction sanction period or when information known to the agency would render ineligibility;*
- *Cases in which the LDSS discovers that the enrollee failed to report information that impacts eligibility; and*
- *Long-term Care patient pay underpayments resulting from any cause.*

2. Corrective Action

Report to DMAS RAU corrective action taken on all discovered eligibility errors. Corrective action is a function of the loss prevention process. All corrected errors shall be reported to DMAS.

3. Cancel Coverage

Cancel the eligibility of all persons convicted of public assistance fraud or medical assistance fraud to the extent allowable under federal and state regulations, using the cancel code for fraud convictions (Cancel Code 014).

4. Discretionary Trust Beneficiaries

Notify DMAS of all instances in which a Medicaid recipient is a beneficiary of a discretionary trust and the trustee refuses to make the assets available for the medical expenses of the recipient, or when a Medicaid recipient has been found to be ineligible for Medicaid benefits as a result of a transfer of assets.

The LDSS shall use the Notice of Recipient Fraud/Non-Fraud Recovery (form # DMAS 751R), located on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi., to report the information listed above. Include in the report any corrective action that has been or will be taken by the LDSS, as well as the name of the supervisor of the person submitting the form. The supervisor's signature is not required.

Include Medicaid expenditures in the computation of misspent funds, where a withholding or a deliberate misrepresentation of a pertinent fact has taken place *when* the *LDSS* has jurisdiction in regard to prosecution of the case *because a public assistance payment program is involved.*

C. DMAS Response

The RAU shall send a written verification of the error to the individual making the referral, including the amount of misspent funds, as well as any further action required of the LDSS.

D. **Recipient Audit Reporting**

The RAU has two prevention efforts for reporting fraud and abuse of Medicaid Services by individuals within the community. Both referral methods should be given to the individual by the LDSS, along with a copy of the Notice of Medicaid Fraud/Non-fraud Recovery. If an individual wishes to make an anonymous referral, the report may be made through.

- the web address, recipientfraud@dmas.virginia.gov.
- the Recipient Audit fraud and abuse hotline. Both a local and a toll free number are available 24 hours daily for reporting suspected fraud and abuse: local (804) 786-1066; and toll free (866) 486-1971.

E. **Statute of Limitations**

There is no "statute of limitations" for Medicaid fraud; cases that are referred for fraud *shall* be flagged to ensure that the information is not purged. Cases cannot be properly investigated without specific documents, i.e. signed applications, bank statements, burial or insurance information. DMAS will notify the agency of the results of the fraud investigation.

COMMONWEALTH of VIRGINIA

CYNTHIA JONES
ACTING DIRECTOR

Department of Medical Assistance Services
Medicaid Claims Request

600 EAST BROAD STREET
RICHMOND, VA. 23219
PHONE: (804) 786-7933
FAX: (804)225-4512

Date:_____

Agency:_____
Worker's Name:_____
Phone No:_____

Recipient Audit Unit Supervisor
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

Dear Supervisor:

I am conducting an investigation of the person(s) listed below for the time period indicated. Please forward proof of claims paid by Medicaid during the investigative period.

Custodian Certificate/Claims needed? Y/N
Written referral following? Y/N
Expected Date to the CA:_____
Expected Court Date:_____

I will keep you informed of additional progress and of the outcome of this investigation.

Case Name:_____ Base ID#:_____

(a)_____ Recipient ID#:_____

Period of suspected fraud/overpayment:_____

(b)_____ Recipient ID#:_____

Period of suspected fraud/overpayment:_____

(c)_____ Recipient ID#:_____

Period of suspected fraud/overpayment:_____

(d)_____ Recipient ID#:_____

Period of suspected fraud/overpayment:_____

Sincerely,

CLAIMS REQUEST FORM INSTRUCTIONS

FORM NUMBER - DMAS 750R

PURPOSE:

This form serves as a multi-purpose form. It can be used to receive certified claims from DMAS reporting the total expended amount of Medicaid services for the period of time in question. These claims are used in court testimony, as evidence against the defendant. Restitution is ordered based on the amount of claims in the form of a custodian certificate that is submitted by the supervisor of the Recipient Audit Unit. This information is notarized, and is attesting to the fact that the information is accurate and that the supervisor serves as the keeper of the records for DMAS. The claims inquiry will also assist the agency in determining whether to include the Medicaid claims with a joint criminal referral. If the agency determines that a joint criminal referral will not be made, the worker/investigator must send the Recipient Fraud/Non-Fraud Referral to DMAS. DMAS determine if non-fraud recovery is appropriate and request restitution.

NOTE: Providers have up to one year to bill for services, therefore the amount of claims may not be accurate or complete at the time of prosecution or inquiry. It is suggested that the Commonwealth's Attorney be advised of this information, should additional claims develop at a later time and additional restitution be requested by DMAS.

USE OF FORM – Request of recipient claims for any investigation conducted by the local agency as it relates to person(s) receiving a money grant under the Temporary Assistance for Needy Families and Food Stamp program(s). Also, request for an estimate of claims when determining whether or not the Medicaid-Only case *will be included with a joint criminal referral.*

NUMBER AND DISTRIBUTION OF COPIES – Prepare original; make a copy for the agency record before sending to the Recipient Audit Unit at DMAS.

INSTRUCTIONS FOR PREPARATION OF FORM – The form should contain the case name, the base case ID number, each recipient ID number and the period of suspected fraud/overpayment for each recipient. Each recipient should be listed separately as shown on the form by the letters (a) through (d). Should there be additional recipients on the same base case ID, a second page should be attached.

The requestor must complete the *four* questions in the lower left corner of the form in order for DMAS to determine the priority of the request. Failure to complete the questions will result in a delay of claims processing.

The recipient(s) should be referred to DMAS if there was a period of time when the recipient was not eligible to receive benefits and the agency is unsure of how to handle the case.

COMMONWEALTH of VIRGINIA
Department of Medical Assistance Services, Recipient Audit Unit

MANAGED CARE ORGANIZATION (MCO) CAPITATION FEES RECOVERY FORM

Date:_____

Agency:_____
Worker's Name:_____
Phone No:_____
Recipient ID#:_____
Recipient Name:_____
Period of Overpayment:_____
Amount of Overpayment:_____

Dear Recipient:

The above named agency has conducted an investigation of the person(s) listed above and determined that Medicaid ineligibility existed. Medicaid paid Managed Care Organization (MCO) capitation fees on your behalf for the time period indicated and recovery of those fees is requested. The Code of Virginia $32.1-321.2 authorizes the recovery of those fees.

Managed Care Organization capitation fees are monthly insurance premiums paid to the MCO to ensure that you have medical coverage. These premiums, or capitation fees, are paid by Medicaid to the MCO every month even if you do not utilize medical services. These premiums are considered losses to the program and can be recovered if you are determined ineligible for any prior period. If you are found to be ineligible for prior months of coverage due to your failure to report truthful information or changes in your circumstances to your caseworker, you may be liable to repay these monthly premiums.

If your repayment for services includes a benefit administered through your local agency, your payment arrangements will be administered through that agency. However, if these arrangements are not made, and you are repaying only Medicaid services, please make a check or money order payable to the Department of Medical Assistance Services. Include your Medicaid number on the check, and send it to the following address:

Department of Medical Assistance Services
Financial Management Division, FAR
600 E. Broad St., 8th Floor
Richmond, VA 23219
Attn: LaVera Land, 804-786-5431

Thank you for your cooperation in this matter.

DMAS 752RMCO (9/09)

MCO CAPITATION FEES RECOVERY FORM INSTRUCTIONS

FORM NUMBER - DMAS 752R (9/09)

PURPOSE:

This form serves as a multi-purpose form. It is used to accompany the certified claims from DMAS reporting the total expended amount of Medicaid capitation fees for the period of time in question. These claims are used in court testimony, as evidence against the defendant. Restitution is ordered based on the amount of claims in the form of a custodian certificate that is submitted by the supervisor of the Recipient Audit Unit. This information is notarized, and is attesting to the fact that the information is accurate and that the supervisor serves as the keeper of the records for DMAS. The form also provides an explanation of the MCO capitation fees submitted and paid as claims on the recipient's behalf during the recovery period.

USE OF FORM – *Request of recipient claims for any investigation conducted by the local agency as it relates to person(s) receiving a money grant under the Temporary Assistance for Needy Families and Food Stamp program(s). The form is used to accompany the recipient's request letter where the claims only include MCO capitation fees paid by DMAS on the recipient's behalf during the recovery period.*

NUMBER AND DISTRIBUTION OF COPIES – An original MCO fact sheet will be forwarded to the agency along with the completed claims request. Prepare original; make a copy for the agency record and a copy for the Recipient Audit Unit at DMAS.

INSTRUCTIONS FOR PREPARATION OF FORM – *The form should contain: the agency of record; eligibility worker/fraud investigator's name and phone number; case/recipient name, the base case/recipient ID number; the period of suspected fraud/overpayment and the amount of the overpayment. A separate fact sheet should accompany each recovery letter to the recipient.*

The recipient(s) should be referred to DMAS if there was a period of time when the recipient was not eligible to receive benefits and the agency is unsure of how to handle the case or if there are questions regarding the recovery of capitation fees.

M18 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/01/11	pages 3, 4, 16
TN #95	3/1/11	page 9
TN #94	9/1/10	page 12
TN #93	1/1/10	pages 4, 5
TN #91	5/15/09	page 2 pages 5, 6 page 8

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MEDICAL SERVICES

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M1800 MEDICAL SERVICES

M1810.100 MEDICAID ELIGIBILITY CARD

A. Medicaid Card Issuance

A Medicaid card is issued to an individual who has been found eligible for Medicaid and is enrolled with the Department of Medical Assistance Services (DMAS). *The card is plastic with the enrollee's name, gender and birth date on the front, and a strip on the back that providers can "swipe" to ascertain the type of coverage and the begin date of coverage. The card is intended to be permanent.* Presentation of the card to the Medicaid-enrolled (certified) provider of medical services authorizes the provider to bill Medicaid for the needed services, if such services are covered by the Medical Assistance Program and DMAS has pre-authorized the service, when pre-authorization is required.

Exception: The following recipients do not receive a Medicaid card:

- individuals eligible for Medicare premium payment only, *and*
- *individuals enrolled in a closed period of coverage in the past with no ongoing coverage*.

B. Use of the Medicaid Card

1. General

Local social services departments must provide recipients with information concerning use of the Medicaid card. This includes information that misuse of the card is fraud and can result in prosecution. Examples of misuse include:

- using the card following cancellation of eligibility,
- alteration of names, dates, or other information to secure medical care to which the individual is not entitled, and
- knowingly permitting another person to use an individual's card to secure medical care.

2. Foster Care Children in Institutional Facilities

The local department of social services (LDSS) should use the local department's address when enrolling a foster care child whose custody is held by the local department of social services and who is placed in a child caring institution or admitted to an institution for the mentally retarded. Upon receipt of the Medicaid card, it should be sent to the appropriate institution for use on the child's behalf. The local department has the responsibility of advising the child caring institution of the medical and dental services covered by Medicaid.

3. Nursing Facility Patients

Patients in long-term nursing facilities receive Medicaid cards. The nursing facility also receives a computer-generated list at the first of the month which lists all eligible Medicaid patients in that facility. Each patient's name, Medicaid number, and medical resources code is included on this listing.

This listing reflects only those Medicaid-eligible patients for whom the nursing facility has submitted an "admission packet" to Medicaid, and whom Medicaid has entered on its Long-Term Care Information computer subsystem.

DMAS staff enters the patient information into the subsystem and assigns a patient control number to the facility for use in billing Medicaid for the patient's care.

When a patient dies or is discharged from the facility, the facility is responsible for notifying DMAS and the LDSS of the date of discharge or death. Long-term care providers have been instructed to notify the LDSS of death or discharge via the *Medicaid Long-term Care Communication Form (DMAS-225).*

M1820.100 SERVICE PROVIDERS

A. Enrollment Requirement

Providers of medical services must be enrolled by DMAS to receive Medicaid payment for their services. Lists of enrolled providers are available to local departments of social services *and enrollees* from DMAS and are available online at *www.dmas.virginia.gov*.

B. Out-of-State Providers

1. Covered Services

Medicaid will cover medical services rendered by out-of-state providers when the use of such providers is:

a. the general custom of the eligible individual (e.g., a recipient living near the border of another state),

b. needed by a non IV-E Foster Care child placed outside Virginia,

c. necessitated when an eligible person is temporarily outside Virginia and has a medical emergency, or

d. indicated because of referral to an out-of-state facility when preauthorized by DMAS.

1. Provider Enrollment

In instances where an out-of-state provider is not currently enrolled as a DMAS provider, DMAS will accept the provider's initial billing and will contact the provider to determine the provider's wish to become enrolled so that subsequent services can be paid through the computerized Medicaid claims processing system.

M1830.100 MANAGED CARE

A. General Information

Most Virginia Medicaid enrollees are required to receive medical care through a managed care program. There are two managed care programs that operate simultaneously within the Commonwealth: The MEDALLION Program, a Primary Care Case Management program, and Medallion II, a program that requires mandatory enrollment into a contracted Managed Care Organization (MCO) for certain groups of Medicaid enrollees. Both programs require enrollees to choose a primary care provider (PCP) who provides primary health care services and makes referrals as needed. Enrollment in managed care is based on information provided by the eligibility worker to the Medicaid Management Information System (MMIS) during Medicaid enrollment.

B. Enrollees Exempt from Managed Care

General

The following enrollees are not required to enroll in a managed care program and may seek medical care from any provider enrolled by DMAS as eligible to receive payment:

- children in Foster Care (including Treatment Foster Care), Adoption Assistance, and Residential Treatment Facility programs;

- inpatients in State mental hospitals, including but not limited to:

  - Central State Hospital,
  - Eastern State Hospital,
  - Western State Hospital,
  - Hiram W. Davis Medical Center,
  - Northern Virginia Mental Health Institute,
  - Southern Virginia Mental Health Institute,
  - Southwestern Virginia Mental Health Institute, and
  - The Commonwealth Center for Children and Adolescents (formerly known as the DeJarnette Center);

- inpatients in long-stay hospitals, nursing facilities, and intermediate care facilities for the mentally retarded (ICF-MR);

- enrollees *approved for or receiving* Medicaid community-based care services *under the Technology Assisted Waiver;*

- *enrollees receiving* Medicaid community-based care waiver services, except for the Technology Assisted Waiver, *who were not in an MCO prior to being enrolled in waiver services. Enrollees who were enrolled in an MCO when they began receiving waiver services, other than Technology Assisted Waiver services, continue to receive primary and acute care services through their MCO. Waiver services are provided through fee-for-service Medicaid.*

- Qualified Medicare Beneficiaries (QMB), dually-eligible enrollees, Special Low-income Medicare Beneficiaries (SLMB), Qualified Individuals, and Qualified Disabled and Working Individuals (QDWI);

- enrollees with other comprehensive group or individual health insurance coverage, including Medicare, insurance provided to military dependents, and any insurance purchased through the Health Insurance Premium Payment Program;

- women enrolled in the Breast and Cervical Cancer Prevention and Treatment Act (BCCPTA) covered group;

- individuals enrolled in the Plan First (family planning services) covered group;

- enrollees who receive hospice services in accordance with DMAS criteria;

- refugees; and

- enrollees on a spenddown.

MEDALLION

The following enrollees are excluded from participating in MEDALLION:

- enrollees who are not accepted to the caseload of any participating PCP, and

- enrollees whose enrollment in the caseload of the assigned PCP has been terminated and whose enrollment has been declined by other PCPs.

Medallion II

The following enrollees are excluded from participating in Medallion II:

- enrollees, other than students, who permanently live outside their area of residence for greater than sixty (60) consecutive days, except those placed there for medically necessary services funded by the MCO;

- newly eligible Medallion II enrollees who are in their third trimester of pregnancy and who request exclusion by the 15th of the month in which their MCO enrollment becomes effective. Exclusion may be granted only if the member's obstetrical provider (physician or hospital) does not participate with any of the state-contracted MCOs. The enrollee, MCO, or obstetrical provider can make exclusion requests. Following end of pregnancy, these individuals shall be required to enroll in Medallion II to the extent they remain eligible for full Medicaid benefits.

- recipients who have been pre-assigned to the MCO but have not yet been enrolled, who have been diagnosed with a terminal condition, and whose physician certifies a life expectancy of six (6) months or less may request exclusion from Medallion II. Requests must be made during the pre-assignment period.

- recipients who are inpatients in hospitals, other than those listed above, at the scheduled time of enrollment or who are scheduled for inpatient hospital stay or surgery within 30 calendar days of the enrollment effective date. The exclusion shall remain effective until the first day of the month following discharge.

- Certain children between birth and age three certified by the *Department of Behavioral Health and Developmental Services (DBHDS)* as eligible for services pursuant to Part C of the Individuals with Disabilities Education Act (IDEA) and who meet DMAS review.

1. Foster Care/ Adoption Assistance Children

All Foster Care and Adoption Assistance children enrolled in MMIS with an Aid Category (AC) of 072, 074, 076, or 086 or enrolled through ADAPT are automatically excluded from participating in managed care. Foster Care/Adoption Assistance children who are enrolled outside ADAPT under any other *AC* can be exempted from Medicaid managed care programs. If a worker finds that a Foster Care/Adoption Assistance child is enrolled in a managed care program, the worker may request that the child be removed from managed care and placed in fee-for-service Medicaid through the following process:

- Complete the Foster Care Child-Exemption from Managed Care form available on SPARK at http://spark.dss.virginia.gov/divisions/bp/me/forms/general.cgi. The custody order, emergency removal order, or a statement on agency letterhead signed by the director or foster care supervisor verifying the child is in the agency's custody and the date the agency received custody must be attached to the form in order to have the child exempted from managed care.

- Fax the form to (804) 786-5799.

Exemption requests may take up to 5 business days to complete. Disenrollment is effective at the end of the month of notification (not retroactively). The LDSS can verify disenrollments by checking the MMIS Managed Care Assignment screen for a managed care end date.

2. Other Exempt Recipients

Recipients who are exempt from enrollment in managed care are excluded based on information supplied to MMIS at the time of enrollment.

C. Choice of Managed Care Programs/PCPs

Recipients who are required to participate in a managed care program will be notified within 15 - 45 days of enrollment in Medicaid and asked to choose either a MEDALLION PCP or one of the Medallion II MCOs operating in the recipient's geographical region. A list of MCOs operating in each region can be obtained online at www.dmas.*virginia.gov* or by contacting the Managed Care Helpline at 1-800-643-2273 to request a comparison chart.

D. Good Cause

MEDALLION

The MEDALLION program has an annual open enrollment period of 90 days that applies to individuals in MEDALLION only areas. During the open enrollment period, MEDALLION enrollees may change Primary Care Physicians (PCPs). If an enrollee wishes to change his PCP outside of the open enrollment period, he must make a good cause request to DMAS.

MEDALLION II

In the Medallion II program, good cause consists of a pre-defined set of operational conditions that allows an enrollee to change from one Managed Care Organization (MCO) to another. In areas where there is only one MCO, an enrollee may change from either MEDALLION or the MCO to the other program. The good cause provision applies only after the initial 90-day enrollment period has ended.

If a good cause reason exists, the enrollee must write a letter to the DMAS Managed Care Division providing supporting documentation. All written correspondence should be directed to the following address and/or fax number:

Department of Medical Assistance Services
Managed Care Division
600 East Broad Street, 11th Floor
Richmond, VA 23219
(fax) 804-786-5799

DMAS will review all good cause requests. Only the following reasons, if applicable, will result in approval:

- quality of care,
- access issues,
- receipt of care at a Rural Health Clinic or Federally Qualified Health Center that is not enrolled with the current MCO as a participating provider, and
- extreme medical conditions.

E. Enrollment Corrections/ Changes

DMAS pays a capitation rate for every month a recipient is enrolled in managed care regardless of whether the recipient receives medical services during the month. If a recipient is incorrectly enrolled in a Medicaid managed care program, the eligibility worker must refer the case to DMAS at the following address for possible recovery of expenditures (see chapter M1700):

Recipient Audit Unit
Department of Medical Assistance Services
600 East Broad Street, Suite 1300
Richmond, VA 23219

F. Family Access to Medical Insurance Security Plan (FAMIS) Managed Care

FAMIS benefits are different than the benefits that children enrolled in MEDALLION, Medallion II, and Medicaid fee-for-service receive. The FAMIS benefit package is modeled after the Key Advantage benefit package available to state employees. There are benefit limitations and small co-payments similar to those associated with commercial group health insurance.

The FAMIS benefit delivery system is available throughout the Commonwealth through either MCOs or FAMIS fee-for-service. In most of Virginia, children are enrolled with a contracted managed care organization. Whenever possible, DMAS offers FAMIS families a choice when receiving their health care. In most areas, enrollees may choose from at least two MCOs. In a few localities, however, there is currently only one MCO available to FAMIS enrollees. Children in these areas will be covered by the available MCO. They may not request an MCO change and are not eligible for the MEDALLION Program.

In a few areas of Virginia where there are no MCOs, children enrolled in FAMIS receive benefits through FAMIS fee-for-service. They have no co-payments and their benefits are similar to Medicaid. Refer to the FAMIS website at www.FAMIS.org for more information.

M1840.100 UTILIZATION REVIEW AND CLIENT MEDICAL MANAGEMENT

A. Utilization Review

Federal regulations require the Department of Medical Assistance Services (DMAS) to regularly review recipients' use and need for the covered medical services they receive. Regulations require that Medicaid pay only for medically necessary covered medical services. Medicaid cannot pay for duplicate services since they are not necessary.

DMAS staff in the Long Term Care and Quality Assurance Division reviews provider claims and recipient utilization histories for medical necessity. If it is determined that services were not medically necessary, providers are obligated to reimburse DMAS for any Medicaid payment they have received.

Recipients in long-term care are reviewed at least once every six months to determine the continued need for long-term care. Their treatment and level of functioning is compared to the Medicaid long-term care regulations for nursing care. If a recipient no longer meets the regulations for long-term care, DMAS notifies the provider and the recipient at least 10 days in advance that Medicaid payment for the care will stop. The recipient has the right to appeal this decision. Long-term care providers have been instructed to notify the LDSS of discharge via the *DMAS-225 form.*

B. Client Medical Management Program

Recipients' utilization of Medicaid cards for physicians' services and pharmaceutical services is monitored regularly by DMAS. Whenever the utilization of one or both of these services is unusually high, the services will be reviewed for medical necessity. If some services are considered not medically necessary, recipients who are not enrolled in a managed care program will be placed in the Client Medical Management Program and required to select a primary physician and/or pharmacy or both.

Recipients identified as high utilizers will receive a letter of notification with instructions about selecting primary providers and identifying those providers to DMAS. The local agency service worker will be asked to interview the recipient and gather information for DMAS. Following receipt of that information by DMAS, the recipient’s MMIS record will have the names and provider numbers of the selected physician and pharmacy on it. Recipients who do not respond to the letter within the specified time will have their primary physician and pharmacy designated by DMAS.

For recipients who have been placed in the Client Medicaid Management Program, Medicaid payment for physicians' services will be limited to those services rendered by the primary physician (including a physician providing services to the patients of the primary physician when the primary physician is not available), physicians seen on referral from the primary physician, and emergency medical services.

Prescriptions may be filled by a non-designated pharmacy only in emergency situations when the designated pharmacy is closed or cannot readily obtain the drug.

M1850.100 COVERED SERVICES

A. General Information

Information on Medicaid covered services is provided to assist the eligibility worker in responding to general inquiries from applicants/recipients. Recipients who have problems with bills or services from providers of care should be referred as follows:

Fee-for-Service Medicaid Recipients

Fee-for-service Medicaid recipients should be referred to the DMAS Recipient Helpline at 804-786-6145. Recipients who need assistance with transportation should be referred to the DMAS transportation broker at 866-386-8331.

Recipients Enrolled in Managed Care

Recipients enrolled in managed care should be referred to the Managed Care Helpline at 800-643-2273. Medallion II enrollees may also contact their MCO directly. MEDALLION enrollees who need assistance with transportation should be referred to the DMAS transportation broker at 866-386-8331. Medallion II enrollees who need assistance with transportation must contact their MCO directly.

B. Copayments

a. Medicaid Enrollees without Medicare

Most Medicaid covered services have a "copayment," which is the portion of the cost of the service for which the recipient is responsible. Copayment amounts range from $1.00 to $3.00 for most services. There is a $100.00 copayment per admission for inpatient hospital stays. The provider collects the copayment directly from the recipient at the time the service is provided.

b. Medicare Beneficiaries

Individuals with Medicare and full-benefit Medicaid (dual eligibles) and Qualified Medicare Beneficiaries (QMB) are responsible for Medicaid copayments only. Medicaid covers the remainder of the Medicare copayment for these individuals. However, a provider is allowed to collect the Medicare copayment at the time of service. If the provider requires the individual to pay the Medicare copayment, the individual must be reimbursed or credited the difference between the Medicare and Medicaid copayments once the provider receives payment of the Medicaid claim.

B. Individuals Exempt from Copayments

The following individuals are exempt from the Medicaid copayments:

- children under 21 years old,
- individuals who receive long-term care services in a nursing facility, rehabilitation hospital, or long-stay hospital, and
- individuals receiving Medicaid community-based care (CBC) waiver services and hospice care.

C. Services with No Copayments

The following services do not have copayments:

- emergency-room services,
- pregnancy-related services,
- family planning services, and
- dialysis services.

D. Covered Services

The services listed below are covered:

- case management services;
- certified pediatric nurse and family nurse practitioner services;
- *Children's Mental Health Program services;*
- clinical psychologist services;
- community mental retardation services, including day health rehabilitation services and case management;
- dental services for individuals under age 21 years;
- emergency hospital services;
- Early Periodic Screening, Diagnostic and Treatment (EPSDT) services;
- family planning services;
- Federally Qualified Health Center clinic services;
- home and community-based care waiver services, including personal care, adult day health care, respite care, private duty nursing, case management, mental retardation services, and services for the developmentally disabled;
- home health services: nurse, aide, supplies, treatment, physical therapy, occupational therapy, and speech therapy services;

- hospice services;
- inpatient hospital services;
- intermediate care facility-mental retardation (ICF-MR) services;
- laboratory and x-ray services;
- Medicare premiums: Hospital Insurance (Part A); Supplemental Medical Insurance (Part B) for the Categorically Needy (CN) and Medically Needy (MN);
- mental health services, including clinic services, case management, psychosocial rehabilitation, day treatment/partial hospitalization, therapeutic day treatment for children and adolescents, intensive in-home services for children and adolescents, and crisis intervention services;
- nurse-midwife services;
- nursing facility care;
- other clinic services: services provided by rehabilitation agencies, ambulatory surgical centers, renal dialysis clinics, and local health departments;
- outpatient hospital services;
- physical therapy and related services;
- physician services;
- podiatrist services;
- prescribed drugs;
- prosthetic devices;
- Rural Health Clinic services;
- skilled nursing facility services for individuals under age 21 years;
- *substance abuse services;*
- transplant services;
- transportation to receive medical services; and
- *vision services.*

Explanations of some covered services are provided below:

1. Children's Mental Health Program Services

Intensive community-based services for children and youth who have been in a psychiatric residential treatment facility may be provided. The services available are:

- respite,
- in-home residential supports,
- companion services,
- training and counseling for unpaid caregivers,
- environmental modifications, and
- consultative clinical and therapeutic services.

2. Clinic Services

Covered clinic services include therapeutic, rehabilitative, or palliative items or services, and renal dialysis furnished to an outpatient by or under the direction of a physician, in a certified facility which is organized and operated to provide medical care to outpatients.

3. Community-Based Care Waiver Services

Virginia provides services under community-based care (CBC) waivers to specifically targeted individuals. These services are not available to all Medicaid recipients. The CBC waivers are:

- Acquired Immunodeficiency Syndrome (AIDS) Waiver,
- Elderly or Disabled With Consumer Direction (EDCD) Waiver,
- *Intellectual Disabilities/*Mental Retardation (*ID/*MR) Waiver,
- Technology Assisted Individuals Waiver,
- Individual and Family Developmental Disabilities Support (DD) Waiver,
- Day Support (DS) Waiver, and
- Alzheimer's Assisted Living (AAL) Waiver.

Services covered under the waivers are listed in M1410.040.

4. Community Mental Health and Mental Retardation Services

Certain mental health and mental retardation services are covered for Medicaid-eligible recipients when provided by Medicaid-enrolled mental health providers. Examples of community mental health services are mental health case management, psychosocial rehabilitation, mental health support, day treatment/partial hospitalization, therapeutic day treatment for children and adolescents, intensive in-home services for children and adolescents, and crisis intervention services.

Mental retardation case management is available to recipients who are not enrolled in the *ID/*MR Waiver. Other community mental retardation services are available to recipients enrolled in the *ID/*MR Waiver and include mental retardation case management, day support, residential support, and supported employment services.

***5.* Dental Services**

a. Smiles for Children Program

Beginning July 1, 2005, all Medicaid and FAMIS covered dental services are provided under the "**Smiles For Children**" program, administered by Doral Dental USA. The managed care organizations (MCOs) no longer provide dental services to Medicaid and FAMIS recipients who are enrolled in an MCO. All recipients use their Commonwealth of Virginia Department of Medical Assistance Services or MCO-issued ID card to receive dental services. Coverage for medical services is not impacted by this change.

The toll-free telephone number for the **Smiles For Children** member services is 888-912-3456 (Monday through Friday from 8:00 a.m. to 6:00 p.m.). Recipients can obtain provider lists, appointment assistance, member handbooks, and information about dental services and claims.

b. Covered Dental Services For Recipients Under Age 21

Covered services include services for relief of pain and elimination of infection, preventative services such as oral prophylaxia and flouride treatment, routine therapeutic services for the restoration of carious teeth, and diagnostic services.

Procedures such as orthodontics, dentures, braces, partial and permanent bridge work must be preauthorized by Smiles for Children.

c. Covered Dental Services For Recipients Over Age 21

Covered services include limited oral surgery services when performed by a participating dentist and when generally covered under Medicare and/or are medically necessary. Examples of covered services include removal of cysts and tumors not related to the teeth, biopsies for suspected malignancies, repair of traumatic wounds, and extraction of teeth for severe abscesses.

Items and services in connection with the care, treatment, filling, removal, or replacement of teeth or structures directly supporting the teeth are not covered.

***6.* Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services**

a. General

1) Health screening services are provided to all eligible individuals under age 21 including those who are married or emancipated. The local agency must inform eligible individuals of the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Program; however, participation is voluntary. Screening services and treatment may be provided by local health departments and private practitioners.

2) Medicaid must cover any medical service identified as medically necessary by an EPSDT screening. When the identified service is not a Medicaid-covered service, DMAS must pre-authorize payment for the service. The service provider and the EPSDT screener are responsible for obtaining this pre-authorization.

3) Some examples of non Medicaid-covered medical services that must be covered by Medicaid under EPSDT are inpatient psychiatric hospitalization, chiropractic care, and specific therapies such as speech and language therapy.

b. Types of Screening

1) Initial physical examinations to screen all children committed to the care and custody of an LDSS to ascertain any physical or mental defects and other health needs of each child are covered.

2) Usually, not more than one screening examination per 12-month period is covered for each foster care child between the ages of 3 and 21 years.

3) Children from birth to age 3 may be covered for screening at more frequent intervals. Immunizations given during visits for screening examinations will be covered for foster care children.

4) Procedures for the EPSDT screening of children are specified in the Social Services Manual, Volume VII.

7. **Family Planning Services**

Covered family planning services are those family planning drugs, supplies, and devices provided under the supervision of a physician. They do not include any services to promote or restore fertility or sexual function.

8. **Home Health Services**

Covered home health services include all services provided by an authorized home health agency under a plan of treatment prescribed by a physician.

9. **Hospice Services**

Care in a Medicaid-certified and enrolled hospice is covered for terminally- ill Medicaid recipients. DMAS must pre-authorize the payment for eligible recipients.

10. **Inpatient Hospital Services**

a. Inpatient hospital stays for recipients age 21 and over must be preauthorized by DMAS. Emergency admissions must be authorized within 24 hours of admission.

Inpatient hospital stays for children under age 21 years must be medically necessary and preauthorized by the DMAS.

b. Inpatient psychiatric hospital stays are covered only for recipients over age 65 years, and for children under age 21 if identified as necessary by EPSDT screening or exam and pre-authorized by DMAS.

11. **Laboratory and X-Ray Services**

Laboratory and x-ray services are covered when ordered by a physician and may be provided in a physician's office, certified independent laboratory, State Health Department laboratory, or local health department.

12. **Medical Supplies and Equipment**

Medicaid will cover blood glucose self-monitoring test strips for children under the age of 21 with diabetes and pregnant women with gestational diabetes. Medicaid will cover blood glucose self-monitoring test strips for individuals over the age of 21 who are eligible for durable medical equipment, when certain criteria are met.

Medicaid will cover prosthetic devices (artificial arms, legs, and supportive devices) when prescribed by the physician, preauthorized by the Department of Medical Assistance Services, and furnished by a qualified participating provider.

Respiratory equipment and oxygen supplies are covered.

Ostomy supplies are covered.

Other medical supplies and equipment are covered only for patients receiving renal dialysis or home health care services, and for children under age 21 when the need for the supply or equipment is identified as medically necessary through an EPSDT screening or exam. Medicaid will cover the balance of charges for supplies and equipment covered by Medicare when Medicare has made partial payment on the supplies and/or equipment.

13. **Nurse-Midwife Services**

Services are covered when provided by a licensed Medicaid-enrolled nurse-midwife, as allowed under Virginia law.

14. **Nursing Facility Care**

a. Nursing facility services are covered when provided in medical institutions licensed as nursing facilities by the State Health Department and certified by DMAS.

b. Nursing care in intermediate care facilities for the mentally retarded (ICF/MR) is not a covered service for recipients enrolled as MN.

15. **Outpatient Hospital Services**

Outpatient hospital services are covered when furnished by or under the direction of a physician or a doctor of dental surgery. Diagnostic services are covered only when ordered by a physician.

16. **Physical, Occupational and Speech Therapy**

Therapy services are covered only as an element of hospital care (inpatient or outpatient), nursing facility care, or home health care, or if prescribed by a physician and provided by a Medicaid-enrolled therapy provider.

17. **Physician Services**

Services are covered when provided by physicians licensed to practice medicine, osteopathy, and psychiatry.

18. **Podiatrist Services**

Medicaid payment is limited to medically necessary diagnostic, medical, or surgical treatment of the foot. Routine and preventive foot care is not covered.

19. **Prescribed Drugs**

Services are limited to generic legend drugs except when the physician specifies "brand necessary" name drugs. When prescribed by a physician, insulin, insulin syringes and needles, and family planning drugs and supplies are covered.

20. Rehabilitation Services

Preauthorization requirement

All rehabilitative services must be pre-authorized by DMAS.

Intensive Inpatient Rehabilitation

Medicaid covers intensive inpatient rehabilitation services provided in facilities certified as rehabilitation hospitals or in rehabilitation units in acute care hospitals, which are certified by the Department of Health as excluded from the Medicare prospective payment system.

Intensive Outpatient Rehabilitation

Intensive outpatient rehabilitation services provided by facilities certified as comprehensive rehabilitation facilities (CORFs), or by an outpatient program administered by a rehabilitation hospital or exempted rehabilitation unit of an acute care hospital, which are certified and participating in Medicaid are covered.

21. Substance Abuse Services

Substance abuse (SA) services are covered as follows:

- assessment and evaluation,
- outpatient therapy (individual, family, and group),
- crisis intervention,
- intensive outpatient services,
- day treatment,
- case management, and
- opioid treatment.

Treatment for nicotine and caffeine dependence/abuse is not covered.

22. Transplant Services

Transplant services are covered as follows:

- kidney, cornea, heart, lung, liver without age limits;
- liver, heart, lung, small bowel, bone marrow, and any other medically necessary transplant procedures that are not experimental or investigational for enrollees under age 21; and
- bone marrow transplants for individuals over age 21 for a diagnosis of lymphoma, breast cancer, leukemia, or myeloma.

DMAS must preauthorize all transplants except corneal transplants.

23. Transportation to Receive Medical Services

Transportation *services must be pre-authorized and* are only covered when the enrollee is being transported for the purpose of receiving or returning home from a Medicaid-covered service. For individuals *not enrolled in an MCO or enrolled in an MCO that does not provide its own transportation services, n*on-emergency transportation to a medical provider must be preauthorized by the DMAS transportation broker The toll-free telephone number for the *DMAS* transportation broker is 866-386-8331

If the enrollee's MCO provides transportation services, the enrollee must call his MCO for preauthorization.

***24. Vision* Services**

Eye examinations that licensed optometrists and *ophthalmologists* are legally authorized to provide are covered. A routine, comprehensive eye examination is allowed once every 24 months. Preauthorization is not required. Eyeglasses (lenses and frames) are covered for children under age 21 years. Preauthorization for eyeglasses is not required.

E. Babycare Services

Medicaid has a program of expanded services for all Medicaid-eligible pregnant women and high risk infants under age 2 years. The package of services is called Babycare. Physician, hospital, clinic, and nurse-midwife services are covered, as described above. Risk-assessment, nutrition counseling, patient education, homemaker services, and substance abuse residential and day-treatment services are also covered when prescribed by the physician.

Women and infants who are determined by the physician to be at high-risk for birth-related complications, as defined by DMAS, are eligible for maternity care coordination services, when referred by the physician, in addition to the other Babycare services. The maternity care coordinator is a case manager (usually a nurse or social worker) who develops a plan of care for the pregnant woman or the infant, ensures that the recipient has access to necessary services, provides counseling, and assures that the recipient keeps medical services appointments.

DMAS prints a Babycare pamphlet which is available to local social services agencies and must be ordered from DMAS. It is available in several languages. Recipients may also call the Babycare toll-free Helpline at 1-800-421-7376 between 10:00 a.m. and 3:30 p.m., Monday through Friday, to receive information about Babycare services.

F. Medical Coverage for Specified Aliens

Medicaid covers emergency services for unqualified aliens and qualified aliens eligible for emergency medical services only who meet all other Medicaid eligibility requirements when these services are provided in a hospital emergency room or inpatient hospital setting. DMAS determines both whether services are considered emergency services and the period of coverage.

M1860.100 SERVICES RECEIVED OUTSIDE VIRGINIA

A. General

Medicaid must pay for covered medical services received by any eligible person who is temporarily absent from Virginia if the medical service provider agrees to accept Medicaid payment.

B. Out-of-State Institutional Placements

Preauthorization Requirement

Virginia Medicaid will cover a recipient who is placed in a long-term care facility in another state only if the placement is preauthorized by the DMAS Long Term Care Section.

Foster Care Children

A child in IV-E Foster Care who is placed in an institution outside Virginia is eligible for Medicaid through the state in which he resides. A child in non-IV-E Foster Care is eligible for Virginia Medicaid when the child is in an institution outside Virginia, since the child is considered to be a resident of the locality which holds custody.

FOSTER CARE CHILD
EXEMPTION FROM MEDICAID MANAGED CARE PROGRAMS
(MEDALLION and Medallion II)

A copy of the Custody Order or Removal Order must be attached to this form in order for the disenrollment to be processed. In the event the Custody Order or Removal Order is not available, a statement on agency letterhead signed by the director or a foster care supervisor verifying the child is in the custody of the agency and the date the agency received custody must be included with this form.

In order for exemptions to occur in a timely manner, please fax this form to Tabitha Taylor at 1-804-786-5799.

Medicaid Enrollee ID#_____ Name_____

Address_____ Date _____

_____ City/County Code _____

_____ Case Worker _____

Medicaid Enrollee ID#_____ Name_____

Address_____ Date _____

_____ City/County Code _____

_____ Case Worker _____

Disenrollment is not retroactive. Disenrollment can be confirmed by checking the VaMMIS Managed Care Assignment screen for a managed care end date.

CHAPTER M20

EXTRA HELP - MEDICARE PART D LOW-INCOME SUBSIDY

M20 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	Table of Contents pages 1, 2 Pages 3-18 and Appendices 1-9 were removed.
Update (UP) #3	3/01/10	Table of Contents, page ii Appendix 3, page 1
TN #93	1/1/10	Table of Contents, page ii pages 3, 5, 6, 7, 10, 11, 15 Appendix 1, page 1 Appendix 2, page 1 Appendix 3, page 1 Appendix 4, page 1

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M2000.000 EXTRA HELP - MEDICARE PART D LOW-INCOME SUBSIDY

M2010.100 EXTRA HELP GENERAL INFORMATION

A. Introduction

The Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 (Public Law 108-173) amended Title XVIII of the Social Security Act by establishing Medicare Part D, the Voluntary Prescription Drug Benefit Program for individuals who are entitled to Medicare Part A and/or enrolled in Medicare Part B.

B. *Medicaid and Medicare Part D Prescription Drug Coverage*

For the purposes of Medicare Part D, *individuals* who *are* eligible for both Medicare and Medicaid benefits *are considered dually eligible*. Effective January 1, 2006, Medicaid *does not* provide prescription drug coverage for *dually eligible individuals. These individuals* receive their prescription drug coverage through Medicare Part D. *Medicaid will only cover prescription medication that cannot be covered by Medicare under the MMA, including some controlled medications.*

Medicare beneficiaries who are not eligible for Medicaid and who choose to participate in Medicare Part D are subject to cost-sharing obligations, including monthly premiums, deductibles, and copayments.

C *Extra Help Low Income Subsidy*

Extra Help is the subsidy provided under Medicare Part D that reduces out-of-pocket expenses for Medicare Part D enrollees who, based on their income and resources, are determined to be low-income. *Extra Help is the public name for the subsidy program; the Social Security Administration (SSA) generally refers to the subsidy as Low-Income Subsidy (LIS) in its contacts with state Medicaid programs. There are two levels of the LIS - the partial subsidy and the full subsidy. The individual's income and resources determine the level of subsidy an eligible individual receives.*

1. Dually Eligible Individuals Have Full LIS – No Premiums, Deductibles or Copays

Dually eligible individuals are automatically eligible for *the full LIS* and are enrolled using data matches from the Department of Medical Assistance Services (DMAS) and the Centers for Medicare and Medicaid Services (CMS). *Under the full LIS, dually* eligible *individuals* have no Medicare Part D premiums, deductibles, or threshold costs. All dually eligible individuals except those in nursing facilities have copayments ranging from $1 to $5 per prescription.

2. Non Dually Eligible Individuals

Medicare beneficiaries who are not eligible for Medicaid must apply for the subsidy and be determined eligible in order to receive assistance with their Medicare Part D cost-sharing obligations. More information about the benefits available under the LIS for non-dually eligible individuals is available on-line at http://www.centerforbenefits.org.

D. *LIS Medicaid Applications*

Effective January 1, 2011, all applications for the Extra Help LIS made to SSA are also considered applications for Medicaid. The SSA transmits data on all LIS applicants residing in Virginia to the Virginia Department of Social Services. A pre-populated Application for Adult Medical Assistance is generated by the Medicaid LIS system for individuals who are not currently enrolled in Medicaid and transmitted to the appropriate local agency. See M0120.240 B.8 for additional information about LIS Medicaid applications.

E. Extra Help LIS Eligibility for Non Dual Eligibles

Individuals who are not dually eligible and *not* automatically eligible for the LIS may be eligible for the LIS if all of the following are met:

- he is a resident of the United States,
- he is entitled to Medicare Part A and/or enrolled in Medicare Part B,
- he and his spouse, if married and living together, have countable income less than 150% of the federal poverty level (FPL) for his assistance unit size,
- he, and his spouse if married, has countable resources within the limits *for the LIS*, and
- he resides in the service area of a Part D prescription drug plan (service area does not include facilities in which individuals are incarcerated but otherwise covers the 50 States, District of Columbia, and U.S. Territories).

F. ***LDSS Responsibilities***

The MMA mandates that eligibility for the Extra Help LIS can be determined by both the Social Security Administration (SSA) and the states. The local department of social services (LDSS) may also assist an individual with applying for Extra Help from the SSA in several ways, such as helping complete and/or submit the subsidy application directly to SSA, referrals to the SSA toll-free helpline, and helping to complete the on-line SSA application form. When the LDSS assists the individual with the application but does not determine eligibility, the LDSS does not have responsibility for the case.

1. Individual Requests LDSS Determine LIS Eligibility

If an individual requests that the LDSS determine his eligibility for Extra Help, inform the individual that, when the Social Security Administration determines eligibility for Extra Help, the SSA is able to verify most income and resources ***without*** *requesting documentation from the individual. Indicate that assistance with completing the application for the Extra Help LIS can also be provided by the SSA.*

2. LDSS Responsibility for LIS Applications

LDSS must determine eligibility for the LIS only in situations where an individual specifically requests that the agency do so. If such a request is made, the LDSS must comply with the request and must:

- determine eligibility,
- enroll the recipient if eligible,
- provide notice,
- participate in appeals,
- comply with reporting requirements, and
- provide ongoing case maintenance, including notices, appeals, and redeterminations, unless the applicant is later found to be deemed eligible for Extra Help or has been found eligible by SSA.

If the LDSS is required to determine an individual's eligibility for the LIS, contact a regional Medical Assistance Program Consultant for additional instructions.

E. Extra Help Policy Principles

Extra Help provides assistance with the out-of-pocket costs associated with Medicare Part D. An individual is eligible for Extra Help if all of the following are met:

- he is a resident of the United States,
- he is entitled to Medicare Part A and/or enrolled in Medicare Part B,
- he and his spouse, if married and living together, have countable income less than 150% of the federal poverty level (FPL) for his assistance unit size,
- he, and his spouse if married, has countable resources *within the limits listed in M20, Appendix 3*, and
- he must reside in the service area of a Part D prescription drug plan (service area does not include facilities in which individuals are incarcerated but otherwise covers the 50 States, District of Columbia, and U.S. Territories).

M2020.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

The nonfinancial eligibility requirements for Extra Help are different than the nonfinancial requirements for the Medicare Savings Programs (see chapter M02). An individual who does not meet the nonfinancial requirements for the Medicare Savings Programs may meet the nonfinancial requirements for Extra Help.

B. Extra Help Nonfinancial Requirements

Only the following nonfinancial eligibility requirements apply when Extra Help eligibility is determined by the LDSS:

- residency in Virginia, and
- entitlement to Medicare. The individual does not need to be enrolled in Medicare at the time of application, but Extra Help will not begin until he has enrolled in Medicare Part D.

M2030.100 DETERMINING EXTRA HELP SUBSIDY ELIGIBILITY

A. Introduction

In the event that an applicant requests an Extra Help determination by the LDSS, the LDSS must comply with the request. Unless the applicant is later found to be deemed eligible for Extra Help or has been found eligible by SSA, the LDSS will also be responsible for ongoing case activity, including notices, appeals, and redeterminations.

B. Applicant's Representative

The applicant may be represented by any of the following individuals:

- an individual who is authorized to act on behalf of the applicant;
- if the applicant is incapacitated or incompetent, someone acting responsibly on his or her behalf; or
- an individual of the applicant's choice who is requested by the applicant to act as his or her representative in the application process;

Anyone may help the individual apply for the subsidy. The person assisting the applicant is required to attest to the accuracy of the information on the application.

C. Interview

A face-to-face interview is not required for Extra Help.

D. Screening for Deemed Status

LDSS must conduct its usual screening process to determine if the applicant is enrolled in Medicaid (full benefit or the limited benefit QMB, SLMB, or QI) or receives SSI. If the applicant is found to be in one of these programs, the applicant is deemed eligible for the subsidy and no application is required. M20, Appendix 1, Screening Script for Help with Medicare Costs (Form #032-03-701) and M20, Appendix 2, Screening Worksheet for Help with Medicare Costs (Form #032-03-702) are suggested screening tools.

E. Clearances

Eligibility workers should conduct their usual SDX/SVES/SOLQ clearances to verify the applicant's entitlement/enrollment in Medicare Parts A and B. If no Medicare entitlement/enrollment can be confirmed, deny the Extra Help application. If the available data confirm Medicare Buy-In in another U.S. jurisdiction, the applicant has already been deemed eligible for the subsidy. The LDSS must inform the applicant's former state of the change of address, and offer a Medicaid application to the applicant explaining that if he qualifies for Medicaid in Virginia, he automatically qualifies for Extra Help.

F. Spenddown

If the applicant is on a Medicaid spenddown in the month of application for the subsidy, continue with the Extra Help determination, using monthly countable income. If the applicant meets Medicaid eligibility during the month of subsidy application, he is deemed eligible for Extra Help. Once deemed eligible, the individual will receive the subsidy for the remainder of the calendar year.

G. Family Size

For the purpose of establishing the applicable income limit only, the following persons are counted in the family size:

- the applicant;
- the applicant's spouse, if living together; and
- any persons who are related by blood, marriage, or adoption, who are living with the applicant and spouse and who are dependent on the applicant or spouse for at least one half of their financial support. Accept the applicant's statement that he has a dependent.

M2040.100 FINANCIAL REQUIREMENTS

A. Introduction

Modified Supplemental Security Income (SSI) regulations are used to evaluate income and resources for Extra Help. For certain sections, the worker is referred to the on-line Program Operations Manual System (POMS) at http://policy.ssa.gov/poms.nsf/aboutpoms for more information. All types of countable income and resources must be verified.

The intent of the MMA was that the state and SSA determinations would be identical given the same information about the applicant/spouse. The guidance in this chapter and POMS must be used to determine eligibility for Extra Help.

M2040.200 RESOURCE REQUIREMENTS

A. Evaluating Resources

Resources of the applicant and his spouse if living together, but not resources of dependent family members are used to determine resource eligibility.

Count liquid resources which are cash or can be converted to cash within 20 days, including but not limited to:

- stocks;
- bonds;
- mutual fund shares;
- promissory notes (including mortgages held by the applicant);

- financial institution accounts, including:

  - savings and checking accounts; and
  - time deposits, also known as certificates of deposit;
  - individual Retirement Accounts (IRAs) and
  - 401(K) accounts; and

- the equity value of real property not contiguous with home property (see M2040.200.E).

B. Resource Standards

The maximum subsidy resource standards are listed in M20, Appendix 3. Resources at or below $6,600 for an individual and $9,910 for a married couple and income at or below 135% FPL entitles the applicant(s) to the full subsidy.

Note: The SSA *Low Income* Subsidy application (SSA-1020) lists *higher* resource limits *that include* the burial fund exclusion of $1500 for one person and $3000 for a couple. These amounts apply **only** if the applicant/spouse indicates intent to use resources for burial or funeral arrangements. If the applicant/spouse has no intent to use resources for burial or funeral arrangements, do not give the burial fund exclusion.

C. Resource Exclusions

The following resources are not to be considered for purposes of determining Extra Help eligibility:

- the applicant's home. For the purposes of this exclusion, a home is any property in which the applicant and his spouse have an ownership interest and which serves as his principal place of residence. There is no restriction on acreage of home property. This property includes the shelter in which an individual resides, the land on which the shelter is located, and any outbuildings;

- non-liquid resources, other than real property. These include, but are not limited to

  - household goods and personal effects;
  - automobiles, trucks, tractors and other vehicles;
  - machinery and livestock;
  - noncash business property;

- property of a trade or business which is essential to the applicant/spouse's means of self-support;

- nonbusiness property which is essential to the applicant/spouse's means of self-support;

- stock in regional or village corporations held by natives of Alaska during the twenty-year period in which the stock is inalienable pursuant to the Alaska Native Claims Settlement Act;

- ***all*** life insurance owned by an individual (and spouse, if any);

- restricted, allotted Indian lands, if the Indian/owner cannot dispose of the land without the permission of other individuals, his/her tribe, or an agency of the Federal government;

- payments or benefits provided under a Federal statute where exclusion is required by such statute (see http://policy.ssa.gov/poms.nsf/lnx/0501130050);

- federal disaster relief assistance, including accumulation of interest, or comparable state or local assistance, received due to a Presidentially-declared major disaster;

- funds of $1,500 for the individual and $1,500 for the spouse who lives with the individual if these funds are intended to be used for funeral or burial expenses of the individual and spouse;

- burial spaces, including burial plots, gravesites, crypts, mausoleums, urns, niches, vaults, headstones, markers, plaques, burial containers, opening and closing of the grave site, and other customary and traditional repositories for the deceased's bodily remains, for the applicant/spouse;

- retained retroactive SSI or Social Security benefits for nine months after the month they are received;

- certain housing assistance;

- refunds of Federal income taxes and advances made by an employer relating to an earned income tax credit for the month following the month of receipt, and refunds of child tax credits for nine months after the month they are received;

- payments received as compensation incurred or losses suffered as a result of a crime (Victims' compensation payments), for nine months beginning with the month following the month of receipt;

- relocation assistance from a state or local government, for nine months, beginning with the month following the month of receipt;

- funds received from a government or nongovernmental agency, program, or health insurance policy whose purpose is to provide medical care or medical services or social services and conserved to pay for medical and/or social services.

D. Determining Countable Resources

Countable resources are determined as of the first moment of the first day of the month of application or redetermination for the subsidy.

E. Equity Value

Resources, other than cash, are evaluated according to the applicant/spouse's equity in the resources. The equity value of an item is the current market value of the item minus any encumbrances on it. Encumbrances include liens, mortgages, and other obligations against the value of the resource.

The current market value of an item is the documented value of the item or the going price for which it can reasonably be expected to sell on the open market in the particular geographic area involved, based on information from a knowledgeable source.

Documented value includes tax-assessed value for real property. Information from a knowledgeable source includes an estimate from a real estate broker, bank, mortgage company, or similar lending institution. There are other rules that apply in calculating the value of resources. See POMS at http://policy.ssa.gov/poms.nsf/aboutpoms for additional information, and contact your Medical Assistance Program Specialist for assistance if needed.

F. Funds Held in Financial Institutions

Cash received by the applicant or his spouse during a month is evaluated under the rules for counting income during the month of receipt. If the cash is retained until the first moment of the following month, the cash is countable as a resource unless it is otherwise excludable.

1. Owner of the Account

Funds held in a financial institution account (including savings, checking, and time deposits also known as certificates of deposit) are considered the applicant/spouse's resources if he or she owns the account and can use the funds for his or her support and maintenance.

2. Individually-held Account

If the applicant/spouse is designated as the sole owner by the account title and can withdraw and use funds from that account for his or her support and maintenance, all of the account's funds are the applicant/spouse's resource regardless of the source. For as long as these conditions are met, presume that the applicant/spouse owns 100 percent (%) of the funds in the account. This presumption is not rebuttable.

3. Jointly-held Account

If the applicant/spouse is the only subsidy claimant or subsidy recipient who is an account holder on a jointly held account, presume that all of the funds in the account belong to the applicant/spouse. If more than one subsidy claimant or subsidy recipient are account holders, presume that the funds in the account belong to those individuals in equal shares. If the applicant/spouse disagrees with the ownership presumption described in this paragraph, he or she may rebut the presumption. Rebuttal is a procedure which permits an individual to furnish evidence and establish that some or all of the funds in the jointly-held account do not belong to him or her. See the SSA POMS at http://policy.ssa.gov/poms.nsf/aboutpoms for additional information.

M2040.300 INCOME REQUIREMENTS

A. Introduction

Income is anything the applicant/spouse receives in cash or in-kind that can be used to meet his needs for food or shelter. The gross income of the applicant and spouse if living together, but not dependent family members, will be considered, however, dependent family members will be counted in the family size.

Income to be counted is income expected to be received on a monthly basis. Convert income to a monthly amount by multiplying weekly income by 4.3, bi-weekly income by 2.15 and semi-monthly income by 2. Income from a terminated source must only be verified and counted when it was received in a month in which eligibility is being determined.

B. Earned Income

Earned income consists of the following types of payments:

- wages;
- net earnings from self-employment;
- payments for services performed in a sheltered workshop or work activities center; and
- royalties earned by an individual in connection with any publication of his/her work and any honoraria received for services rendered.

1. Wages

Wages are counted at the earliest of the following points:

- when received;
- when credited to the person employed; or
- when set aside for the employee's use.

Net earnings from self-employment are counted on a taxable year basis. Net losses, if any, are deducted from other earned income, but not from unearned income.

Payments for services performed in a sheltered workshop or work activities center are counted when received or set aside for the employee's use.

2. In-Kind Earned Income

In-kind earned income, *other than contributed food and/or shelter,* is counted based on current market value. If the applicant/spouse receives an item that is not fully paid for and he or she is responsible for the balance, only the paid up value is income to the applicant.

In-kind earned income in the form of contributed food and shelter is not counted.

3. Honoraria

Honoraria for services rendered and royalty payments that an individual receives in connection with any publication of their work counts as earned income.

4. Earned Income Exclusions

Apply exclusions in the order listed below:

- refund of Federal income taxes and payments under the Earned Income Tax Credit;
- the first $30 of earned income per calendar quarter that is received too irregularly or infrequently to be counted as income;
- any portion of the $20 per month exclusion that has not been excluded from combined unearned income (see S02030.200.D);
- $65 per month of the applicant/spouse's earned income;
- for applicants/spouses who are under age 65 and receive a Social Security Disability Insurance benefit based on disability, 16.3% of gross earnings for impairment related work expenses (IRWE).
- one half of the applicant/spouse's remaining earned income; and
- for applicants/spouses who are under age 65 and receive a Social Security Disability Insurance benefit that is based on blindness, 25% of gross earnings for blind work expenses (BWE).

C. Unearned Income

Unearned income is all income that is not earned income. Unearned income is counted at the earliest of the following points:

- when received;
- when credited to the applicant; or
- when set aside for the applicant's use.

Unearned income includes, but is not limited to:

- Social Security;
- Railroad Retirement;
- VA Benefits;

- Temporary Assistance for Needy Families (TANF);
- pensions;
- annuities;
- alimony and support payments
- rental income;
- Workers' Compensation;
- in-kind support and maintenance;
- death benefits;
- royalties not counted as earned income; and
- dividends and interest not otherwise excluded under SSI rules.

1. In-kind support and maintenance

In-kind support and maintenance is any food and shelter that is given to the applicant/spouse or received because someone else pays for it. This includes room, rent, mortgage payments, real property taxes, heating fuel, gas, electricity, water, sewage, and garbage collection services. ***In-kind support and maintenance is not counted as income.***

2. Overpayments

When benefits are reduced for overpayments or garnishments, count the gross benefit before deductions.

Example: Mr. Poplar failed to pay income taxes and his Social Security check has been garnished to pay IRS. The gross amount of his benefit is $1,150 per month; he actually receives $750. The gross amount ($1,150) is countable.

3. Expenses

If part of a payment reflects expenses the applicant/spouse incurred in getting the payment, such as legal fees, or damages, such as medical expenses, incurred because of an accident, reduce the payment by the amount of the expenses. Do not reduce the payment by the amount of personal income taxes owed on the payment.

4. VA Benefits

Subtract from VA Benefits any amount included in the payment for a dependent. If the applicant/spouse is the dependent, count the portion of the benefit attributable to the dependent if they reside with the veteran or receive their own separate payment from the Department of Veteran Affairs.

5. Death benefits Subtract from death benefits the expenses of the deceased person's last illness and death paid by the applicant.

D. Unearned Income Exclusions The following types of unearned income are not considered for purposes of determining Extra Help eligibility:

- Supplemental Security Income (SSI) benefits;
- any public agency's refund of taxes on real property or food;
- need-based assistance wholly funded by a State or one of its subdivisions, including State supplementation of SSI benefits but not a Federal/State grant program such as TANF;
- any portion of a grant, scholarship, fellowship, or gift used for paying tuition, fees, or other educational expenses. Any portion set aside or used for food, clothing or shelter is countable;
- food which the applicant or their spouse raise if it is consumed by them or their household;
- assistance received under the Disaster Relief and Emergency Assistance Act and assistance provided under any Federal statute because of a catastrophe which the President of the United States declares to be a major disaster;
- payments for providing foster care to a child who was placed in the applicant's home by a public or private nonprofit child placement or child care agency;
- any interest earned on excluded burial funds and any appreciation in the value of an excluded burial arrangement which are left to accumulate and become part of the separate burial fund;
- home energy assistance (any assistance related to meeting the costs of heating or cooling a home);
- one-third of support payments made to or for the applicant by an absent parent if the applicant is a child;
- the first $20 of any unearned income in a month other than income in the form of in-kind support and maintenance received in the household of another and income based on need;

- housing assistance any assistance paid with respect to a dwelling unit under:
  - The United States Housing Act of 1937;
  - The National Housing Act;
  - Section 101 of the Housing and Urban Development Act of 1965;
  - Title V of the Housing Act of 1949; or
  - Section 202(h) of the Housing Act of 1959;
- any interest accrued on and left to accumulate as part of the value of an excluded burial space purchase agreement;
- gift of a domestic travel ticket received by the applicant or their spouse and not converted to cash;
- payments made to the applicant or their spouse from a fund established by the State to aid victims of crime;
- relocation assistance provided to the applicant or their spouse by the State or local government that is comparable to relocation assistance provided under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;
- hostile fire pay received from one of the uniformed services;
- the first $60 of unearned income received per calendar quarter that is received too irregularly or infrequently to be counted as income; or
- any dividends or interest earned on countable resources, any dividends or interest earned on resources excluded under a Federal statute other than the Social Security Act, and any dividends or interest excluded under the Social Security Protection Act of 2004 (see POMS SI 01130.050).

M2050.100 CALCULATING EXTRA HELP ELIGIBILITY

A. Introduction

When an applicant insists on an Extra Help determination by the LDSS, the eligibility worker must determine the applicant's eligibility for Extra Help and if eligible, the amount of the subsidy to which he is entitled. The amount of the subsidy is based on the amount of the individual's countable income and resources.

B. Steps for Determining the Amount of the Subsidy

To determine the amount of the subsidy, use the following steps:

1. Using the family size reported by the applicant and their countable net income, determine where the applicant and his spouse, if living together, fall on the appropriate Extra Help Income Limits table to determine the percentage of the federal poverty level (FPL) (see M20, Appendix 3).

2. Using the percentage of the FPL and the applicant/spouse's countable resources, find the subsidy code (A through F) on the subsidy calculation table for one person or a couple (see M20, Appendix 4).

3. Using the subsidy code, identify the applicable benefits on the subsidy benefits table (see M20, Appendix 4). The SSA Calculator Tool may be used for this calculation. This resource may be found at www.ssa.gov under "Medicare Outreach."

Example: Mr. and Mrs. Spruce are Medicare beneficiaries who are raising their 15-year-old grandson. Their countable net income is $1,500 per month. They have $18,000 in countable resources.

1. Find their income range on the Family Size-3 line of the Extra Help Income Limits in M020, Appendix 3. The income limits show that their income falls below 135% of the FPL.

2. Using the percent of FPL and the total countable resources, find the subsidy code on the subsidy calculation table for couples (M20, Appendix 4). The correct code is "B".

3. Transpose the percentage of premium level for "B" onto the Spruces' approval notice.

M2060.100 NOTICES

A. Introduction

When the LDSS determines or redetermines eligibility for Extra Help, notice must be sent to the applicant. All notices must provide adequate information and meet the Medicaid advance notice requirements.

B. Approval Notice

When the LDSS approves an application for Extra Help, an approval notice must be sent and must include the following required information:

- application date;
- description of how the subsidy was calculated; what income, family size, and resources were used;
- premium percentage;
- effective date of eligibility;
- who made the decision and how to contact them;
- appeal rights and procedures; and
- a reminder to apply for a prescription drug plan.

M20, Appendix 5 contains the Notice of Approval on Your Application for Extra Help with Medicare Part D Costs (Form #032-03-703).

C. Denial Notice

When the LDSS denies an application for Extra Help, a denial notice must be sent and must include the following information:

- application date;
- reason for denial and policy citation;
  - not Medicare-eligible;
  - failure to complete the application process;
  - income is equal to or exceeds 150% FPL;
  - resources exceed *the current resource limit listed in M20, Appendix 3 (include the actual resource limit amount in the notice)*;
  - not a resident of the State;
  - not a resident of U.S./incarcerated;
- description of how the denial was calculated; what income, family size, and resources were used;
- who made the decision and how to contact them;
- appeal rights and procedures; and
- depending on the denial reason, a reminder to apply for a prescription drug plan.

M20, Appendix 6 contains the Notice of Denial on Your Application for Extra Help with Medicare Part D Costs (Form #032-03-704).

D. Termination Notice

When the LDSS determines an individual is no longer eligible for Extra Help, a termination notice must be sent and must include the following information:

- reason for termination and policy citation;
  - not Medicare-eligible;
  - failure to complete the redetermination process;
  - income is equal to or exceeds 150% FPL;
  - resources exceed *the current resource limit listed in M20, Appendix 3 (include the actual resource limit amount in the notice)*;
  - not a resident of the State;
  - not a resident of U.S./incarcerated.

- description of how the termination was calculated; what income, family size, and resources were used;
- effective date of termination;
- who made the decision and how to contact them;
- appeal rights and procedures; and
- depending on the termination reason, a reminder that he can still use his prescription drug plan.

M20, Appendix 7 contains the Notice of Termination of Your Extra Help with Medicare Part D Costs (Form #032-03-705).

E. Change Notice

When the LDSS determines that an individual's eligibility for Extra Help has changed, it is required to send a change notice containing the following information:

- reason for change in subsidy level and policy citation;
- new premium percentage;
- description of how the change was calculated; what income, family size, and resources were used;
- effective date of change;
- who made the decision and how to contact them;
- appeal rights and procedures; and
- reminder that he can still use his prescription drug plan but that his costs within the plan have changed.

M20, Appendix 8 contains the Notice of Change in the Amount of Extra Help with Medicare Part D Costs (Form #032-03-706).

All notices must meet the adequate and timely notice requirements of the Medicaid State Plan.

M2070.100 APPEALS AND FAIR HEARINGS

A. Decision made by LDSS

The applicant may appeal his Extra Help determination according to the appeal procedures found in chapter M16. The individual has 30 days from the receipt of the notice to file an appeal.

B. Decision made by SSA

SSA will be responsible for appeals of decisions made by SSA, including decisions made on SSA applications forwarded to SSA by the State.

M2080.100 PERIODS OF ELIGIBILITY

A. Introduction

Initial eligibility determinations made by the LDSS are effective as of the first day of the month of application, but not earlier than January 1, 2006, and remain in effect for a period not to exceed one year. Redeterminations must be made in the same manner and frequency as redeterminations are made under the State plan.

Note: There is no retroactive period for Extra Help.

B. Examples

The subsidy is effective the beginning of the month of application or January 1, 2006, whichever is later.

Example: Ms. Gingko files a subsidy application in August 2005. If she qualifies, her subsidy will be effective January 1, 2006.

Example: Mr. Dogwood files a subsidy application in March 2006. If he qualifies, his subsidy will be effective March 1, 2006.

M2090.100 INTERIM CHANGES (SUBSIDY-CHANGING EVENTS)

A. Introduction

Certain changes in the individual's circumstances can affect their eligibility for the subsidy or change the level of the subsidy. These changes include:

- changes in income,
- changes in resources,
- changes in marital status (marriage, divorce, annulment, etc), or
- changes in eligibility for Medicaid or SSI (deemed status).

The Notice of Approval on Your Application For Extra Help with Medicare Part D Costs instructs the individual to report changes within 10 days. When a change is reported, the eligibility worker must determine the individual's continued eligibility and amount of subsidy to which he is entitled as a result of the change.

If the level of subsidy is increased, decreased or terminated, notification of the action must be sent to the individual at least 10 days plus one day for mail before the action is taken describing the change, the effective date of the change, how the subsidy was calculated, and his right to appeal the decision.

B. Changes in Income or Resources

When a reported change in income or resources results in an increase in the amount of subsidy to which the individual is entitled, the change is effective the month following the month in which the change is reported.

When the reported change results in a decrease in the amount of subsidy to which the individual is entitled or ineligibility for the subsidy, the change is effective the month following the month in which the 10-day notice expires.

C. Changes in Marital Status

When a reported change in marital status results in an increase in the amount of subsidy to which the individual is entitled, the change is effective the month following the month in which the change is reported.

When the reported change results in a decrease in the amount of subsidy to which the individual is entitled or ineligibility for the subsidy, the change is effective the month following the month in which the 10-day notice expires.

D. Changes in Deemed Status

Individuals who become eligible for Medicaid, SSI, QMB, SLMB, and QI after being found eligible for the subsidy join the deemed population. The LDSS can then close its on-going subsidy case for the individual while maintaining the Medicaid case. CMS will notify the individual that he is now deemed eligible for Extra Help.

Individuals who lose deemed status will be notified by CMS of the need to apply at SSA or LDSS to retain eligibility for Extra Help.

M2090.200 REDETERMINATION

A. Introduction

Redeterminations of continued eligibility for Extra Help must be completed annually. A redetermination is due 12 months from the month of application or the last redetermination. For example, when the application is filed in June, the redetermination is due the following May. The next redetermination would be due in May of the following year.

M2090.300 MULTIPLE DETERMINATIONS FOR THE SAME APPLICANT

A. Introduction

The LDSS may not know if a subsidy application has also been filed at SSA. However, CMS is working with states and SSA to facilitate information sharing so that CMS will know whether an individual has been found eligible by SSA or a state.

In the case of multiple determinations based on applications in different months, the later application is void if the individual has received a positive subsidy determination on the earlier application with the State or SSA. This is so even if the earlier decision is a partial subsidy and the later decision is a full subsidy. If two approvals occur in the same month, the SSA decision takes precedence, even if it provides a lower level of subsidy. All decisions may be appealed, including denials, effective dates, and partial subsidies, with the agency that is responsible for the decision. M20, Appendix 9 contains the precedence of Extra Help decisions.

Screening Script for Help with Medicare Costs
Effective 1/1/10

"This is a preliminary, voluntary screening to see if you might be eligible for programs that help pay Medicare expenses. It is not an application for these programs. The information you provide will assist us in determining if you may be eligible for these programs.

Do you have Medicare Part A or Part B Yes _____ No _____

Are you: (1) single or married but not living with your spouse? _____ Go to A. below
or
(2) married and living with your spouse? _____ Go to B. below

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A. Single or Not Living with Spouse

"Income includes Social Security benefits such as retirement, disability, or SSI; any pensions; earned wages; interest; dividends; monthly cash gifts; and contributions."

Is your monthly income before any deductions less than $1,353.75 per month? Yes _____ No _____

"Resources are things such as cash on hand, bank accounts such checking, savings, certificates of deposit, IRAs, Christmas Clubs, and trusts; as well as stocks, bonds, the cash value of life insurance policies; and property that does not adjoin your home. Your home and adjoining property, vehicles, burial plots, household furnishings, and personal items such as jewelry are not counted as resources."

Do you have less than $11,010 in resources? Yes _____ No _____

B. Married and Living with Spouse

"Income includes Social Security benefits such as retirement, disability, or SSI; any pensions; earned wages; interest; dividends; monthly cash gifts; and contributions."

Is your combined monthly income before any deductions less than $1,821.25 per month? Yes _____ No _____

"Resources are things such as cash on hand, bank accounts such checking, savings, certificates of deposit, IRAs, Christmas Clubs, and trusts; as well as stocks, bonds, the cash value of life insurance policies; and property that does not adjoin your home. Your home and adjoining property, vehicles, burial plots, household furnishings, and personal items such as jewelry are not counted as resources."

Do you and your spouse have less than $22,010 in resources? Yes _____ No _____

"Based on this screening, it appears that you (choose one) may / may not be eligible for Extra Help with your Medicare Part D costs. You may apply for Extra Help directly at the Social Security Administration office or by calling 1-800-772-1214. You may apply even if it appears that you may not be eligible. Your income and resources can be verified by the Social Security Administration."

"If your income is less than $1,219 for one person or $1,640 for a couple and your resources are less than $*6,600* for one person or $*9,910* for a couple, you may want to apply for Medicaid. If you are found eligible, Medicaid will cover some or all of your Medicare expenses, and you will automatically be eligible for Extra Help with your Medicare Part D costs ."

Screening Worksheet for Help with Medicare Costs
Effective 1/1/10

I. Do you have Medicare Part A or Part B Yes _____ No _____

II. Marital status:
Is person single? Yes _____ No _____
Or married and living with spouse? Yes _____ No _____
(Count income and resources of a couple who are married and living together).

III. Income:
a. Total monthly earned income: _____
b. Minus $65 and ½ : _____ = countable earned
c. Total monthly unearned income _____
d. Minus $20 _____ = countable unearned

Total countable income (add lines b. and d.): _____

IV. Total countable resources: _____

V. Dependents: Does the individual/couple live with any relatives for whom he/she provides at least 1/2 of their financial support? Yes _____ How Many? _____ No _____

VI. Screen:

Countable Limits	MSP Eligible		Extra Help Eligible			
	1	2	1	2	3	4
Income	$1,219	$1,640	< $1,353,75	< $1,821.25	< $2,288.75	< $2,756.25
Resources	$6,600	$9,910	$11,010	$22,010 (C)	$11,010 (S) $22,010 (C)	$11,010 (S) $21,010 (C)

S = Single C = Married Couple

If income is less than or equal to 135% and resources do not exceed MSP limits, the individual may be eligible for Medicaid. A Medicaid application must be completed and all information must be verified.

If income is greater than 135% and/or resources do not exceed the Extra Help limits, offer to assist the individual with applying for Extra Help from the Social Security Administration.

EXTRA HELP INCOME LIMITS
ALL LOCALITIES
EFFECTIVE 1/23/09
MONTHLY GUIDELINES

FAMILY SIZE	PERCENT OF FEDERAL POVERTY LEVEL (FPL)				
	100%	135%	140%	145%	150%
1	$902.50	$1,218.38	$1,263.50	$1,308.63	$1,353.75
2	1,214.17	1,639.13	1,699.83	1,760.54	1,821.25
3	1,525.83	2,059.88	2,136.17	2,212.46	2,288.75
4	1,837.50	2,480.63	2,572.50	2,664.38	2,756.25
5	2,149.17	2,901.38	3,008.83	3,116.29	3,223.75
6	2,460.83	3,322.13	3,445.17	3,568.21	3,691.25
7	2,772.50	3,742.88	3,881.50	4,020.13	4,158.75
8	3,084.17	4,163.63	4,317.83	4,472.04	4,626.25

For family units of more than 8 members, contact a Medical Assistance Program Consultant.

EXTRA HELP RESOURCE LIMITS – EFFECTIVE 1/1/10

	Extra Help			
	1	2	3	4
Income	< $1,353.75	< $1,821.25	< $2,288.75	< $2,756.25
Resource Limit	$11,010	$22,010 (C)	$11,010 (S) $22,010 (C)	$11,010 (S) $21,010 (C)

CALCULATION TABLES
Effective *1/1/10*

Subsidy Calculation for One Person

Countable Resources in $	≤135% FPL	> 135% to ≤140% FPL	> 140% to ≤ 145% FPL	> 145% to < 150% FPL	≥ 150%
≤ $6,600	A	C	D	E	F
> $6,600 to ≤ $11,010	B	C	D	E	F
> $11,010	F	F	F	F	F

Subsidy Calculation for a Couple

Countable Resources in $	< 135% FPL	> 135% to ≤ 140% FPL	> 140% to ≤ 145% FPL	> 145% to < 150%	≥ 150%
≤ $9,910	A	C	D	E	F
> $9,910 to ≤ $22,010	B	C	D	E	F
> $22,010	F	F	F	F	F

Subsidy Benefits

Subsidy	Subsidized Monthly Premium	Yearly Deductible	Pre-Catastrophic Co-pay per Prescription	Coverage Gap? Y/N	Catastrophic Co-pay per Prescription
A	100%	$0	*$2.50/$6.30*	N	$0
B	100%	$60	15%	N	*$2.50/$6.30*
C	75%	$60	15%	N	*$2.50/$6.30*
D	50%	$60	15%	N	*$2.50/$6.30*
E	25%	$60	15%	N	*$2.50/$6.30*
F (No subsidy)	0%	$*310*	25%	Y	@5%

Commonwealth Of Virginia
Department Of Social Services

County/City:	Case Number:
Case Name:	

NOTICE OF APPROVAL ON YOUR APPLICATION FOR EXTRA HELP WITH MEDICARE PART D COSTS

[Last Name, First Name, Middle Initial]
[Address]
[City, Virginia, Zip Code]

Your application for Extra Help dated _____ has been approved. You are eligible for Extra Help with your Medicare prescription drug plan (Medicare Part D) costs beginning _____. To take advantage of this benefit, you must enroll in a Medicare-approved prescription drug plan or Medicare Advantage plan with prescription drug coverage, if you are not already enrolled in one. You will receive more information from Medicare about how to choose a prescription drug plan. You may also visit www.medicare.gov or call toll-free 1-800-MEDICARE (1-800-633-4227) for more information. If you are hearing impaired, you may call the Medicare TTY number toll-free at 1-877-486-2048.

What Help You Are Eligible For

You are eligible for Extra Help (subsidy) to pay your Medicare prescription drug costs. You are eligible for:
_____ % subsidy to help pay your Medicare prescription drug plan premiums;
$ _____ prescription drug annual deductible; and
reduced co-payment amounts when you have a prescription filled.

Information Used To Determine Your Eligibility

We used the following information you reported on your application for Extra Help to determine your eligibility:

Countable income of $ _____ per month;
Countable resources of $ _____;
Household size of _____ person/people. To determine your household size, we count you, your spouse who lives with you, and any relative who lives with you and receives one-half of his or her support from you or your spouse.

To determine your eligibility, we compared your countable income and resources to the limits adopted by law for your household size.

What To Do If Your Situation Changes

If your mailing address changes, report it to your eligibility worker listed below immediately. Certain changes may affect the amount of Extra Help you can receive. Please contact your eligibility worker within 10 days to report any of the following changes:

- You get married;
- Your spouse who lives with you dies;
- You and your spouse who lives with you divorce, or separate or have your marriage annulled;
- You and your separated spouse begin living together again, or
- Your income or resources change.

Your application was processed by:

_____	_____		_____
Date Mailed	Worker's Name	Title	Worker's Phone Number

If You Disagree With This Decision

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. **You have 30 days to ask for an appeal.** The 30 days start the day after you receive this letter. You must have a good reason for waiting more than 30 days. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you desire free legal advice, you may contact your local legal aid office.

A fair hearing provides you the opportunity to review the way a local social services agency has handled your situation concerning your stated need for Extra Help. The fair hearing is a private, informal meeting at the local social services agency with you and anyone you wish to bring as a witness or to help you tell your story, such as a relative, friend, or lawyer. The person who conducts the hearing is someone from the Department of Medical Assistance Services, not someone from your local social services agency. The hearing officer makes a decision on your appeal.

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(1) examine all documents and records, which are used at the hearing;

(2) present your case or have it presented by a lawyer or by another authorized representative;

(3) bring witnesses;

(4) establish pertinent facts and advance arguments; and

(5) question or refute any testimony or evidence, including the opportunity to confront and cross-examine adverse witnesses.

The decision or recommendation of the hearing officer shall be based exclusively on testimony and evidence provided before and during the hearing, except when medical information is requested or other essential information is needed. In such an event, you and the local social services agency would be given the opportunity to question or refute this additional information.

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Commonwealth Of Virginia
Department Of Social Services

County/City:	Case Number:
Case Name:	

NOTICE OF DENIAL ON YOUR APPLICATION FOR EXTRA HELP WITH MEDICARE PART D COSTS

[Last Name, First Name, Middle Initial]
[Address]
[City, State, Zip Code]

Your application for Extra Help with your Medicare prescription drug plan (Medicare Part D) costs dated _____ has been denied. The information below explains the reason(s) for the denial and how we determined you are not eligible for Extra Help.

Why Your Application Was Denied

Your application for Extra Help was denied for the following reason(s): Policy Citation: _____

You are not Medicare-eligible.

You did not complete the application process.

Your income *equals or* exceeds 150% (percent) of the Federal Poverty Guideline for your household size. This is the income limit for Extra Help established by law.

Your resources exceed the limit of $ _____ established by law for your income level and household size.

You are not a resident of Virginia.

You are incarcerated.

Information Used To Determine Your Eligibility

We used the following information you reported on your application for Extra Help to determine your eligibility:

Countable income of $ _____ per month;
Countable resources of $ _____;
Household size of _____ person/people. To determine your household size, we count you, your spouse who lives with you, and any relative who lives with you and receives one-half of his or her support from you or your spouse.

To determine your eligibility, we compared your countable income and resources to the limits adopted by law for your household size. We also used your information about where you live and whether you have Medicare to verify whether you meet the Virginia residency requirement and Medicare eligibility requirement for Extra Help.

About Medicare Prescription Drug Coverage

If you are not already enrolled in a Medicare-approved prescription drug plan, you may still enroll in one if you have Medicare Part B or are eligible for Medicare Part A. You will receive more information from Medicare about how to choose a prescription drug plan. You may also visit www.medicare.gov or call toll-free 1-800-MEDICARE (1-800-633-4227) for more information. If you are hearing impaired, you may call the Medicare TTY number toll-free at 1-877-486-2048.

Your application was processed by:

_____ _____ _____
Date Mailed Worker's Name Title Worker's Phone Number

If You Disagree With This Decision

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. **You have 30 days to ask for an appeal.** The 30 days start the day after you receive this letter. You must have a good reason for waiting more than 30 days. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you desire free legal advice, you may contact your local legal aid office.

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The decision or recommendation of the hearing officer shall be based exclusively on testimony and evidence provided before and during the hearing, except when medical information is requested or other essential information is needed. In such an event, you and the local social services agency would be given the opportunity to question or refute this additional information.

You will be notified in writing of the hearing officer's decision on your appeal within 90 days of the date your appeal request is received by the Department of Medical Assistance Services.

Commonwealth Of Virginia
Department Of Social Services

County/City:	Case Number:
Case Name:	

NOTICE OF TERMINATION OF YOUR EXTRA HELP WITH MEDICARE PART D COSTS

[Last Name, First Name, Middle Initial]
[Address]
[City, Virginia, Zip Code]

Your Extra Help with your Medicare prescription drug plan (Medicare Part D) costs will be terminated effective _____. The information below explains the reason(s) for the termination and how we determined that you are no longer eligible for Extra Help.

Why Your Extra Help Was Terminated

Your application for Extra Help was terminated for the following reason(s): Policy Citation: _____

You are not Medicare-eligible.

You did not complete the redetermination process.

Your income *equals or* exceeds 150% (percent) of the Federal Poverty Guideline for your household size.

Your resources exceed the limit of $ _____ .

You are no longer a resident of Virginia.

You are incarcerated.

Information Used To Determine You Are No Longer Eligible

We used the following information you reported to your local department of social services to determine that you are no longer eligible for Extra Help:

Countable income of $ _____ per month;
Countable resources of $ _____;
Household size of _____ person/people. To determine your household size, we count you, your spouse who lives with you, and any relative who lives with you and receives one-half of his or her support from you or your spouse.

To determine your continued eligibility, we compared your countable income and resources to the limits adopted by law for your household size. We also used your information about where you live and whether you have Medicare to verify whether you meet the Virginia residency requirement and Medicare eligibility requirement for Extra Help.

About Your Medicare Prescription Drug Coverage

Even though your Extra Help has been terminated, you will still have prescription drug coverage under your prescription drug plan if you have Medicare Part B or are eligible for Medicare Part A. If you have moved out of Virginia, you may need to choose a new prescription drug plan in your area. To find out how the termination of your Extra Help will affect you, please contact your prescription drug plan provider. You may also visit www.medicare.gov or call toll-free 1-800-MEDICARE (1-800-633-4227) for more information. If you are hearing impaired, you may call the Medicare TTY number toll-free at 1-877-486-2048.

The decision on the termination of your Extra Help was made by:

_____ _____ _____
Date Mailed Worker's Name Title Worker's Phone Number

If You Disagree With This Decision

It is YOUR RIGHT TO APPEAL decisions of the local social services agency. **You have 30 days to ask for an appeal.** The 30 days start the day after you receive this letter. You must have a good reason for waiting more than 30days. If you want more information or help with an appeal, you may contact the local social services agency. It will not cost you anything to request a fair hearing, and you will not be penalized for asking for a fair hearing. If you desire free legal advice, you may contact your local legal aid office.

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The decision or recommendation of the hearing officer shall be based exclusively on testimony and evidence provided before and during the hearing, except when medical information is requested or other essential information is needed. In such an event, you and the local social services agency would be given the opportunity to question or refute this additional information.

You will be notified in writing of the hearing officer's decision on your appeal within 90 days of the date your appeal request is received by the Department of Medical Assistance Services.

Commonwealth Of Virginia
Department Of Social Services

NOTICE OF CHANGE IN THE AMOUNT OF EXTRA HELP WITH MEDICARE PART D COSTS

County/City:	Case Number:
Case Name:	

[Last Name, First Name, Middle Initial]
[Address]
[City, Virginia, Zip Code]

The amount of your Extra Help with Medicare prescription drug plan (Medicare Part D) costs will change effective _____. The information below explains the reason(s) for the change and how we determined that the change was necessary:

About Your New Extra Help Amount

The amount of your Extra Help, also known as subsidy, will change beginning on the effective date above. Your Extra Help will be:
_____ % subsidy to help pay your Medicare prescription drug plan premiums;
$ _____ prescription drug annual deductible; and
reduced co-payment amounts when you have a prescription filled.

Why The Amount Of Your Extra Help Was Changed Policy Citation: _____

The amount of your Extra Help was changed for the following reason(s):

☐ Your income is now under 135% (percent) of the Federal Poverty Guideline for your household size. This is the income limit for the full Extra Help subsidy established by law.

☐ Your resources are now under the limit of $ _____ established by law for your income level and household size. This is the resource limit for the full Extra Help subsidy established by law.

☐ Your income now exceeds 135% (percent) of the Federal Poverty Guideline for your household size. This is the income limit for the full Extra Help subsidy established by law. You are now eligible for a partial subsidy.

☐ Your resources now exceed the limit of $ _____ established by law for your income level and household size. This is the resource limit for the full Extra Help subsidy established by law. You are now eligible for a partial subsidy.

Information Used To Determine The Change

We used the following information you reported to your local department of social services to determine that the change in the amount of your Extra Help is necessary:

Countable income of $ _____ per month;
Countable resources of $ _____;
Household size of _____ person/people. To determine your household size, we count you, your spouse who lives with you, and any relative who lives with you and receives one-half of his or her support from you or your spouse.

To determine the amount of your Extra Help, we compared your countable income and resources to the limits adopted by law for your household size.

About Your Medicare Prescription Drug Coverage

You will still have prescription drug coverage under your prescription drug plan, but the amount of the costs within the plan will change. You will receive information about these changes from your prescription drug plan provider. If you have questions about these changes, please contact your prescription drug plan provider. You may also visit www.medicare.gov or call toll-free 1-800-MEDICARE (1-800-633-4227) for more information. If you are hearing impaired, you may call the Medicare TTY number toll-free at 1-877-486-2048.

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_____ _____ _____
Date Mailed Worker's Name Title Worker's Phone Number

PRECEDENCE OF EXTRA HELP DECISIONS

Scenario	SSA	LDSS	Outcome
1	Denial	Approval	Approval is official determination. Beneficiary may appeal either decision.
2	Approval	Denial	Approval is official determination. Beneficiary may appeal either decision.
3	Denial	Denial	The beneficiary may appeal either decision. If both are appealed and overturned, see scenarios 4 and 5.
4	Approval (Different Month)	Approval (Different Month)	If the subsidy effective dates are in different months, the decision with the earlier effective date is the official determination. The second decision is void.
5	Approval (Same Month)	Approval (Same Month)	If the subsidy effective dates are the same, the SSA decision is the official determination. The beneficiary may appeal either decision.

M21 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	pages 3, 8
TN #95	3/1/11	Table of Contents pages 5, 6, 14, 15, page 16 added Appendix 1
TN #94	9/1/10	page3 Appendix 3, pages 1 and 2
UP #3	3/1/10	pages 2-5
TN #93	1/1/10	page 2-4, 8
Update (UP) #2	8/24/09	page 4

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M2100.000 FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)

M2110.100 FAMIS GENERAL INFORMATION

A. Introduction

The Balanced Budget Act of 1997 created the State Children's Health Insurance Program, enacted as Title XXI of the Social Security Act, to provide funds to States to enable them to initiate the provision of child health insurance to **uninsured low-income children**.

FAMIS is not an entitlement program, which means that if funds for this program are exhausted, no additional individuals will receive benefits under the program. The Department of Medical Assistance Services (DMAS) will notify the Department of Social Services (DSS) Central Office if funds for this program run out.

Initial eligibility for FAMIS is determined by local DSS, including DSS outstationed sites, or by the FAMIS Central Processing Unit (CPU). Children found eligible for FAMIS receive benefits described in the State's Title XXI Child Health Insurance Program. Eligible children are enrolled for benefits effective the first day of the child's application month if all eligibility requirements are met in that month, but no earlier than the date of the child's birth.

Retroactive coverage is only available to an eligible child who was born within the 3 months prior to the FAMIS application month. Eligibility for FAMIS coverage will be effective retroactive to the child's date of birth if the child would have met all eligibility criteria during that time.

Case management and ongoing case maintenance, and selection for managed care, are handled by the FAMIS CPU.

B. Legal Base

The 1998 Acts of Assembly, Chapter 464, authorized Virginia's Children's Health Insurance Program by creating the Children's Medical Security Insurance Plan for uninsured children under 19 years of age. In August 2001, the program was revised and renamed the Family Access to Medical Insurance Security Plan (FAMIS).

C. Policy Principles

FAMIS covers uninsured low-income children under age 19 who are not eligible for FAMIS Plus (children's Medicaid) and whose gross family income is less than or equal to 200% of the federal poverty level (FPL) for the family size (see M2130.100 for the definition of the FAMIS assistance unit and Appendix 1 for the income limits).

A child is eligible for FAMIS if all of the following are met:

- he is **not** eligible for FAMIS Plus *and he has* income *in excess of the FAMIS Plus limits*;
- he is under age 19 and a resident of Virginia;

- he is uninsured;
- he is **not** a member of a family eligible for health benefits coverage under the State Employee Health Insurance Plan on the basis of a family member's employment with a State agency (see Appendix 2 to this chapter);
- he is **not** a member of a family who has dropped health insurance coverage on him within 4 months of the application without good cause;
- he is **not** an inmate of a public institution;
- he is **not** an inpatient in an institution for mental diseases;
- he meets the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 with certain exceptions; and
- he has gross family income less than or equal to 200% FPL.

M2120.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

A. Introduction

The child must meet, with certain exceptions, the Medicaid Nonfinancial Eligibility Requirements in chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.

B. M02 Requirements

The Medicaid Nonfinancial Eligibility Requirements in Chapter M02 that must be met are:

- citizenship and alienage requirements, including Afghan and Iraqi special immigrants in M0220.313 A, with the exceptions noted in M2120.100 C.1. below;
- Virginia residency requirements;
- institutional status requirements regarding inmates of a public institution.

C. M02 Exceptions

The exceptions to the Medicaid Nonfinancial Eligibility Requirements in Chapter M02 are**:**

1. Citizenship & Identity Verification Required

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 mandates that effective January 1, 2010, all applicants for coverage in a Title XXI program must provide verification of citizenship and identity *(C&I).* If the child is a United States (U.S.) citizen, the child must meet the U.S. citizenship requirements in M0220.001.

Verification of citizenship is required; declaration of the child's U.S. citizenship is no longer accepted. However, like Medicaid, a reasonable

opportunity period must be given to the applicant. The C&I verification requirements in M0220.100 apply to FAMIS, including use of the Social Security Administration (SSA) data match when a Social Security number (SSN) has been provided. If an SSN has not been provided for the child, a reasonable opportunity to provide acceptable documentation of C&I must be given. The reasonable opportunity period will last until the time of the first annual renewal.

If the child is not a U.S. citizen, the child must meet the FAMIS alienage requirements.

1. Alienage Requirements

Alien status must be verified. Refer to sections M0220.200, M0220.201 and M0220.202 for information about verifying alien status.

FAMIS alienage requirements are different from the Medicaid alienage requirements. Qualified aliens who entered the U.S. before August 22, 1996 meet the alienage requirements and are not subject to time limitations.

a. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **without regard to time limitations**:

- refugees or Cuban-Haitian Entrants (see M0220.310 A. 2 and 7),
- asylees (see M0220.310 A. 4),
- veteran or active military (see M0220.311),
- deportation withheld (see M0220.310 A. 6),
- victims of a severe form of trafficking (see M0220.313 B.5), and
- Iraqi and Afghan Special Immigrants (see M0220.313 A.6).

b. The following qualified aliens who entered on or after August 22, 1996 meet the alienage requirements **after five years of residence in the United States:**

- lawful permanent residents (LPR),
- conditional entrants-aliens admitted pursuant to 8 U.S.C.1153(a)(7),
- aliens, other than Cuban-Haitian Entrants, paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA, and
- battered aliens, alien parents of battered children, alien children of battered parents.

3. *Lawfully Residing Non-citizen* Children < 19 Not Applicable

The *lawfully residing non-citizen* children policy in M0220.314 does **NOT** apply to the FAMIS program.

4. No Emergency Services Only For Unqualified Aliens

Unqualified aliens, including illegal and non-immigrant aliens, do not meet the alienage requirements and are not eligible for FAMIS.

5. Alien Eligibility Chart — Appendix 3, FAMIS Alien Eligibility Chart, lists alien groups that meet or do not meet the alienage requirements.

6. SSN — A Social Security number (SSN) or proof of application for an SSN (M0240) is **not** a requirement for FAMIS.

7. Assignment of Rights — Assignment of rights to payment for medical care from any liable third party is a condition of eligibility for the child.

D. FAMIS Nonfinancial Requirements — The child must meet the following FAMIS nonfinancial requirements:

1. Age Requirement — The child must be under age 19 for at least one day during the month. No verification is required.

A child no longer meets the age requirements for FAMIS effective the end of the month in which the child reaches age 19 years, provided he was under age 19 on the first day of the month. If the child was born on the first day of the month, his eligibility ends the last day of the month prior to the month he reaches age 19.

2. Uninsured Child — The child must be uninsured, that is, he must not be covered under any health insurance plan offering hospital and medical benefits. See M2120.200.

3. State Employee Prohibition — A child is ineligible for FAMIS if he is a member of a family eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of the family member's employment with a State agency.

4. IMD Prohibition — The child cannot be an inpatient in an institution for mental diseases (IMD).

M2120.200 HEALTH INSURANCE COVERAGE

A. Introduction — The intent of FAMIS is to provide health coverage to low-income uninsured children. Eligibility for this program is prohibited when creditable health insurance coverage is dropped within 4 months of the application for FAMIS unless good cause for discontinuing the insurance is demonstrated, or the child is pregnant.

B. Definitions

1. Creditable Coverage — For the purposes of FAMIS, creditable coverage means coverage of the individual under any of the following:

- church plans and governmental plans;
- health insurance coverage, either group or individual insurance;
- military-sponsored health care;
- a state health benefits risk pool;
- the federal Employees Health Benefits Plan;

- *Medicare*
- a public health plan; and
- any other health benefit plan under section 5(e) of the Peace Corps Act.

The definition of creditable coverage includes short-term limited coverage.

2. Family Member When determining whether the child is eligible for coverage under a State Employee Health Insurance Plan, or whether the discontinuance of health insurance affects the child's eligibility, family member means:

- parent(s) with whom the child is living, and
- a stepparent with whom the child is living if the stepparent claims the child as a dependent on his federal tax return.

3. Health Benefit Plan "Health benefit plan" is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:

- "any accident and health insurance policy or certificate,
- health services plan contract,
- health maintenance organization subscriber contract,
- plan provided by a Multiple Employer Welfare Arrangement (MEWA)".

Health benefit plan does not mean:

- Medicaid, FAMIS Plus, or State/Local Hospitalization;
- accident only;
- credit or disability insurance;
- long-term care insurance;
- dental only or vision only insurance;
- specified disease insurance;
- hospital confinement indemnity coverage;
- limited benefit health coverage;
- coverage issued as a supplement to liability insurance;
- insurance arising out of workers' compensation or similar law;
- automobile medical payment insurance; or
- insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

4. Insured means having creditable health insurance coverage or coverage under a health benefit plan.

5. Uninsured means having no insurance; having insurance that is not creditable; having coverage which is not defined as a health benefit plan, or having a health insurance plan that does not have a network of providers in the area where the child resides.

C. Policy A nonfinancial requirement of FAMIS is that the child be uninsured. A child **cannot:**

- have creditable health insurance coverage;

- have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.) *or Medicare*;

- be a member of a family eligible for health benefits coverage under a State Employee Health Insurance Plan (a full-time, salaried, classified State employee or a permanent, full-time, salaried State education institution faculty member) [see Appendix *2* to this chapter], or

without good cause (see item E. below), have had creditable health insurance coverage terminated within 4 months prior to the month of application.

D. Health Insurance Coverage Discontinued

If the child's insurance coverage was discontinued by a parent or other individual who does NOT live with the child, the discontinuance of the insurance does NOT affect the child's eligibility for FAMIS.

A child is ineligible for FAMIS coverage if creditable health insurance coverage was terminated by a family member, as defined in M2120.200 B.3, above, without good cause within four months prior to the month for which eligibility is being established, unless the child was pregnant at the time of application.

Example: A child's health insurance was terminated without good cause in November. A FAMIS application was filed the following February. The child is ineligible for February because his health insurance was terminated within four months of November. He may be eligible in April because his insurance was terminated more than four months prior to April.

NOTE: For purposes related to FAMIS eligibility, a child is NOT considered to have been insured if health insurance coverage was provided under FAMIS Plus, Medicaid, HIPP, FAMIS, FAMIS Select, or if the insurance plan covering the child does not have a network of providers in the area where the child resides.

E. Good Cause for Dropping Health Insurance

The ineligibility period can be waived if there is good cause for the discontinuation of the health insurance. A parent, guardian, legal custodian, authorized representative, or adult relative **with whom the child lives** may claim to have good cause for the discontinuation of the child(ren)'s health insurance coverage. The local agency or the CPU will determine that good cause exists and waive the period of ineligibility if the health insurance was discontinued for one of the following reasons:

1. Employment Stopped

The family member who carried insurance changed jobs or stopped employment, and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.

2. Employer Stopped Contributing

The employer stopped contributing to the cost of family coverage and no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.

3. Insurance Company Discontinued Insurance

The child's coverage was discontinued by an insurance company for reasons of uninsurability, e.g., the child has used up lifetime benefits or the child's coverage was discontinued for reasons unrelated to payment of premiums. Verification is required from the insurance company.

4. Discontinued By Family Member

Insurance was discontinued by a family member who was paying the full cost of the insurance premium under a COBRA policy AND no other family member's employer contributes to the cost of family health insurance coverage. Verification is not required.

5. Discontinued By Other Contributor

Insurance on the child is discontinued by someone other than the child (if 18 years of age), or, if under age 18, the child's parent or stepparent, e.g. the insurance was discontinued by the child's grandparent, aunt, uncle, godmother, etc. Verification is not required.

6. Discontinued Because Cost Exceeds 10% of Income

Insurance on the child is discontinued because the cost of the health insurance premiums for all family members exceeds 10% of the family's GROSS monthly income or exceeded 10% of the family's GROSS monthly income at the time the insurance was discontinued.

Documentation of the amount of the monthly health insurance premiums for all family members is required. If the amount of the premium is less than or equal to 10% of the family's current gross monthly income, a declaration from the family will be requested as to the amount of gross monthly income received at the time the child(ren)'s insurance was discontinued.

a. Use the applicant's month-prior-to-application gross income verification.

b. Calculate 10% of the family's gross monthly income.

c. Compare to total amount of monthly premiums.

d. If monthly premium is less than or equal to 10% of current gross monthly income:

1) Ask applicant "what was your family's gross income in the month in which you discontinued the health insurance (include all amounts of income received in that month)?" Document the applicant's statement in the record.

2) Calculate 10% of the family's gross monthly income (in the month in which the insurance was discontinued).

3) Compare to total amount of monthly premiums.

i If monthly premiums are less than or equal to 10% of this gross monthly income, good cause is NOT met. The children are not eligible for 4 months following the discontinuance of the insurance.

ii. If monthly premiums are more than 10% of this gross monthly income, good cause is met and there is no waiting period for FAMIS.

M2120.300 NO CHILD SUPPORT REQUIREMENTS

A. Policy There are no child support requirements for FAMIS.

M2130.100 FINANCIAL ELIGIBILITY

A. Financial Eligibility

1. FAMIS Assistance Unit

The FAMIS assistance unit consists of:

- the child applicant under age 19;
- the parent(s) and stepparent who live in the home with the child;
- any siblings, half-siblings, and stepsiblings under age 19 who live in the home with the child; and
- *any half-sibling's parent who is not married to the child's parent and who lives in the home.*

NOTE: Medicaid family/budget unit rules do not apply to FAMIS. A child who is pregnant is counted as 1 individual; DO NOT COUNT the unborn child.

2. Asset Transfer Asset transfer rules do not apply to FAMIS.

3. Resources Resources are not evaluated for FAMIS.

4. Income

a. Countable Income

The source and amount of all income other than Workforce Investment Act, Supplemental Security Income (SSI) and student income must be verified and counted. FAMIS uses the same income types and methods for estimating income as FAMIS Plus (see chapter M07). There are no income disregards and no budget units in FAMIS.

b. Available Gross Income

Retroactive period (for newborns only) – available income is the gross income actually received in each month in the retroactive period.

Application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months.

c. Income Limits

The FAMIS income limit is 200% of the FPL (see Appendix 1 to this subchapter) for the number of individuals in the FAMIS assistance unit.

5. Spenddown

Spenddown does not apply to FAMIS. If the family's gross income exceeds the FAMIS income limits, the child is not eligible for the FAMIS program regardless of medical expenses.

M2140.100 APPLICATION and CASE PROCEDURES

A. Application Requirements

The Health Insurance for Children and Pregnant Women application is the application form for FAMIS. The Application for Benefits or the ADAPT Statement of Facts are also acceptable application/renewal forms for FAMIS. These forms are available on the intranet at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi.

The parent, legal guardian, authorized representative age 18 or older, an adult relative age 18 or older with whom the child lives, or the child if age 18, must sign the application. The adult relative must be related by blood or marriage. Accept declaration of relationship; documentation of the relationship is not required. The child's parent or legal guardian may designate in writing an authorized representative age 18 or older to complete and sign the application. The date of the application is the date the application is received at the local DSS, including DSS outstationed sites, or at the FAMIS CPU.

Applications can be mailed to the local DSS or the CPU. A face-to-face interview is not required.

B. Eligibility Determination

When an application is received and the child is not eligible for FAMIS Plus due to excess income, determine eligibility for FAMIS. In order to complete an eligibility determination, both the FAMIS nonfinancial requirements in M2120.100 and the financial requirements in M2130.100 must be met. Income must be verified.

1. Notice

The applicant/enrollee must be notified in writing of the required information and the deadline by which the information must be received. Applications must be acted on as soon as possible, but no later than 45 days from the date the signed application was received at the local DSS or the FAMIS CPU.

2. Transfer Approved Cases

Cases approved for FAMIS must be transferred to the FAMIS CPU for case management and ongoing case maintenance.

C. Entitlement and Enrollment

1. Begin Date

Children determined eligible for FAMIS are enrolled for benefits in the Medicaid Management Information System (MMIS) effective the first day of the child's application month if all eligibility requirements are met in that month, **but no earlier than the date of the child's birth.**

2. Retroactive Coverage For Newborns Only

Retroactive FAMIS coverage is effective with applications received on or after September 1, 2006.

Retroactive coverage is available ONLY to an eligible child who was born within the 3 months prior to the FAMIS application month. Eligibility for FAMIS coverage will be effective retroactive to the child's date of birth if the child was born within the retroactive period and would have met all eligibility criteria during the retroactive period.

The following eligibility requirements must be met in order for a newborn child to be enrolled in FAMIS for retroactive FAMIS coverage:

a. Retroactive coverage must be requested on the application form or in a later contact.

b. The child's date of birth must be within the three months immediately preceding the application month (month in which the agency receives the signed application form for the child).

c. The child must meet all the FAMIS eligibility requirements during the retroactive period.

3. FAMIS Aid Categories

The aid categories (ACs) for FAMIS are:

AC	Meaning
006	child under age 6 with income > 150% FPL and ≤ 200% FPL
007	child 6 – 19 with income > 150% FPL and ≤ 200% FPL
008	child under age 6 with income > 133% FPL and ≤ 150% FPL
009	child 6 – 19 with income > 133% FPL and ≤ 150% FPL

4. Separate FAMIS and FAMIS Plus MMIS Case Numbers

Because FAMIS Plus and FAMIS are separate programs, FAMIS Plus eligible individuals and FAMIS eligible children cannot share the same case number in the MMIS. When a child is determined eligible for FAMIS and the child has family members enrolled in FAMIS Plus in the MMIS, the FAMIS child must be given a new case number when enrolled in the MMIS. Only children eligible for the same program can share the same base case number in the MMIS.

After the child is enrolled in the MMIS, the local DSS worker must change the MMIS worker number to V0000 to transfer the case to the FAMIS CPU.

The local DSS worker must not change the FIPS code or make any other change to the case after the case has been transferred to FAMIS in the MMIS.

D. Notification Requirements

The local DSS worker must send a Notice of Action on Medicaid and FAMIS to the family informing them of the action taken the application. The notice must include the eligibility determination for both FAMIS Plus and FAMIS.

If the child is eligible for FAMIS, the notice must inform the family that the case has been transferred to FAMIS and that further information on the program will come from FAMIS.

If the child is ineligible for both FAMIS Plus and FAMIS, the family must be sent a notice that the child is not eligible for either program and must be given the opportunity to have a Medicaid medically needy evaluation. Along with the notice, send the Application for Benefits to the family and advise them that if the signed application is returned within 10 calendar days, the original application date will be honored.

E. FAMIS Case Transfer Procedures

1. ADAPT Cases

a. Electronic Case Transfer

If the application is processed in ADAPT, individuals approved for FAMIS are enrolled in MMIS by ADAPT. ADAPT will automatically transfer the FAMIS enrollees' data to the FAMIS CPU.

If a family has both Medicaid (including FAMIS Plus) FAMIS-eligible individuals, a separate FAMIS case is created in MMIS via the ADAPT "Medicaid Authorization" (AEAUTM) screen. When granted, ADAPT changes the worker number to V0000 on the FAMIS case in the MMIS and automatically transfers the FAMIS case and enrollee data to the FAMIS CPU. The LDSS has responsibility for ongoing case maintenance of the FAMIS Plus case.

Do not send a paper case file to the FAMIS CPU when the case is automatically transferred by ADAPT. The LDSS retains the original application, verifications and notices.

b. Resolve Enrollment Rejections BEFORE Granting

It is important that workers resolve any MMIS Enrollment Rejections immediately when they are received. ADAPT will NOT transfer a FAMIS-

eligible individual when ADAPT has received an enrollment rejection message from MMIS on the individual. ADAPT ***will transfer*** *the other FAMIS-enrolled individuals in the ADAPT case if there are no enrollment rejections on the individuals. In order for all FAMIS-eligible individuals in the case to be transferred to the FAMIS CPU* ***at the same time****, all individuals must be successfully enrolled in MMIS before close of business on the day the case is granted in ADAPT.*

After the worker corrects the error(s) that caused the enrollment rejection(s), reruns EDBC and the MMIS enrollment is accepted, ADAPT will automatically transfer the FAMIS-eligible individuals in the case during the "batch" FAMIS case transfer process at the end of the work day.

2. Cases Not in ADAPT

If the application is NOT processed in ADAPT, the worker must manually enroll the FAMIS eligible individuals in MMIS, then change the worker number *on the case* to "V0000" *in MMIS.*

The worker must transfer the paper case record to the FAMIS CPU as follows:

a. **Case Material Sent to CPU**

To allow the FAMIS CPU to enroll the child in their computer system and into managed care, the eligibility worker must send the CPU the following documents:

1) Send a copy of the most recent application form. If transferring a case after a renewal, send a copy of the most recent completed application form plus the most recent renewal form. The CPU cannot accept the Medicaid Renewal Form by itself because it does not contain all the demographic information necessary to enter the family into the CPU's computer system.

2) The CPU needs to know the source of the income, the employer's name (if the income is earned), the amount of income received each time it is paid to the individual, and the frequency of the income. Include a copy of a written eligibility evaluation form that has the income source details (source name, employer name, date(s) the income was received, frequency, and the eligibility calculations).

3) **Income verifications if any individual in the assistance unit has income.**

4) Copy of a written eligibility evaluation form.

5) Copy of the written NOA that was sent to the applicant about the FAMIS or FAMIS MOMS eligibility.

6) A completed Case Record Transfer sheet.

Additional case information that is not used to determine FAMIS eligibility should **not** be sent to the CPU.

***b.* Sending Case to the CPU**

When transferring a case, confidentiality must be ensured by placing the case documents in a sealed interdepartmental envelope that is addressed to the FAMIS CPU (FIPS 976) and sent via the courier no later than the business day following the FAMIS eligibility determination. This ensures timely receipt of the case by the CPU so that the managed care assignment can be initiated, and the eligible individuals can be sent a FAMIS eligibility confirmation "packet" of information about their managed care assignment and the amount of their co-pay for covered services.

If the case is mailed via the United States Postal Service's certified mail, the envelope must contain the full mailing address of the FAMIS CPU:

FAMIS CPU
P.O. Box 1820
Richmond, VA 23218-1820

F. Transitions Between FAMIS Plus And FAMIS (Changes and Renewals)

When excess income for FAMIS Plus causes the child's eligibility to change from FAMIS Plus to FAMIS, the new income must be verified. Copies of the income verifications must be sent to the FAMIS CPU with the transferred case material.

1. Actions Required

Transitions between FAMIS Plus and FAMIS require cancellation of the current coverage and reinstatement in the new coverage, and may require additional coordination between the LDSS and the FAMIS CPU. Certain MMIS transactions can only be done by the FAMIS CPU, the DMAS FAMIS Plus Unit or the LDSS. Only the FAMIS CPU can cancel FAMIS or FAMIS MOMS coverage when the case is in worker number V0000. Only the LDSS can cancel FAMIS Plus coverage for cases that are active or connected to active cases in ADAPT or MMIS.

The DMAS FAMIS Plus Unit can add or reinstate FAMIS Plus coverage only on cases processed by the DMAS FAMIS Plus Unit. The LDSS is responsible for reinstating FAMIS Plus coverage on cases processed by the LDSS and may cancel FAMIS Plus coverage and reinstate FAMIS coverage.

2. Case Transfer When Program Changes

a. Cases in ADAPT

If the case is processed in ADAPT, individuals approved for FAMIS are enrolled in MMIS by ADAPT, the worker number is changed to "V0000" by ADAPT and the case is transferred to the FAMIS CPU. ADAPT will automatically transfer the FAMIS enrollees' data to the FAMIS CPU. The worker does not send any paper document to the FAMIS CPU.

If a family has at least one child who is FAMIS Plus or Medicaid-eligible and at least one child who is FAMIS-eligible, the Medicaid case remains at the LDSS and a separate FAMIS case is created in MMIS via the ADAPT "Medicaid Authorization" (AEAUTM) screen. When granted, ADAPT changes the worker number to V0000 on the FAMIS case in the MMIS. ADAPT automatically transfers the FAMIS case and enrollee data to the

FAMIS CPU. The worker does not send any paper case material to the FAMIS CPU. The LDSS retains the original application, verifications and the notice, and has responsibility for ongoing case maintenance of the FAMIS Plus case.

b. Cases Not in ADAPT

When eligibility transitions between FAMIS Plus and FAMIS, there must be communication between the FAMIS CPU, the LDSS, and the applicant. The Case Record Transfer Form (#032-32-227) must be completed by the sender and attached to the case record. The sender must also notify the applicant of the case transfer. The receiver must confirm receipt of the case by completing the Case Record Transfer Form and returning it to the sender. The receiving agency is not required to complete a FAMIS Plus redetermination until a change is reported or at the time of the next annual redetermination.

So that the FAMIS CPU will be able to enroll the child in their computer system and into managed care, the eligibility worker must send the CPU the documents listed in section M2140.100 E., above.

G. Communicating Changes to the CPU

The Children's Health Insurance Communication Form (#032-03-630) is used by the LDSS to communicate changes to the FAMIS CPU on FAMIS and FAMIS MOMS cases. This form can be downloaded from the DSS intranet at: http://localagency.dss.virginia.gov/divisions/bp/me/forms/general.cgi.

The form must include the case name, the MMIS name and enrollee identification number, the reason for the communication, and all other relevant information. The FAMIS CPU must receive the Communication Form by the 10th calendar day of the month in order for the FAMIS/FAMIS MOMS cancellation to be effective by the end of the current month. If the form is received after the 10th calendar day of the month, the cancellation will be effective the last day of the following month.

H. FAMIS CPU Responsibilities and Procedures

Applications, Redetermination applications (sent to a FAMIS recipient when a change is reported to the CPU), and renewals are faxed or mailed to the FAMIS CPU by applicants or recipients. Within three days of receipt, the CPU staff logs the application, redetermination or renewal into the FAMIS eligibility system. There are no drop-offs and no face-to-face contact with applicants or recipients at the CPU. All applications are scanned and linked for electronic data recovery.

If an application is complete when it arrives at the FAMIS CPU, it takes approximately 12 business days or less to process the case. In order for an application to be complete, it must be signed and must include all required verifications. If the application is not complete when it is received, a "deficiency letter" is sent and the family is given 30 days to respond. In such cases, it can take more than 30 days to process the case. If the required verification is not received by the 30th day, the application is denied for failure to provide information, and the family is notified of the action.

When an application is approved for FAMIS or FAMIS MOMS, the FAMIS CPU initiates the managed care assignment and provides ongoing case maintenance. When an application is not FAMIS Plus-likely and is not eligible for FAMIS or FAMIS MOMS, the CPU sends the denial or cancellation notice to the applicant. When an application is determined as FAMIS Plus-likely, the application is sent over to the DMAS FAMIS Plus Unit for a Medicaid eligibility determination.

I. DMAS FAMIS Plus Unit Responsibilities and Procedures

FAMIS Plus-likely applications referred to the DMAS FAMIS Plus Unit from the FAMIS CPU are recorded on a daily log. All referred applications are screened for FAMIS Plus eligibility by the DMAS FAMIS Plus Unit. FAMIS Plus-likely applications connected to active cases in ADAPT or MMIS are transferred to LDSS for processing, and notice of the transfer is sent to the family. The application, the verifications, and a copy of the notice are placed in a sealed envelope and transferred to the LDSS via the courier no later than the next business day.

The DMAS FAMIS Plus Unit processes FAMIS Plus-likely applications that have been pending 25 days or more, and transfers enrolled FAMIS Plus cases to the LDSS. If the unit's screening determines that the application is not FAMIS Plus-likely, then a FAMIS eligibility determination is completed and the case is returned to the FAMIS CPU in an approved or denied status.

FAMIS redeterminations and renewals are also screened for FAMIS Plus eligibility and, if FAMIS Plus-likely, are referred to the DMAS FAMIS Plus Unit. If the FAMIS Plus-likely FAMIS redetermination or renewal is connected to an active case in ADAPT or MMIS, the case is transferred to the LDSS for the FAMIS Plus determination. If the FAMIS Plus-likely FAMIS redetermination/renewal is not connected to an active case, the DMAS FAMIS Plus Unit completes the FAMIS Plus determination and transfers the approved ongoing case to the LDSS.

J. *FAMIS Administrative Renewals*

The FAMIS CPU uses an administrative renewal procedure for all FAMIS redeterminations of eligibility. The CPU sends the FAMIS family a pre-printed renewal form containing the information, including gross income, contained in the CHAMPS (FAMIS) eligibility system. Families are asked to review the form and, if there have been no changes in the family situation or income, attest to the correctness of the information and send the form back to the CPU for processing.

If the returned form indicates no changes, eligibility staff at the CPU administratively renews the case for another year without the need for receipt of any verifications. If the family returns the form, but indicates a change in income, staff at the CPU first tries to electronically verify the income through available sources. If online verification is not available, a "deficiency" letter is sent to the family requesting proof of income. Cases that are administratively renewed are subject to random audits to ensure that correct income information was used in determining ongoing eligibility for FAMIS.

It is possible that the family may inadvertently send the pre-printed FAMIS renewal form to the LDSS. If that occurs, send the form to the FAMIS CPU for case processing.

K. **DMAS Contacts at the CPU**

The DMAS FAMIS Plus Unit eligibility workers are designated as the liaisons between the LDSS workers and the FAMIS CPU staff. The FAMIS Plus Unit workers are assigned to specific geographic areas. These assignments were made to improve communication and facilitate resolution to problems involving cases that have been transferred between the CPU and LDSS. The DMAS FAMIS Plus workers are assigned to five geographic areas of the state. The geographic areas correspond to the LDSS regions. The list of the DMAS FAMIS Plus workers and the areas they serve is available on the DSS intranet in the Benefit Programs, Medicaid Eligibility, ME Contacts folder at: http://localagency.dss.virginia.gov/divisions/bp/me/contacts.cgi.

The DMAS FAMIS Plus workers will:

- act as contact persons for cases transferred to the CPU and the LDSS, answer non-policy related questions regarding transferring or closing cases, and
- change worker number V0000 to M0000 when necessary.

The DMAS FAMIS Plus workers will not provide policy clarification and will not handle client complaints. Please continue to contact your supervisor or Medical Assistance Program Consultant for assistance with policy clarifications, computer system problems, and client complaints.

Please note that the DMAS FAMIS Plus workers' telephone numbers are for the LDSS workers only and **are not to be given to clients**. The CPU has a separate toll-free FAMIS helpline number (1-866-87FAMIS or 1-866-873-2647) designated for client use. This toll-free FAMIS telephone number is **not** for use by LDSS workers.

L. **FAMIS Select**

Under the FAMIS program, a family, whose child(ren) are determined eligible for FAMIS and who has access to health insurance through an employer or wishes to purchase a private policy, has the option of enrolling the family in that health plan. "FAMIS Select" allows the choice of the private or employer's insurance instead of FAMIS. Children enrolled in FAMIS whose families have access to private or employer sponsored health insurance coverage may qualify to have the State pay part of the family's share of the health insurance premium.

Once a child is enrolled in FAMIS, the FAMIS CPU will identify if the family is interested in more information about FAMIS Select. Families who have access to health insurance will receive information from DMAS about the benefits of enrolling in the FAMIS Select component of FAMIS and information about how to participate in the program. Participation in the FAMIS Select component is voluntary.

***M*. 12-Month Continuous Coverage**

Children under age 19 who are enrolled in FAMIS are entitled to 12 months of continuous coverage provided the family continues to reside in Virginia and the family income is less than or equal to 200% of the FPL.

Children enrolled in FAMIS who subsequently apply for FAMIS Plus or Medicaid and are found eligible must have their FAMIS coverage cancelled so they can be reinstated in FAMIS Plus or Medicaid.

M2150.100 REVIEW OF ADVERSE ACTIONS

A. Case Reviews

An applicant for FAMIS may request a review of an adverse determination regarding eligibility for FAMIS. FAMIS reviews follow the procedures established by Medicaid for client appeals (see chapter M16).

The payment of medical services on the part of any child or any right to participate in the program is not subject to review if funds for FAMIS are exhausted.

FAMILY ACCESS TO MEDICAL INSURANCE SECURITY PLAN (FAMIS)
INCOME LIMITS
ALL LOCALITIES

EFFECTIVE *1/20/11*

# of Persons in FAMIS Assistance Unit	FAMIS 150% FPL		FAMIS 200% FPL	
	Annual Limit	Monthly Limit	Annual Limit	Monthly Limit
1	*$16,335*	*$1,362*	*$21,780*	*$1,815*
2	*22,065*	*1,839*	*29,420*	*2,452*
3	*27,795*	*2,317*	*37,060*	*3,089*
4	*33,525*	*2,794*	*44,700*	*3,725*
5	*39,255*	*3,272*	*52,340*	*4,362*
6	*44,985*	*3,749*	*59,980*	*4,999*
7	*50,715*	*4,227*	*67,620*	*5,635*
8	*56,445*	*4,704*	*75,260*	*6,272*
Each additional, add	*5,730*	*478*	*7,640*	*637*

STATE AGENCY LISTING - 07/30/02

Accountancy, Board of
Accounts, Dept. of
Administration, Secretary of
Aging, Dept. for the
Agriculture and Consumer Services, Dept. of
Alcoholic Beverage Control, Dept. of
Arts, Virginia Commission for the
Atlantic States Marine Fisheries Commission
Attorney General, Office of the
Auditor of Public Accounts
Aviation, Dept. of
Bar Examiners, State Board of
Blind and Vision Impaired, Dept. for the
Blue Ridge Community College
Blue Ridge Hospital
Business Assistance, Virginia Dept. of
Capitol Police, Division of
Catawba Hospital
Center for Innovative Technology
Central State Hospital
Central Virginia Community College
Central Virginia Training Center
Charitable Gaming Commission
Chesapeake Bay Commission
Chesapeake Bay Local Assistance
Child Day Care & Early Childhood Programs, Virginia Council on
Christopher Newport University
Civil Air Patrol
College of William and Mary
Commerce and Trade, Secretary of
Commonwealth Center for Children and Adolescents
Commonwealth Competition Council
Commonwealth, Secretary of the
Commonwealths Attorneys Services Council
Community College System, Virginia
Compensation Board
Conservation and Recreation, Dept. of
Corporation Commission, State
Correctional Education, Dept. of
Corrections, Dept. of
Court of Appeals of Virginia
Credit Union, Inc., Virginia
Crime Commission, Virginia Stat
Criminal Justice Services, Dept. of
Dabney S. Lancaster Community College
Danville Community College
Deaf and Hard of Hearing, Dept. for the
Delmarva Advisory Council
Eastern Shore Community College
Eastern State Hospital
Economic Development Partnership, Virginia
Education, Dept. of
Education, Secretary of
Elections, State Board of
Emergency Management, Dept. of
Employment Commission, Virginia
Employment Dispute Resolution, Dept. of
Environmental Quality, Dept. of
Finance, Secretary of
Fire Programs, Dept. of
Forestry, Dept. of
Frontier Culture Museum of Virginia
Game and Inland Fisheries, Dept. of
General Services, Dept. of
George Mason University
Germanna Community College
Governor, Office of the
Gunston Hall
Health and Human Resources, Secretary of
Health Professions, Dept. of
Health, Dept. of
Higher Education for Virginia, State Council of
Hiram W. Davis Medical Center
Historic Resources, Dept. of
House of Delegates
Housing and Community Development, Dept. of
Housing Development Authority, Virginia
Housing Study Commission, Virginia
Human Resource Management, Dept. of
Human Rights, Council on
Information Technology, Dept. of
J. Sargeant Reynolds Community College
James Madison University
Jamestown-Yorktown Foundation

John Tyler Community College
Joint Commission on Health Care
Joint Legislative Audit and Review Commission
Judicial Inquiry and Review Commission
Juvenile Justice, Dept. of
Labor and Industry, Dept. of
Legislative Automated Systems, Division of
Legislative Services, Division of
Liaison Office, Virginia
Library of Virginia, The
Lieutenant Governor, Office of the
Local Government, Commission on
Longwood University
Lord Fairfax Community College
Lottery, Dept. of the
Marine Resources Commission
Marine Science, Virginia Institute of
Mary Washington College
Medical Assistance Services, Dept. of
Medical College of Virginia
Melchers Monroe Memorials
Mental Health, Mental Retardation & Substance Abuse Services, Dept
Military Affairs, Dept. of
Milk Commission
Mines, Minerals and Energy, Dept. of
Minority Business Enterprise, Dept. of
Motor Vehicle Dealer Board
Motor Vehicles, Dept. of
Mountain Empire Community College
Museum of Fine Arts, Virginia
Museum of Natural History, Virginia
Natural Resources, Secretary of
New River Community College
Norfolk State University
Northern Virginia Community College
Northern Virginia Mental Health Institute
Northern Virginia Training Center
Office of Commonwealth Preparedness
Old Dominion University
Outdoors Foundation, Virginia
Parole Board, Virginia
Patrick Henry Community College
Paul D. Camp Community College
People With Disabilities, Virginia Board for
Piedmont Geriatric Hospital
Piedmont Virginia Community College
Planning and Budget, Dept. of
Port Authority, Virginia
Potomac River Fisheries Commission
Professional & Occupational Regulation, Dept. of
Public Broadcasting, Virginia
Public Defender Commission
Public Safety, Secretary of
Racing Commission, Virginia
Radford University
Rail and Public Transportation, Dept. of
Rappahannock Community College
Rehabilitation Center for the Blind & Visually Impaired
Rehabilitative Services, Dept. of
Retirement System, Virginia
Richard Bland College (of William and Mary)
Science Museum of Virginia
Senate, Virginia State
Social Services, Dept. of
Southeastern Virginia Training Center
Southern Virginia Mental Health Institute
Southside Virginia Community College
Southside Virginia Training Center
Southwest Virginia Community College
Southwestern Virginia Mental Health Institute
Southwestern Virginia Training Center
State Internal Auditor, Dept. of the
State Police, Dept. of
Supreme Court of Virginia
Taxation, Dept. of
Technology Planning, Dept. of
Technology, Secretary of
Thomas Nelson Community College
Tidewater Community College
Tourism Corporation, Virginia
Transportation, Dept. of
Transportation, Secretary of
Treasury, Dept. of the
University of Virginia
University of Virginia College at Wise
University of Virginia Medical Center
VA School for the Deaf and Blind-Staunton
VA School for Deaf, Blind & Multi-Disabled - Hampton
Veterans Affairs, Dept. of
Virginia Alcohol Safety Action Program, Commission on
Virginia Baseball Stadium Authority
Virginia College Savings Plan

Virginia Commonwealth University
Virginia Criminal Sentencing Commission
Virginia Freedom of Information Advisory Council
Virginia Highlands Community College
Virginia Information Providers Network
Virginia Military Institute
Virginia Office for Protection and Advocacy
Virginia Polytechnic Institute and State University
Virginia Resources Authority
Virginia State Bar
Virginia State University
Virginia Treatment Center for Children
Virginia Veterans Care Center
Virginia Western Community College
Virginia Workers Compensation Commission
Western State Hospital
Western Tidewater Community Services Board
Woodrow Wilson Rehabilitation Center
Wytheville Community College
Youth, Commission on

FAMIS ALIEN ELIGIBILITY CHART

QUALIFIED ALIEN GROUPS	ARRIVED BEFORE AUGUST 22, 1996	ARRIVED ON OR AFTER AUGUST 22, 1996	
		1ST 5 YEARS	AFTER 5 YEARS
Qualified aliens who are Veterans or Active Military (includes spouses/dependent children); certain American Indians Form DD 214-veteran	Eligible	Eligible	Eligible
Permanent Resident Aliens (Aliens lawfully admitted for permanent residence), except Amerasians I-151; AR-3a; I-551; I-327; I-688B-274a.12(a)(1)	Eligible	NOT Eligible	Eligible
Conditional entrants-aliens admitted Pursuant to 8 U.S.C. 1153(a)(7), section 203(a)(7) of the INA I-94	Eligible	NOT Eligible	Eligible
Aliens, other than Cuban or Haitian Entrants, paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA I-94; I-688B – 274a(12)(c)(11)	Eligible	NOT Eligible	Eligible
Battered aliens, alien parents of battered children, alien children of battered parents U.S. Attorney General	Eligible	NOT Eligible	Eligible

QUALIFIED ALIEN GROUPS	ELIGIBLE REGARDLESS OF ENTRY DATE OR LENGTH OF RESIDENCE
Aliens granted asylum pursuant to section 208 of the INA I-94; I-688B – 274a.12(a)(5)	Eligible
Aliens admitted as refugees pursuant to section 207 of the INA, or as Cuban or Haitian Entrants as defined in section 501(e) of the Refugee Education Assistance Act of 1980 {including those under section 212(d)(5)} I-551; I-94; I-688B	Eligible
Aliens whose deportation has been withheld pursuant to Section 243(h) or 241(b)(3) of the INA I-688-B – 274a.12(a)(10) Immigration Judge's Order	Eligible
Victims of a severe form of trafficking pursuant to the Trafficking Victims Protection Act of 2000 (P.L. 106-386) [ORR certification/eligibility letter]	Eligible
Iraqi and Afghan Special Immigrants admitted on a Special Immigrant Visa (SIV), including the spouse and children under age 21 living in the home with the principal visa holder. [I-551 or passport/ I-94 indicating categories SI1, SI2, SI3, QQ1, SQ2, or SQ3 and bearing Department of Homeland Security stamp or notation]	*Eligible*

UNQUALIFIED ALIEN GROUPS NOT ELIGIBLE REGARDLESS OF ENTRY DATE OR LENGTH OF RESIDENCE
Aliens residing in the US pursuant to an indefinite stay of deportation (I-94; Immigration Letter)
Aliens residing in the US pursuant to an indefinite voluntary departure (I-94; Immigration Letter)
Aliens on whose behalf an immediate relative petition has been approved and their families covered by the petition who are entitled to voluntary departure under 8 CFR 242.5(a)(2)(vi) and whose departure the INS does not contemplate enforcing (I-94; I-210)
Aliens who have filed an application for adjustment of status pursuant to §245 INA that the INS has accepted as properly filed and whose departure the INS does not contemplate enforcing (I-181; Endorsed Passport)
Aliens granted stay of deportation by court order, statute or regulation, or by individual determination of the INS whose departure the agency does not contemplate enforcing (I-94; Court Order; INS Letter)
Aliens granted voluntary departure pursuant to section 242(b) of the INA whose departure the INS does not contemplate enforcing (I-94; I-210; I-688B – 247a.12(a)(11) or (13))
Aliens granted deferred action status pursuant to INS Operations Instruction 103.1(a)(ii) prior to 6/15/84 or 242.1a22 issued 6/15/84 and later (I-210; INS Letter)
Aliens residing in the U.S. under orders of supervision (I-220B)
Aliens who entered before January 1972 and have continuously resided in the U.S. since January 1972 (Case Record)

UNQUALIFIED ALIEN GROUPS **NOT ELIGIBLE REGARDLESS OF ENTRY DATE OR LENGTH OF RESIDENCE**
Aliens granted suspension of deportation pursuant to Section 244 of the INA and whose deportation the INS does not contemplate enforcing (Immigration Judge Court Order)
Any other aliens living in the US with the knowledge and permission of the INS whose departure the agency does not contemplate enforcing (INS Contact)
Illegal aliens – aliens not lawfully admitted or whose lawful admission status has expired
Visitors (non-immigrants): tourists, diplomats, foreign students, temporary workers, etc. (I-688B – 274a.12(b)(1)-(20); I-94; I-185: I-I186; SW-434; I-95A)

CHAPTER M22

FAMIS MOMS

M22 Changes

Changed With	Effective Date	Pages Changed
TN #96	10/1/11	pages 3, 3a
TN #95	3/1/11	pages 4-6 Appendix 1
UP #4	7/1/10	page 10
TN #94	9/1/10	page 3
UP #3	3/01/10	page 2
TN #93	1/1/10	pages 2-10
UP #2	8/24/09	page 3
Update (UP) #1	7/1/09	pages 1, 2, 7 Appendix 1, page 1

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M2200.000 FAMIS MOMS

M2210.100 FAMIS MOMS GENERAL INFORMATION

A. Introduction

The 2005 Appropriations Act directed the Department of Medical Assistance Services (DMAS) to amend the Family Access to Medical Insurance Security Plan (FAMIS) and expand medical coverage to uninsured pregnant women who are ineligible for Medicaid and have income in excess of the Medicaid limits, but whose family income is less than or equal to *200*% of the federal poverty level (FPL). An eligible woman will receive coverage through her pregnancy and 60 days following the end of the pregnancy.

FAMIS MOMS is not an entitlement program, which means that if funds for this program are exhausted, no additional individuals will receive benefits under the program. The DMAS will notify the Department of Social Services (DSS) Central Office if funds for this program run out.

Initial eligibility for FAMIS MOMS is determined by local departments of social services (LDSS), including LDSS outstationed sites, or by the FAMIS Central Processing Unit (CPU). Pregnant women found eligible for FAMIS MOMS receive the same benefits as Medicaid pregnant women.

Eligible women are enrolled for benefits effective the first day of the application month if all eligibility requirements are met in that month. There is no retroactive coverage in FAMIS MOMS. Case management and ongoing case maintenance, and selections for managed care, are handled by the FAMIS CPU.

B. Policy Principles

FAMIS MOMS covers uninsured low-income pregnant women who are not eligible for Medicaid due to excess income, and whose countable income is less than or equal to *200*% of the FPL.

A pregnant woman is eligible for FAMIS MOMS if all of the following are met:

- she is not eligible for Medicaid and has income in excess of the Medicaid limits;
- she is a resident of Virginia;
- she is uninsured;
- she is **not** a member of a family eligible for health benefits coverage under the State Employee Health Insurance Plan on the basis of a family member's employment with a State agency (see Appendix 3 to Chapter M21 for a list of state agencies);
- she is not an inmate of a public institution;

- she is **not** an inpatient in an institution for mental diseases; and
- she has countable family income less than or equal to 200% FPL.

M2220.100 NONFINANCIAL ELIGIBILITY REQUIREMENTS

A. Policy

The pregnant woman must meet, with certain exceptions, the Medicaid nonfinancial eligibility requirements in Chapter M02 and the nonfinancial eligibility requirements imposed by FAMIS.

B. M02 Applicable Requirements

The Medicaid nonfinancial eligibility requirements in Chapter M02 that must be met are:

- citizenship or alien status;
- Virginia residency requirements;
- assignment of rights;
- application for other benefits;
- institutional status requirements regarding inmates of a public institution.

C. FAMIS Nonfinancial Requirements

The FAMIS nonfinancial eligibility requirements are**:**

1. Citizenship & Identity Verification Required

The Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 mandates that, effective January 1, 2010, all applicants for coverage in a Title XXI program must provide verification of citizenship and identity *(C&I).* If the pregnant woman is a United States (U.S.) citizen, *she* must meet the U.S. citizenship requirements in M0220.100. Verification *of citizenship* **is** required; declaration of the woman's U.S. citizenship is **no longer** accepted. However, *as with* Medicaid, *a reasonable opportunity period must be given.*

The *C&I* verification requirements in M0220.100 apply to FAMIS MOMS, *including the use of the Social Security Administration (SSA) data match when a Social Security Number (SSN) has been provided. If an SSN has not been provided, a reasonable opportunity to provide acceptable documentation of C&I must be given.*

If not a U.S. citizen, the pregnant woman must meet the alienage requirements.

2. Alienage Requirements

FAMIS MOMS alienage requirements are the same as the FAMIS alienage requirements.

a. Citizens and qualified aliens who entered the U.S. before August 22, 1996 meet the citizenship/alienage requirements.

b. The following qualified aliens who entered the U.S. on or after August 22, 1996 meet the alienage requirements **without any time limitations**

- refugees (see M0220.310 A. 2),
- asylees (see M0220.310 A. 4),
- veteran or active military (see M0220.311),
- deportation withheld (see M0220.310 A. 6),
- victims of a severe form of trafficking (see M0220.313 A. 5), and
- Iraqi and Afghan Special Immigrants (see M0220.313 A.6)..

c. The following qualified aliens who entered the U.S. on or after August 22, 1996 meet the alienage requirements **after 5 years of residence in the United States:**

- lawful permanent residents (LPRs),
- conditional entrants-aliens admitted pursuant to 8 U.S.C.1153(a)(7),
- aliens paroled in the US pursuant to 8 U.S.C. 1182(d)(5), section 212(d)(5) of the INA, and
- battered aliens, alien parents of battered children, alien children of battered parents.

d. Appendix 3 to Chapter M21 contains a FAMIS Alien Eligibility Chart that lists the alien groups that meet or do not meet the FAMIS MOMS alienage requirements.

3. FAMIS MOMS for Certain Qualified Aliens Ineligible for Full Medicaid Benefits

If a pregnant woman is ineligible for full-benefit Medicaid because the she does not meet the alien status requirements for full-benefit Medicaid, the woman is to be enrolled in FAMIS MOMS as long as she (1) meets the FAMIS MOMS alien status requirements and all other FAMIS MOMS non-financial eligibility requirements and (2) has income less than or equal to 200% FPL. See subchapter M0220 for additional information. This policy does NOT apply to Unqualified aliens, including illegal and non-immigrant aliens, because they do not meet the alien status requirements for FAMIS MOMS. FAMIS MOMS does not provide any emergency services eligibility for unqualified aliens (see M2220.100 C.5, below).

The table below lists the differences between the qualified alien status policies for full Medicaid coverage and FAMIS MOMS coverage for individuals who entered the U.S. on or after August 22, 1996:

Qualified Alien Group (see M0220.400)	***Meets Medicaid alien status requirement for full coverage***	***Meets FAMIS MOMS alien status requirement***
veterans or active military	*yes, with no time limit*	*yes, with no time limit*
refugees; asylees; deportation withheld; Cuban/Haitian entrants; victims of a severe form of trafficking; and Iraqi and Afghan Special Immigrants	*yes, only for first 7 years in U.S.*	*yes, with no time limit*
lawful permanent residents (LPRs),	*yes, only **after** 5 years in U.S. and with 40 qualifying work quarters*	*yes, only after 5 years in U.S., no work requirement*
conditional entrants; aliens paroled in the U.S.; and battered aliens, alien parents of battered children, alien children of battered parents	*No*	*yes, only after 5 years in U.S.*

*If a pregnant woman is ineligible for full-benefit Medicaid because of her alien status **and** her countable income is less than or equal to the Medicaid 133% FPL income limit, the pregnant woman's FAMIS MOMS eligibility determination and enrollment (if she is eligible for FAMIS MOMS) must be performed manually **outside of ADAPT**. If the pregnant woman is eligible for FAMIS MOMS, she is to be enrolled in FAMIS MOMS aid category 005.*

Because this process is a manual determination, the paper case record must be transferred to the FAMIS CPU for ongoing case maintenance. The case transfer must include copies of the application, evaluation of eligibility, proof of income and notice of action. Case transfer procedures are located in M2140.100 E.2.

4. ***Lawfully Residing Non-citizen* Children < 19 Not Applicable**

The *lawfully residing non-citizen* children policy in M0220.314 does NOT apply to the FAMIS *and FAMIS MOMS* programs.

5. **No Emergency Services for Unqualified Aliens**

Unqualified aliens, including illegal and non-immigrant aliens do not meet the alienage requirements. FAMIS MOMS does not provide any emergency services eligibility for unqualified aliens.

6. **SSN not Required**

The applicant is not required to provide an SSN or proof of an application for an SSN.

D. FAMIS MOMS Covered Group Requirements

1. Verification of Pregnancy

Verification of pregnancy, including the expected delivery date, must be provided. Acceptable verification is a written or verbal statement from a physician, public health nurse or similar medical practitioner.

Documentation of how the pregnancy was verified must be included in the case record.

2. Must be Uninsured

The pregnant woman must be uninsured; that is, she must not be covered under any creditable health insurance plan offering hospital and medical benefits. If a pregnant woman has creditable health insurance that does not cover pregnancy, labor and/or delivery services, the pregnant woman is ineligible for FAMIS MOMS because she is insured.

3. IMD Prohibition

The pregnant woman cannot be an inpatient in an institution for mental diseases (IMD).

4. State Employee Health Benefits Prohibition

A pregnant woman is ineligible for FAMIS MOMS if she is eligible for health insurance coverage under any Virginia State Employee Health Insurance Plan on the basis of her or a family member's employment with a State agency. A woman who cannot be enrolled until an open enrollment period is not prohibited from FAMIS MOMS coverage.

See Appendix 2 to Chapter M21 for a list of state government agencies.

M2220.200 HEALTH INSURANCE COVERAGE

A. Introduction

The intent of FAMIS MOMS is to provide health coverage to low-income uninsured pregnant women. A pregnant woman who has creditable health insurance coverage is not eligible for FAMIS MOMS.

B. Definitions

1. Creditable Coverage

For the purposes of FAMIS MOMS, creditable coverage means coverage of the individual under any of the following:

- church plans and governmental plans;
- health insurance coverage, either group or individual insurance;
- military-sponsored health care;
- a state health benefits risk pool;
- the federal Employees Health Benefits Plan;
- *Medicare;*
- a public health plan; and
- any other health benefit plan under section 5(e) of the Peace Corps Act.

The definition of creditable coverage includes short-term limited coverage.

2. Employer-Sponsored Dependent Health Insurance

Employer-sponsored dependent health insurance means the employer pays a portion of the premium payment. COBRA coverage in which the employer makes no contribution to the payment of the premium is not employer-sponsored insurance.

3. Family Member

ONLY when determining whether the pregnant woman is eligible for coverage under a State Employee Health Insurance Plan, "family member" means the pregnant woman's spouse with whom she lives, or her parent(s) with whom she lives when the pregnant woman is unmarried and is under age 23. "Family member" includes the pregnant woman's stepparent with whom she is living if the pregnant woman is under age 21 and her stepparent claims the pregnant woman as a dependent on his federal tax return. State employee health benefits are available to the state employee's unmarried **dependent** child or stepchild under age 23 years.

4. Health Benefit Plan

"Health benefit plan" is defined in the Virginia Bureau of Insurance Regulations (14VAC5-234-30) and means:

- any accident and health insurance policy or certificate,
- health services plan contract,
- health maintenance organization subscriber contract,
- plan provided by a Multiple Employer Welfare Arrangement (MEWA)".

Health benefit plan does NOT mean:

- Medicaid or State/Local Hospitalization;
- accident only;
- credit or disability insurance;
- long-term care insurance;
- dental only or vision only insurance;
- specified disease insurance;
- hospital confinement indemnity coverage;
- limited benefit health coverage;
- coverage issued as a supplement to liability insurance;
- insurance arising out of workers' compensation or similar law;
- automobile medical payment insurance; or
- insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

5. Insured

means having creditable health insurance coverage or coverage under a health benefit plan. A woman is considered to be insured if she is covered by a creditable health insurance plan, even if the policy or plan does not cover pregnancy-related services.

6. Uninsured

means having no insurance; having insurance that is not creditable; having coverage which is not defined as a health benefit plan, or having a health insurance plan that does not have a network of providers in the area where the pregnant woman resides.

C. Policy

1. Must be Uninsured

A nonfinancial requirement of FAMIS MOMS is that the pregnant woman be uninsured. A pregnant woman **cannot:**

- have creditable health insurance coverage;
- have coverage under a group health plan (TRICARE, federal employee benefit plan, private group insurance such as Anthem, etc.) *or Medicare*;
- be a member of a family eligible for health benefits coverage under a State Employee Health Insurance Plan (a full-time, salaried, classified State employee or a permanent, full-time, salaried State education institution faculty member) [see Appendix 3 to chapter M21].

2. Prior Insurance

Prior insurance coverage is not a factor as long as the pregnant woman is uninsured during the month for which FAMIS MOMS eligibility is being determined.

M2220.300 NO CHILD SUPPORT COOPERATION REQUIREMENTS

A. Policy

There are no requirements for FAMIS MOMS applicants or recipients to cooperate in pursuing support from an absent parent.

M2230.100 FINANCIAL ELIGIBILITY

A. Financial Eligibility

1. FAMIS MOMS Assistance Unit

The FAMIS MOMS assistance unit policy is the same as the Medicaid pregnant woman assistance unit policy. Use subchapter M0520, F&C Family/Budget Unit, to determine the pregnant woman's family unit for her financial eligibility determination. If ineligible in the family unit, determine her eligibility in the budget unit (if appropriate). The unborn child(ren) is counted as part of the family unit.

2. Asset Transfer

Asset transfer rules do not apply to FAMIS MOMS.

3. Resources

Resources are not evaluated for FAMIS MOMS.

4. Income

a. Countable Income

The source and amount of all income other than Workforce Investment Act, Supplemental Security Income (SSI) and student income, must be verified and counted. FAMIS MOMS uses the same income types and methods for estimating income as in Medicaid Families & Children (F&C) policy (see chapter M07).

Medicaid F&C income disregards, other than the $30 plus 1/3 earnings disregard in LIFC, apply when determining countable income for FAMIS MOMS (see chapter M07).

b. Available Gross Income

For the application month and ongoing months - available income is the average gross monthly income that is expected to be received in the application and ongoing months. There is no retroactive coverage in FAMIS MOMS.

c. Income Limits

The FAMIS MOMS income limit is 200% of the FPL (see Appendix 1 to this chapter) for the number of individuals in the FAMIS MOMS family unit, or budget unit (if applicable).

5. No Spenddown

Spenddown does not apply to FAMIS MOMS. If countable income exceeds the FAMIS MOMS income limit, the pregnant woman is not eligible for the FAMIS MOMS program and she must be given the opportunity to have a medically needy (MN) Medicaid evaluation.

M2240.100 APPLICATION and CASE PROCEDURES

A. Application Requirements

The following forms are acceptable application forms for FAMIS MOMS:

- Health Insurance for Children and Pregnant Women application**,**
- Medicaid Application for Medically Indigent Pregnant Women
- Application for Benefits, and
- ADAPT Statement of Facts.

Applications can be mailed to the LDSS or the FAMIS Central Processing Unit (CPU). A face-to-face interview is not required.

The date of the application is the date the signed application is received at the LDSS, including DSS outstationed sites, or at the FAMIS CPU.

For applicants under the age of 18, the parent, legal guardian, authorized representative, or an adult relative with whom the child lives must sign the application. The adult relative must be related by blood or marriage.

Documentation of the relationship is not required. The child's parent or legal guardian may designate in writing an authorized representative to complete and sign the application.

For applicants age 18 or older, the applicant, family substitute relative, authorized representative or the guardian can sign the application.

B. Eligibility Determination

1. Pregnant Teenager Under Age 19

When an application is received for a pregnant teenager who is under age 19, is not eligible for Medicaid and has income in excess of the Medicaid limits, process her eligibility in the following order:

a. first, process eligibility as a Medicaid MI child under age 19; if not eligible because of excess income, go to item b.

b. second, process eligibility as a Medicaid MI pregnant woman; if not eligible because of excess income, go to item c.

c. third, process eligibility as a FAMIS child under age 19; if not eligible because of excess income, go to item d.

d. fourth, process eligibility as a FAMIS MOMS pregnant woman. In order to complete the eligibility determination, the FAMIS MOMS nonfinancial requirements in M2220.100 and the financial requirements in M2230.100 must be met. If she is not eligible for FAMIS MOMS because of excess income, she must be given the opportunity to have a medically needy evaluation completed.

2. 10-day Processing

Applications for pregnant women must be processed as soon as possible, but no later than 10 working days from the date the signed application was filed. If all necessary verifications are not received, the application continues to pend until the 45 day processing time limit is met.

3. Notice Requirements

The applicant/recipient must be notified in writing of the required information and the deadline by which the information must be received.

The agency must have all necessary verifications within 10 working days in order to determine eligibility. If all verifications are not received within 10 working days, a Notice of Action on Medicaid and FAMIS Programs (NOA), form #032-03-008 (see subchapter M0130, Appendix 1) must be sent to the applicant. The NOA must state why action on the application could not be taken, specify what documentation is necessary in order to determine eligibility, and give a deadline of at least 10 calendar days to submit the verification.

Once all necessary verifications for the pregnant woman are received, an eligibility determination must be made immediately and the applicant must be notified of the decision.

C. Case Setup Procedures for Approved Cases

Because Medicaid and FAMIS MOMS are separate programs, Medicaid eligible individuals and FAMIS MOMS eligible individuals cannot share the same base case number in the Virginia Medicaid Management Information System (MMIS). Only individuals eligible for the same program (Medicaid or FAMIS/FAMIS MOMS) can share the same base case number in the MMIS.

When an individual is determined eligible for FAMIS MOMS and the individual has family members enrolled in Medicaid, the FAMIS MOMS individual must be given a new MMIS base case number when enrolled.

The local DSS worker cannot change the FIPS code or make any other change to the case after the case has been transferred to the FAMIS CPU in MMIS.

D. Entitlement and Enrollment

1. Begin Date of Coverage

Pregnant women determined eligible for FAMIS MOMS are enrolled for benefits in the Virginia Medicaid Management Information System (MMIS) effective the first day of the application month, if all eligibility requirements are met in that month.

2. No Retroactive Coverage

There is no retroactive coverage in the FAMIS MOMS program.

3. Aid Category

The FAMIS MOMS aid category (AC) is "005."

E. Notification Requirements

Notice must be sent to the pregnant woman informing her of the action taken on the application. The notice must include the eligibility determination results for both Medicaid and FAMIS MOMS.

If the pregnant woman is eligible for FAMIS MOMS, the notice must inform the pregnant woman that the case has been transferred to the FAMIS CPU and that further information on the program will come from the FAMIS CPU.

If the pregnant woman is ineligible for both Medicaid and FAMIS MOMS due to excess income, she must be sent a notice that she is not eligible for either program and must be given the opportunity to have a Medicaid medically needy evaluation completed. Send the notice and an Application for Benefits to the pregnant woman and advise her that if the signed application is returned within 10 days the original application date will be honored.

NOTE: The ADAPT NOA meets the notification requirements. When a NOA is generated by ADAPT, do not send the NOA form #032-03-008.

F. Transfer Case to FAMIS CPU

Once the enrolled FAMIS MOMS case is transferred in MMIS and the notice is sent to the family, the case must be transferred to the FAMIS CPU for ongoing case maintenance.

See chapter M21, section M2140.100 E for the procedures to use when transferring a FAMIS MOMS case to the FAMIS CPU.

G. Transitions Between Medicaid And FAMIS MOMS (Changes and Renewals)

See chapter M21, sections M2140.100 F through J for the procedures to use when an enrollee transitions between Medicaid and FAMIS MOMS.

H. Application *Not* Required for Newborn

The newborn child born to a FAMIS MOMS enrollee is deemed eligible for FAMIS or Medicaid *coverage until his first birthday. A Medical Assistance application is not required until the month in which the child turns age 1. The newborn's eligibility, enrollment and case is handled by the FAMIS CPU.*

M2250.100 REVIEW OF ADVERSE ACTIONS

An applicant for FAMIS MOMS may request a review of an adverse determination regarding eligibility for FAMIS MOMS. FAMIS MOMS follows the procedures established by Medicaid for client appeals (see Chapter M16).

The payment of medical services on the part of any pregnant woman or any right to participate in the program is not subject to review if the reason for denial or cancellation is that funds for the FAMIS MOMS program are exhausted.

FAMIS MOMS INCOME LIMITS ALL LOCALITIES EFFECTIVE *1/20/11*		
# of Persons in FAMIS MOMS Assistance Unit	**FAMIS MOMS 200% FPL**	
	Annual Limit	Monthly Limit
2	*$29,420*	*$2,452*
3	*37,060*	*3,089*
4	*44,700*	*3,725*
5	*52,340*	*4,362*
6	*59,980*	*4,999*
7	*67,620*	*5,635*
8	*75,260*	*6,272*
Each additional, add	*7,640*	*637*